GLOBAL ACTION ON MEN'S HEALTH

NO MAN'S LAND

How men are considered in global primary health care policy

Natalie H Leon and Christopher J Colvin

A report from Global Action on Men's Health

GLOBAL ACTION ON MEN'S HEALTH

Global Action on Men's Health (GAMH) was established in 2013, launched during International Men's Health Week in June 2014 and registered as a UK-based charity in May 2019. GAMH brings together organisations and others with an interest in men's health in a new global advocacy network.

GAMH's mission is to create a world where all men and boys have the opportunity to achieve the best possible health and wellbeing wherever they live and whatever their backgrounds. Far too many men and boys suffer from health and wellbeing problems that can be prevented. Globally, male life expectancy at birth is just 71 years but poor male health is not sufficiently recognised or effectively tackled by global health organisations or most national governments..

GAMH wants to see:

- Global health organisations and national governments address the health and wellbeing needs of men and boys in all relevant policies.
- Men and boys encouraged and supported to take better care of their own health as well as the health of their partners and children.
- Health practitioners take greater account of the specific needs of men and boys in service delivery, health promotion and clinical practice.
- Other agencies and organisations, such as schools and workplaces, helped to be more aware of their significant impact on the health of men and boys.
- Sustained multi-disciplinary research into the health of men and boys.
- An approach to health that fully recognises the needs of both sexes in policy, practice and funding and which promotes greater gender equality.

GAMH uniquely represents a wide range of organisations and individuals with experience of policy development, advocacy, research and service delivery. GAMH's focus is primarily on public health and the social determinants of health, it is concerned about a broad and cross-cutting range of men's health issues and has a strengths-based view of men and boys.

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ABBREVIATIONS

GAMH	Global Action for Men's Health
LMIC	Low and middle-income country
NCDs	Non-communicable diseases
PHC	Primary Health Care
SDG	Sustainable Development Goals
UHC	Universal Health Coverage
WHO	World Health Organization

Foreword

“There are two main explanations for men’s sub-optimal use of primary care. The first is that many men … are reluctant to ask for help. The second is that services are not delivered in ways that men find easy to use.”

Men’s use of primary care services is a critically-important issue in men’s health. We know that men, especially men of working age, make less use of primary care services than women. We also know that men are less likely to be diagnosed, or are diagnosed later, with conditions like hypertension and diabetes or mental health problems.

There are two main explanations for men’s sub-optimal use of primary care. The first is that many men, because of male gender norms such as stoicism and self-reliance, are reluctant to ask for help. The second is that services are not delivered in ways that men find easy to use. Inconvenient opening times, difficult-to-navigate appointment booking systems and long waiting times are among the commonly-cited practical barriers for men. These two explanations are by no means exclusive; in fact, they almost certainly interact to prevent too many men from receiving the diagnoses, advice, treatment and care that could significantly improve their health outcomes.

However, as No Man’s Land shows, men’s use of primary care is almost completely overlooked in global health policy. Of the 27 primary healthcare-related policy reports reviewed in this study, only two engaged explicitly with men’s health needs. While the reports commonly acknowledged gender as an important social determinant of health this was not translated into an analysis of men’s needs and recommendations about how they can be addressed.

Our research provides GAMH and the men’s health sector, nationally and globally, with the evidence base to make the case for a new approach to policy. This has to be an approach that takes proper account of gender and which works to improve the health of everyone, males and females as well as gender-diverse people.

There is already good evidence about what needs to be done, such as offering services at convenient times (fitting around full-time work, for example), going to where men are (workplaces, sports venues, faith organisations, etc) and developing targeted health promotion. Male-specific clinics, e-Health programmes, inviting men to attend health checks and the potential role of community pharmacy services, which are far easier to access than general practice, should also be explored..

It is no accident that GAMH chose to publish No Man’s Land on Universal Health Coverage Day 2024. Universal Health Coverage (UHC) means that all people have access to the full range of quality health services they need, especially primary care, when and where they need them, without financial hardship. UHC is firmly based on the WHO Constitution which declares health a fundamental human right and commits to ensuring the highest attainable level of health for all. UHC will never become a reality if too many men continue to be left outside the doors of primary care.

Peter Baker, Director,
Global Action on Men's Health

“There are important gender differences in utilization of primary care level services, and evidence of the underutilization of primary health care services by men.”

Executive summary

Background

Global health policies provide guidance for global, regional, and national priorities to improve population health, including addressing health inequities. Gender and gender inequality are amongst the social determinants that are known to drive inequities in health and health care. Gender equality strategies in global health policies have, however, largely been equated with addressing social and structural determinants of women’s health (e.g., income inequity, sexual violence and exploitation, unpaid care and domestic work). Important gains have been made in women’s health equality, in part due to policy prioritisation and international gender equality targets like the Sustainable Development Goals (SDGs). Gender-specific surveillance of the health problems of men, however, has not been prioritised and inequities in men’s health have mostly been overlooked by global, regional, and national health organisations.

There are many reasons to extend the focus on addressing gender inequities in men’s health. Globally and nationally, there is increasing recognition of the inequitable gender-related health gaps related to men’s burden of disease. For instance, men confront significant and persistent inequities in burden of disease for a range of health problems, many of which require early access to effective primary care level preventive, promotive, diagnostic and curative health services. Men have disproportionately higher burden of infectious compared to women for TB, and non-communicable diseases (NCD) account for the highest proportion of deaths in men (70%), with cardiovascular disease and cancers accounting for 67% of deaths. Men also have high prevalence of high blood pressure and diabetes. Men have substantially higher mortality from suicide (in some settings, as much as four times higher compared to women), even as women have two to four times higher rates of attempting suicide. Not surprisingly, men also have higher exposure to risk factors for poor health outcomes such as harmful alcohol and tobacco use, and they have higher mortality from injury and violence, including from homicide.

There are important gender differences in utilisation of primary care level services, and evidence of the underutilisation of primary health care (PHC) services by men. This includes not seeking health care when needed and delaying care, resulting in more severe symptoms when presenting for health care. Men also engage less consistently and less successfully in care once linked. A range of barriers have been identified as underlying this underutilisation of PHC services by men, including individual and social factors related to restrictive gender norms of masculinity, self and community stigma as well social, organisational, and structural factors that limit access for men. A robust and progressive policy response will require action on the individual, family, community, social and structural levels. In this report, though, we are focusing on the part played by

access to and engagement in PHC services as an important part of the policy puzzle to understand and address. This report reviews the extent to which global and regional policy-related documents consider men's access to and engagement with PHC, and what, if any, gender-responsive considerations for men are included in these reports.

Methods

The methodological approach drew on rapid review methods to identify, map and synthesise relevant information. Rapid review techniques balance the need for timely results with a commitment to maintaining the robustness, meaningfulness, transparency, and trustworthiness of the findings. The websites of key organisations were searched for primary care policy relevant documentation. Twenty-seven (27) reports were included for analysis, using specified purposive sampling criteria. Data was extracted for each report for the domains in the data extraction template. This data was used in a within and across case analysis, to map and synthesise the information on different elements and themes related to engagement in men's health.

Findings

Policies from the World Health Organization (WHO) were in the majority (16/27). Others were from UNICEF, the World Bank, the United Nations, and related organisations such as UHC 2030. Three non-state global agencies were included, that is, the NCD Alliance, Primary Care International, and World Association for General Practitioners (WONCA). Policies were also sampled to represent the life-course (child and adolescents, adults, and the elderly), and health risks (including substance abuse and injury and violence). The following are key findings:

- Few reports provided sex-disaggregated data to show gender distribution of disease and none provided data on sex or gendered patterns of access to and utilisation of PHC. There was nevertheless widespread recognition of the value of disaggregated data for analysing and addressing inequity associated with social determinants of health and illness, including the need for sex- and gender-disaggregated data.
- References to gender as a determinant of health and illness was common across reports, usually in the context of acknowledging the influence on health of a range of social determinants, including gender.
- While gender equity and gender responsiveness were considered important guiding principles, this was mostly interpreted as referring to gender inequities in women's health.
- Overall, there was little engagement with men's health needs across the reports reviewed. Only six out of 27 (22%) of the reports reviewed made any mention of men's health alongside that of women and only two reports (7% of all reports reviewed) engaged more explicitly with men's health needs.

- The two WHO reports (one on PHC monitoring and one on adolescent health) that showed more engagement with men's health needs did so by more explicitly highlighting gender disparities in PHC health needs for both women and men. These reports described the gendered distribution of risks and illness for both genders, applying a gender lens for analysing gender inequity in patterns of disease, access to and use of primary care services, and acknowledging the need for gender responsive services for both women and men. Even though both these reports prioritised women's health equity, their balanced approach allowed for explicit engagement with men's health needs, which was not the case in other reports.
- The health and well-being of prisoners was addressed in one report. This is of relevance as men are overrepresented in the prison population.
- Gender-mainstreaming was recommended as an approach to address gender equity in health services in a few reports, but with minimal PHC-based strategies to address inequity in men's health.

Discussion and recommendations

"The report outlines recommendations in three areas for moving men up in the global PHC policy agenda."

Given the relative lack of substantive attention to questions of gender and men in these global PHC related policy documents, it is important to think more deeply about where the windows of opportunity might be for increasing recognition of men's PHC needs. The report outlines recommendations in three areas for moving men up in the global PHC policy agenda. The first is the need to better understand the problem, which requires us to generate, make accessible, and use robust, nuanced, and diverse evidence that recognises the diversity of men's health needs. The second area is the need to develop, implement and evaluate evidence informed policy options that are holistic, integrated, feasible and scalable. This requires both consolidating and building on emerging evidence of best practices for men and leveraging lessons from the growing number of national and regional level men's health policies. The third area is the need to form alliances and opportunities for advocacy and political support to make strategic use of both predicted and unpredicted situations to move men up in the PHC policy agenda. This involves engaging in the political environment, building long-term coalitions and networks with individuals and institutions working across public health issues, which may include leveraging parallel policy developments for women and in priority health conditions.

"Gender-specific surveillance of the health problems of males … has not been prioritized and inequities in men's health have mostly been overlooked by global, regional, and national health organisations."

Background

Global health policies provide guidance for global, regional, and national priorities to improve population health, including addressing health inequities. Health equity in health is defined as "absence of systematic and potentially avoidable, unfair and unjust differences in health outcomes between social groups, and is a key health system goal".[1] Sex and gender are amongst other social determinants that are known to drive inequities in health and health care.[2, 3, 4]

Gender equity strategies in global health policies, however, have largely been equated with addressing women's health, in response to the disproportionately negative impact of gender inequality on the health and well-being of women, along with the need to ensure high-quality maternal and child health services. Important gains have been made in women's health equity, in part due to policy prioritisation and international gender equity targets like the Sustainable Development Goals (SDGs).[5] Gender-specific surveillance of the health problems of males, however, has not been prioritised and inequities in men's health have mostly been overlooked by global, regional, and national health organisations.

There are several reasons for incorporating men into the framework of gender equity for health. First, men confront significant and persistent inequities in burden of disease for a range of health problems. They have disproportionately a higher burden for some infectious disease compared to women. For example, men and boys accounted for 64% of TB cases globally in 2017.[6] Men face a higher burden in non-communicable diseases (NCDs), with NCDs accounting for the highest proportion of deaths in men (70%).[6] Of this, cardiovascular disease and cancers account for 67% of deaths, especially liver and stomach cancer, with lung, colorectal and prostate cancers being the most diagnosed.[6] It is estimated approximately one in nine men and one in twelve women died from cancer in 2020.[7] It includes higher incidence and mortality compared to women from lung and colorectal cancer, the two leading causes of cancer deaths globally.[7] Nearly a quarter of men over age 15 had high blood pressure, and 8.8% had high fasting blood glucose in 2015.[6] Men also have substantially higher mortality from suicide (in some settings, as much as four times higher compared to women), even as women have two to four times higher rates of attempting suicide.[6] Not surprisingly, men also have higher exposure to risk factors for poor health outcomes such as harmful alcohol and tobacco use, and they have higher mortality from injury and violence, including from traffic accidents and homicide.[8, 9, 10]

Recognition of these kinds of health inequities in global policy can have important impacts in terms of prioritising focus, actions, resources and monitoring impact, on global, regional, and national levels. Health equity and especially gender equity, is considered a guiding principle in many global health policies. For example, the "Lancet Commission on peaceful societies through health equity and gender equality",[11] highlighted the broader social, economic and political benefits of gender equity in health,

noting that “Improvements to health equity and gender equality can catalyze change in economic systems, social systems, and governance, prompting societies out of harmful cycles and into beneficial ones.”[11]

As part of the broader mission of health equity, global policies need to recognise the health and well-being needs specific to men and to promote interventions that can effectively address these needs.[4, 12, 13, 14] Globally and nationally, there are now several academic centres, international NGOs and advocacy groups bringing greater focus to equity in men’s health, to address the growing evidence on men s health inequities. Several countries have developed national policies that focus on improving male health, notably Australia, Brazil , Iran, Ireland, and more recently, Malaysia, Mongolia, the Philippines, and South Africa.[8,12] In 2018, the WHO’s European Region also published a strategy on the health and well-being of men covering its 53 member States.[15] These male health-focused policies are a major step forward. This momentum should be extended to key areas where men face a specific inequitable burden of disease, including in PHC services, where there is opportunity for illness prevention, health promotion, and treatment at the first point of care for majority of the population. people.

Men and Primary Health Care

There are many drivers of the burden of disease inequities in men’s health described above, including the influence of individual and societal level gender norms associated with masculinity, increased exposure to health risks for a variety of economic and social reasons, and systemic health system factors that limit health seeking and optimal health care.[6 ,13 ,14, 16,17] One important factor is access to PHC services. Many of the infectious and non-communicable diseases affecting men could benefit from appropriate utilisation of preventive, promotive, diagnostic and curative PHC services, yet men are underutilising PHC services.[3, 4, 13, 17, 18] This further impacts their burden of disease, leading to problems of late or missed diagnosis, poor linkage to care and unnecessarily poor treatment outcomes.[4, 6, 19]

“Many of the infectious and non-communicable diseases affecting men could benefit from appropriate utilization of preventive, promotive, diagnostic and curative PHC services, yet men are underutilizing PHC services.”

The Alma-Ata Declaration defines primary care as “the first level of contact for the population with the health care system, bringing health care as close as possible to where people live and work”[1] and notes that PHC should address the main problems in the community, providing preventive, curative, and rehabilitation services. An important distinction should be made between the generic terms ‘primary health care’ which refers to provision of basic preventive and curative services at the first point of health care, and the comprehensive and holistic approach to population health that is intended by the Primary Health Care (PHC) Approach, as outlined in the Alma Ata Declaration of 1975 and reaffirmed by in the 2018 Declaration of Astana.[1, 20, 21, 22]

The PHC approach has the three core functions namely PHC service provision, multisectoral actions and the empowerment of citizens.[1, 20] PHC services encompass a wide range of preventive, promotive and curative services, for a range of different health needs, across the full lifespan.[1, 20]

These include basic biomedical and pharmacy services, additional health services (such as dentistry, optometry), and allied and rehabilitation related health services (such as physiotherapy, occupational therapy, dietetics). PHC services are usually delivered through public and or private sector health care facilities (clinics, outpatient services), general practitioner, via pharmacies and in some settings via community-based and non-governmental health services. Effective PHC services can be thought of as composed of the "4Cs of primary care", which are "first contact, continuous, comprehensive, and coordinated care." [1]

In addition to access to primary care services as the first point of care, the PHC principles of prevention of disease and promotion of health require multisectoral collaboration (across health programmes and other public social and welfare sectors). Effective PHC also requires citizen engagement to promote individual and community level empowerment, agency, and partnership with health services. These PHC principles provide a vehicle for addressing health equity in a comprehensive way (beyond clinical care), through consideration of underlying sex and gender and other individual, social and structural reasons for health inequities.[1, 2, 20]

Appropriate utilisation of primary care health promotion, illness prevention and curative services is thus clearly vital in promoting optimal health of the population. There are important gender differences in utilisation of these services, however, and evidence of the underutilisation of PHC services by men.[3, 4, 13, 17, 18] This includes not seeking health care when needed and delays in seeking health care, resulting in more severe symptoms when presenting at health care services, as well as engaging less consistently and successfully in care once linked. For instance, despite the increased prevalence of TB among men, compared to women, men were less likely to access TB care, delayed seeking care, and had lower treatment completion rates and worse health outcomes.[6] Men also perform poorly throughout the cascade of HIV care compared to women, with lower rates of HIV testing, coverage of and retention in antiretroviral treatment, and with higher mortality rates.[6, 19] While men's need for mental health services may be increasing, especially given their higher suicide mortality, men are still less likely to access mental health care and receive treatment.[6] One barrier is that depression may be underdiagnosed amongst men compared to women, in part be due to gender bias amongst clinicians. Clinicians may not recognise depression when men's emotional distress presents differently from women. For example, distress in men may present with more externalised behavioral disturbances such as substance abuse and aggression, and clinicians may not recognise this as depression symptoms, which may further reduce access to mental health care for men.[4, 6, 8, 17]

Report Rationale and Objectives

A range of barriers have been identified as underlying this underutilisation of PHC services by men, including individual and social factors related to restrictive gender norms of masculinity, self and community stigma as well social, organisational and structural factors

that limit access for men.[4, 13, 17, 18] Many of these factors also shape the other causal pathways that drive the numerous systematic, avoidable, and inequitable differences in health outcomes in infectious and non-communicable diseases, mental health, harmful substance use, injury and violence that men confront. A robust and progressive policy response will require action on all these individual, family, community, social and structural levels. In this report, though, we are focusing on the part played by access to and engagement in PHC services as an important part of the policy puzzle to understand and address.

This report reviews the extent to which global and regional policy-related documents consider men's access to and engagement with PHC, and what, if any, gender-responsive considerations are included in these reports. Specifically, the objectives of this report are to:

- Describe the level and type of unmet need among men in relation to PHC services, with attention to specific sub-populations of men and a variety of health outcome measures.
- Assess the ways in which men are currently considered in global and regional policies on PHC, including policies on Universal Health Coverage (UHC).
- Make specific policy recommendations with respect to both:

    a. Evidence-based policy strategies for better supporting and engaging men in primary care health services, and

    b. Policy advocacy strategies that global, national and local advocates might make use of when promoting better inclusion of men's needs in primary care.

"The review identified around 90 potentially relevant documents of which around 60 were eligible for inclusion. From these, a sample of 27 was selected for analysis."

Methods

Overall methodological approach

The methodological approach drew on rapid review methods to identify, map and synthesise relevant information. This approach involved developing a protocol guide and a stepwise process of searching and screening records for relevance, reviewing eligible full-text records, identifying eligible records and extracting data relevant to the questions of interest, and then synthesising the data. Rapid review techniques balance the need for timely results with a commitment to maintaining the robustness, meaningfulness, transparency, and trustworthiness of the findings.[23]

Searching

The review identified and categorised the relevant organisations working in the field of global PHC policy and searched their websites for their most recent policy-related documentation. Policy can mean many different things, so a variety of sources were looked for including policy documents and resolutions, policy and practice guidelines, strategic plans, progress reports, and best practice recommendations.

The focus was on global level policy organisations, both government and non-governmental agencies, as well as on policy making stakeholders in PHC and related health, research, and advocacy agencies. These included international health agencies concerned about health, mainly World Health Organization (WHO) and related inter-governmental organisations concerned with global health, as well as professional and advocacy organisations associated with promoting the PHC approach.

An iterative search process was used to identify further sources of information, starting with organisations listed in the protocol and identifying more organisations by following leads found in the reports, as well as doing open searches. Suggestions were also gathered from the GAMH Executive members.

Selection of records for inclusion

The websites of key organisations were searched for policy relevant documentation. The following kinds of documents were excluded: regional and national level policy documents, academic papers, except if it related to a Lancet Commission (as the latter is aimed at supporting global policy development), and multi-media data sources that were not presented as a policy-relevant reports (such as multi-media webpages, blogs, webinars, or conference presentations).

The review identified around 90 potentially relevant documents of which around 60 were eligible for inclusion. From these, a sample of 27 was selected for analysis. As this was a rapid review extracting mostly qualitative data, sampling was required to ensure a manageable number of reports for analysis. This was balanced against ensuring the sample is a fair representation of the underlying set of eligible reports and the need to reach data saturation. Purposive sampling criteria included the need to have a comprehensive set of topics in relation to research question, from key organisations that contribute to global PHC policy. Sampling covered multi-national agencies, non-governmental organisations, advocacy, and funding organisations. Most (16/27) were policies of the World Health Organization (WHO). Others were from UNICEF, the World Bank, the United Nations, and related organisations such as UHC 2030. Three non-state global agencies were included, that is, the NCD Alliance, Primary Care International, and World Association for General Practitioners (WONCA). Policies were also sampled to represent the life-course (child and adolescents, adults, and the elderly), and health disorders (including health risks of substance abuse). The most up-to-date documents were prioritised.

Data extraction and synthesis

A set of data extraction domains was developed, based on the questions of interest stated in the protocol, and then adapted based on the emerging data from the reports. If and how men were considered in the policy documents was the key issue of interest. Where there was little direct information on the PHC needs of men in these documents, different sources that could provide an indirect measurement of whether sex and/or gender were examined such as provision of sex-disaggregated data, and or whether the report considered male-dominated target groups (such as people in prison, in the military and veterans). This review also looked at policies on risk factors where males are at high risk, such as substance abuse and injury and violence.

A set of terms to search for relevant information was developed for the following areas: the presence of sex-disaggregated data, reference to gender determinants and gender equality/equity, the context of reference to men and women, gender-differentiated health needs, access to and utilisation of primary care, and if sub-groups were considered where men are more predominant.

Data extraction also looked at whether a gender lens was applied to explaining the underlying cause of gender disparities and if gender-responsive strategies were recommended to address men's health needs. As part of the data extraction, a quick overview of the purpose and scope of the report was done to understand the broader context of each report.

The set of search terms was then used via the Find function in the PDF formats of the papers to identify the relevant areas of the report for review. A Word document was created to extract data on whether key terms appeared in the document, how many times, and information that related to any of the key measures of interest was extracted and pasted.

To map and synthesise the information, an Excel spreadsheet was created to map the key areas of data extraction for each report. Within and across case analysis was done to analyse and synthesise the main categories and themes.

Findings

Overview of included policy related documents

A total of 27 reports were analysed. Table 1 provides an overview of the global PHC policy-relevant documents included for analysis. The table details the type of PHC organisations that authored the reports, the organisation's name, report title and date of publication. The table shows how reports contributed or not, to the key areas of data extraction. Data was extracted on the extent to which the reports engaged with gender and especially with the PHC related health needs of men. This included checking if and how much sex-disaggregated data was reported whether gender was discussed as a determinant of health and health equity. The report noted the extent to which there was engagement on the health needs of men, including PHC access, utilisation, and care amongst men, and with gender-responsive health strategies for men in the PHC context. Where studies contributed data to these areas, this was marked with an X. In places where there was very little data, this was shown with the addition of an asterisk (*). No data was left blank.

Table 1. Global primary health care policy relevant documents

		Sex disag-gregated data	Gender as determi-nant	Women's PHC needs	Men's PHC needs	Gender respon-sivness re: men
	Global state health policy organisations: WHO general PHC policy					
1	WHO and UNICEF 2020. Operational framework for primary health care-transforming vision into action[24]		X			
2	WHO 2019. Primary health care on the road to universal health coverage- 2019 monitoring report[6]	X	X	X	X	X
3	WHO 2019. Thirteenth General Programme of Work, 2019–2023[25]		X	X		
4	WHO 2023. What worked? What didn't? What's next? 2023 progress report on the Global Action Plan for Healthy Lives and Well-being for All[26]		X*	X		
5	WHO 2023.WHO youth led statement PHC policy & practice for better results[27]		X*	X*		
6	WHO and World Bank 2022. Tracking universal health coverage- 2023 global monitoring report (GMR)[28]			X		

Table 1. Global primary health care policy relevant documents

		Sex disaggregated data	Gender as determinant	Women's PHC needs	Men's PHC needs	Gender responsivness re: men
	Global state health policy organisations: WHO general PHC policy					
7	WHO 2023. Civil-society commentary on the 2023 UHC Global monitoring report[29]			X		
8a	WHO 2023. World Health Statistics 2023-monitoring health for the SDGs[9]	X	X	X	X*	
8b	WHO 2016. Framework on integrated people-centered health services (IPCHS) for strengthening health systems[30]		X			
8c	WHO 2024. Implementing the PHC approach. A primer (draft)[1]		X*	X		
	Global state health policy organisations: WHO policy for targeted PHC areas					
9	WHO 2021 Development of Implementation roadmap 2023–2030 for Global action plan for NCDs[31]			X*		
10	WHO 2021. Global alcohol action plan 2022-2030 to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol[32]	X*	X	X		
11	WHO 2022. Preventing injuries and violence-an overview[33]	X	X	X	X*	
12	WHO 2019. World report on vision[34]	X	X	X	X*	
13	WHO 2018. Report on Integrated care of older people. Realigning primary health care to respond to population ageing[35]					
14	WHO 2023. Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation[36]	X	X	X	X	X*
	Other state global health policy organisations					
15a	United Nations General Assembly 2023 Oct. Political declaration of the high-level meeting on universal health coverage[47]		X*	X		
15b	United Nations SDG Group 2022. Operationalizing Leaving No One Behind. Good Practice note for UN Country teams[37]		X	X		

Table 1. Global primary health care policy relevant documents

		Sex disaggregated data	Gender as determinant	Women's PHC needs	Men's PHC needs	Gender responsivness re: men
16	United Nations 2023 The SDG report 2023. Special edition. Towards a Rescue Plan for People and Planet[38]	**X**	**X**	**X**	**X***	
17	UHC2030 2022. Action on health systems, for universal health coverage and health security. A UHC2030 strategic narrative to guide advocacy and action[39]			**X**		
18	UHC2030 2023. From commitment to action. Action agenda on universal health coverage from the UHC movement 2023 UN High-Level Meeting on Universal Health Coverage[21]			**X**		
19	Allies improving PHC 2023 March. Make This Time Different. Prioritize Primary Health Care as a 3-for-1 Investment Towards Health for All. Open letter to prioritize PHC across UN high level mtgs[40]			**X***		
20	Barış et al 2022. World Bank report. Walking the Talk- Reimagining PHC after COVID-19 [41]	**X***	**X**	**X**		
21	Organization of Economic Cooperation and Development (OECD) (2020). Realising the Potential of Primary Health Care[42]		**X**	**X**		
	Global non-state health policy organisations					
22	Primary Care International (PCI) 2022. Annual Report[43]					
23	NCD Alliance 2023. Advocacy Priorities. For the 2023 United Nations High-Level Meeting on Universal Health Coverage[44]					
24	Chetty 2015 The role of PHC improving health equity WONCA Health Equity Special Interest Group (commentary)[45]					

Total = 27 reports

Gender through provision of sex-disaggregated data

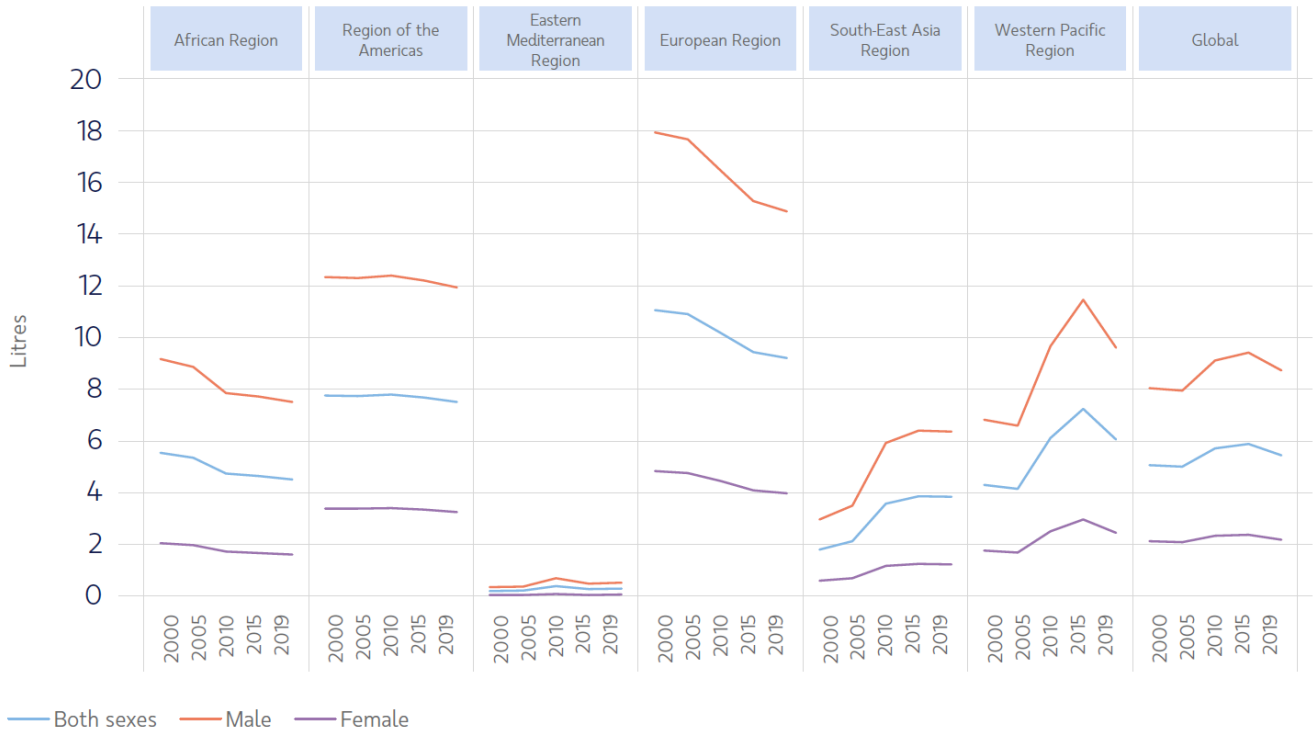
A quick way to examine if and how men have been considered in policymaking is to see whether policy documents provided sex-disaggregated data, and the scope of this data. Sex-disaggregated data give a breakdown by sex of a range of different disease prevalence and outcome measures. Sex-disaggregated data is a crucial first step in understanding and addressing gender disparities that may exist in mental health risk and prevention, service access, and treatment outcomes. When sex-disaggregated data is presented alongside data that is disaggregated by other social determinants such as age, ethnicity, minority, and disability status, it provides opportunity for analysis of underlying disparities in PHC-related health promotion, disease prevention and care.

In most of the reports reviewed (19/27), sex-disaggregated data was either absent or limited in scope and depth. This also applied to disaggregated data on other social determinants. None of reports from non-state organisations included any sex-disaggregated (report #22, 23, 24).[43-45]

Sex-disaggregated data of disease burdens in PHC was provided in 8 out of the 27 reports reviewed. The bulk of these were WHO reports (report # 2, 8a, 10, 11, 12 and 14), [6, 9, 32-34, 36] with one UN report on monitoring progress in SDGs (report #16),[38] and one, from the World Bank, on PHC after COVID (report #20).[41] The amount and scope of the sex-disaggregated data provided differed across these reports. The most data were provided in

Box 1. Alcohol consumption per capita across WHO regions[9]

Figure 1.8 Total alcohol consumption per capita (age 15 years or older), WHO regions and global, 2000–2019



four reports, three of which were monitoring reports where the focus was on statistical representation of global progress in PHC, UHC and/or SDGs. The three monitoring reports were titled: "WHO 2019 Primary health care on the road to universal health coverage - 2019 monitoring report" (report #2),[6] "WHO 2023. World Health Statistics 2023 - Monitoring Health for the SDGs" (report #8a),[9] and "United Nations 2023 The SDG Report 2023. Special Edition. Towards a Rescue Plan for People and Planet" (report #16).[38]

The WHO 2023 World health statistics SDG monitoring report provided data on sex-differentiated alcohol consumption. This was illustrated in a diagram on sex-disaggregated trends in alcohol consumption globally, per WHO region, over the past 2 decades. This diagram is shown in the Figure 1.8, (extracted in Box 1 above) show the sex-distribution of risk from alcohol consumption (report #8a).[9] The data in this figure highlights the higher risk from alcohol consumption amongst males across all WHO regions (see the top, red line for males in each region).

In the WHO SDG monitoring report, the diagram was accompanied by an explanation that highlighted the higher male burden of alcohol consumption globally and across WHO regions. (For ease of reading, key sections of quotes are highlighted in bold).

> **Globally, men consumed nearly four times more pure alcohol per capita than women did – namely, 8.7 (UI: 7.7–9.9) liters versus 2.2 (UI: 1.9–2.5) liters in 2019**. The greatest gaps between the sexes (male-to-female ratio) were observed in the Eastern Mediterranean Region (8.1) and South-East Asia Region (5.1), and the lowest ratio was in the Region of the Americas (3.7) and the European Region (3.7).[9] (pg.11)

Reports listing sex-disaggregated data usually provided only one or two sets of figures on sex-disaggregated disease burden (in table, diagram or in narrative form). When reports provided comparative sex-disaggregated data, in most cases, there was little to no further engagement to highlight clear gendered inequities. For example, though the WHO SDG report and other reports (report #8a, 10, 20)[9, 32, 41] provided figures showing much higher alcohol consumption for males, the reports did not draw attention to this as an inequitable health risk for males. Nor did these reports make any mention of the need for PHC services to have male-specific interventions to respond to this disproportionate health risk.

When reports did highlight a gendered pattern in disease distribution, this was usually to focus attention on women's health needs. Even where little to no sex-disaggregated data was provided, the prioritizing of women's health needs was evident throughout most reports. Women's health needs were prioritized in relation to the disproportionate negative effects of women's gender inequality, the need for effective maternal and child health services, and the need to address high priority sex-specific cancers (breast and cervical cancers).

With respect to access to PHC, data on monitoring of gendered patterns in PHC access was largely absent in these reports. This absence was found even in reports that focussed on monitoring PHC services in particular (report #2),[6] as well as monitoring UHC (report #6)[28] and SDGs (report #15b, 16, 17, 18).[21, 37-39] Sex-disaggregated data on access and universal

coverage in PHC is important to understand gendered patterns and to address any gender-related inequities, especially given the known disparities in access for men.

Two reports stood out for engaging with sex-disaggregated data that went beyond presenting sex-disaggregated data, and that showed recognition of men's health needs. The first is the WHO 2019 PHC monitoring report (#2)[6] and the second is the WHO 2023 adolescent health report (#14).[36] Both reports highlighted gendered patterns and disparities in disease for both women and men. The reports illustrate the health burden of boys and men alongside the health burden of girls and women, in a relatively even-handed manner. This stood in sharp contrast to the rest of the reports, where engagement with gender disparities was in relation to women's health needs only.

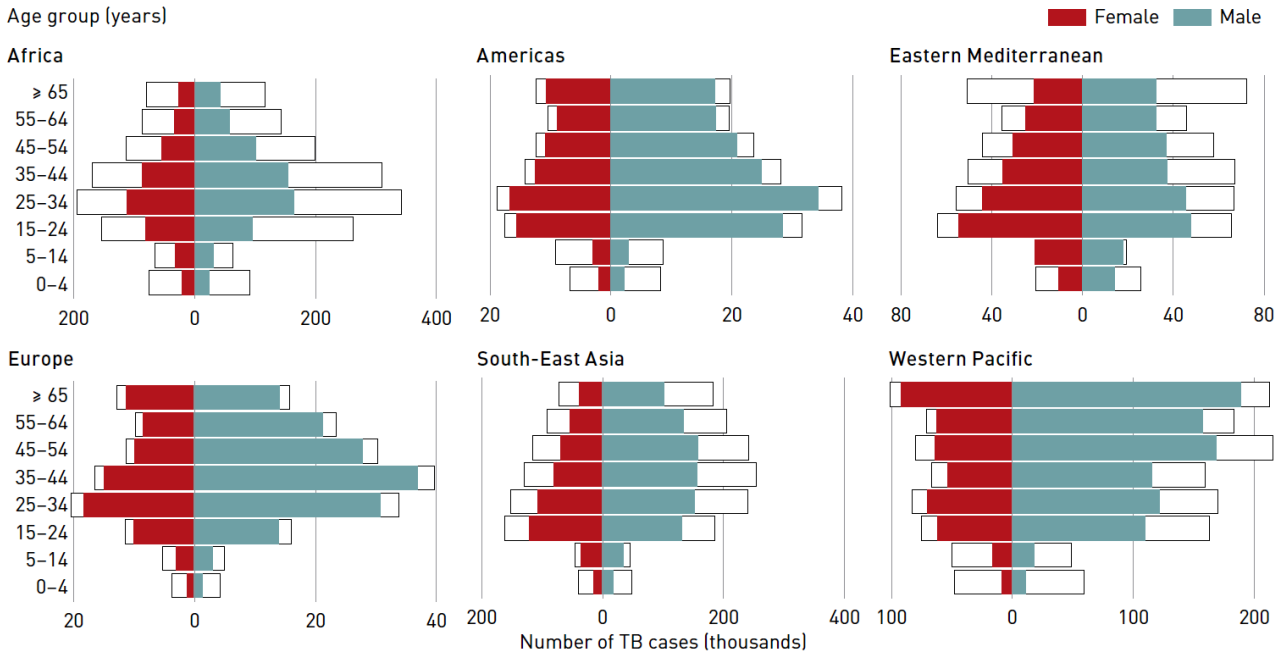
But even these two reports, the authors did not provide data on gender-differentiated patterns in PHC access. Nevertheless, these reports detailed men's health burden of disease in relation to the need for primary care. One example from the WHO 2019 PHC monitoring report, is Figure 3.9 shown in the Box 2 below. Figure 3.9 focussed attention on the higher burden of TB prevalence amongst men across most health regions.[6]

In the accompanying narrative, the WHO 2019 PHC monitoring report noted that despite higher TB prevalence amongst males, there is lower detection and reporting of TB amongst men. This points to barriers for men in access to TB care at the primary care levels. [6]

Box 2. Gender-differentiated TB prevalence showing lower detection and reporting rates in most WHO regions[6]

FIGURE 3.9 Although TB prevalence is higher among men than women, men have lower detection and reporting rates in all WHO regions except Europe and the Americas

Regional estimates of TB incidence and case disaggregated by age and sex, 2017



Source: WHO Global Tuberculosis Report 2018 *(81)*.

"In summary, few reports provided sex-disaggregated to show the gender distribution of disease and none provided data on gendered patterns of access to and utilization of PHC."

In summary, few reports provided sex-disaggregated to show the gender distribution of disease and none provided data on gendered patterns of access to and utilization of PHC. While most reports did not provide substantial sex-disaggregated data, there was widespread recognition of the importance of disaggregated data for analysing and addressing disparities associated with social determinants of health and illness. Several reports called for more data to be disaggregated by gender and other social determinants (for instance, in reports #2, 3, 4, 5, 6, 8a, 14, 17, 18, 20, 23).[6, 9, 21, 25, 26, 27, 28, 36, 39, 41, 44]

Consideration of gender as a determinant of health

Gender as a determinant of health and disease

To examine whether reports engaged with gender beyond merely presenting sex-disaggregated data, this review looked at whether and how the concepts of gender, gender inequality and gender equity were used in these reports. Questions included: To what extent did the reports identify gender as a social determinant of health and health care access, and in what way were gender inequity and responsiveness in policy and practice for both genders addressed?

More than half of the reports (17/27) referred to gender as a determinant of health and illness (#1, 2, 3, 4, 5, 8a, 8b, 8c, 10, 11, 12, 14, 15a, 15b, 16, 20, 21). [1, 6, 9, 25-27, 30, 32-34, 36-38, 41, 43,46, 47] References to gender as a determinant were most often cursory in nature, limited to a few statements that gender is an important factor influencing the distribution of health and illness. Gender as a determinant was most often not the only social determinant noted. Gender was usually mentioned alongside other social determinants such as age, ethnicity, socio-economics status, disability, and other vulnerable and marginalised groups. In most cases, reports did not illustrate gender inequities in disease burden or provide explanations for how gender may be influencing distribution of health and illness or access to care. For instance, only two reports, the WHO 2019 PHC monitoring[6] and the WHO 2023 Adolescent report[36] used sex-disaggregated data to illustrate more in-depth, gender-differentiated patterns of disease across both genders. Such references included consistently noting where burden of disease was higher for one gender compared to the other. Four other reports (# 8a, 11, 12 and 16)[9, 33, 34, 38] also made reference to the health needs of men, but to a much lesser extent than the WHO 2019 PHC monitoring report[6] and the WHO 2023 Adolescent report.[36]

Gender equity, gender equality and gender-responsiveness in health

Equity in health service delivery was named as an important guiding principle in most reports (22/27), either in reference to health equity as a broad principle of global health goals such as UHC and SDGs, or in reference to gender equity in health specifically. Most reports (22/27)

referred to the importance of considering gender equity in PHC services (mainly as a broad guiding principle). In a few reports (5), discussion of gender and gendered health needs were largely absent (report # 1, 13, 22, 23, 24).[35, 43-46]

While some reports defined gender equity as applying to fairness for both genders, most reports, nevertheless, almost exclusively focused on women's health equity. As shown in Table 1, in most reports (21/27), there was an explicit focus on addressing women's health needs. Women's health equity was considered a priority to address the disproportionate burden on women's health needs that are related to gender inequality and to the need to prioritize maternal and child health and priority diseases in females (breast and cervical cancers). To illustrate, in both the UHC2030 reports,[21, 39] gender equity for both women and men is noted as an important guiding principle, while women's health equity was highlighted as the priority. The extract below from the UHC2030 Action on health systems report illustrates a common pattern found across reports, where gender health equity is stated as an important principle, alongside the need to prioritize women's health equity.

> **Gender equity is especially important. Women and girls often cannot access the health services they need.** They are also at greater risk of gender-based violence and of losing economic independence during health crises. **Health systems must be gender-responsive, to meet the spectrum of health needs of women and men throughout their lives**. [39] (pg.14).

While the majority (21/27) of reports focussed on women's health inequities, a minority of reports (6/27) made explicit reference to men's health (#2, 8a, 11, 12, 14, 16),[6, 9, 33, 34, 36, 38] Two of these were monitoring reports that provided extensive sex-disaggregated data. This was accompanied by narrative summaries that described gendered patterns including where men had a disproportionately high burden of disease. Only two of these reports, the WHO 2019 PHC monitoring[6] and the WHO 2023 Adolescent report,[36] provided more explicit and detailed engagement on men's health inequities, beyond merely providing comparative burden of disease statistics. In these two reports, the level of engagement with men's health included discussion of underlying causes for the gendered patterns in men's health, with some mention of the need for gender-responsive strategies to address gender health inequities. It should be noted that neither of these two reports had an exclusive focus on men's health. Rather, the reports applied more even-handed attention to gender health inequities that were identified for both women and men, more so than in other reports reviewed. And further, in both reports, it was made clear that gender inequities in women's health was still the priority given the unique health needs of women for reproductive and maternal health services, and the disproportionate health risks associated with gender inequality. Nevertheless, in these two reports, the acknowledgement of disproportionate women's health needs did not prevent the authors from drawing attention to areas of disproportionately high health risks for men.

Some reports linked principles of gender-equity to the need for interventions to be "gender responsive" (with related terms such as

gender-sensitive, gender-specific and gender mainstreaming). For example, see in reports # 1 2, 3, 8a, 8b, 12, 14, 15b, 16, 17).[6, 25, 30, 34, 36-39, 46] Though several reports made reference to the importance of gender-responsive services, in only two reports, the WHO 2019 PHC monitoring[6] and the WHO 2023 Adolescent report[36] was there acknowledgement that gender responsiveness also applied to men's health needs.

The focus on gender equality and gender responsiveness for women was also addressed in recommendations for gender equity in the PHC health workforce (see reports # 1, 2, 3, 5, 7, 8c, 13, 19, 22).[1, 6, 25, 27, 29, 35, 40, 43, 46] PHC health workforce gender equity was focused on structural issues such as adequate representation in decision-making for the predominantly female frontline PHC, gender parity in renumeration and ensuring a safe and discrimination free working environment, the gender composition of the workforce, and gender-concordance between the gender of the client and the health worker, issues that may influence health seeking behaviour and acceptability of services.

"Except for two reports, the effects of gender on access to PHC and quality of PHC services was not addressed across reports."

To summarise, references to gender as a determinant of health and illness were common across reports, usually in the context of acknowledging the influence on health of a range of social determinants. Except for two reports, the effects of gender on access to PHC and quality of PHC services was not addressed across reports. While gender equity and gender responsiveness were considered important guiding principles, this was mostly interpreted as referring to gender inequities in women's health, with only two reports addressing men's health more explicitly.

Engagement with men's health needs

As shown earlier, the presence or absence of sex-disaggregated data, and general awareness of the gender as a determinant of health and illness, were ways to examine engagement with the role of gender and PHC. While there was recognition in policy reports of the importance of gender equity and gender responsiveness in PHC, this was largely applied to women's health, for health care needs stemming from gender inequality and gender-based needs for effective maternal health services. As in the case for women, addressing gender disparities in the health of men is also important for a gender equitable and gender responsive PHC system. To engage with the PHC needs of men, policy reports need to show an explicit awareness of where men have a disproportionately high burden of disease, apply a gender lens to examining underlying causes, or discuss ways to address gender inequities in a gender-responsive way. In this section, the review examined the extent to which policy reports engaged with inequities in men's health in relation to the burden of disease and access to PHC care.

Limited engagement on men's health in PHC policy reports

As mentioned earlier, gender-differentiated health needs in primary care were in most cases concerned with women's health needs, with little to no reference to men's health needs across most reports. As shown

in Table 1, most reports (21/27) explicitly discussed women's PHC health needs, while 6/27 reports (22% of reports reviewed) made any reference to PHC health needs of men (#2, 8a, 11, 12, 14, 16).[6, 9, 33, 34, 36, 38]

References to the health of men occurred most frequently in relation to sex/gender descriptors used when presenting sex-disaggregated data for men and women, in tables, graphs and narrative summaries. Other than noting the comparative differences in the distribution of disease between women and men, there was usually no further engagement on men's health needs.

Where reports referred to men's health needs, for the most part, this was limited in the scope and depth. In four of the six reports that mentioned men's health, references to men's health consisted of providing one or two sets of comparative sex-disaggregated data and naming where there was a higher burden for men, but without explaining potential underlying reasons for or the benefits of gender-responsive strategies.

Where gender equity included engagement with men's health

"Two out of 27 reports (7% of all reports reviewed) stood out for their explicit consideration of gender-differentiated distribution of disease."

Two out of 27 reports (7% of all reports reviewed) stood out for their explicit consideration of gender-differentiated distribution of disease and discussion of men's health needs alongside that of women. The first is the WHO 2019 PHC monitoring report that assessed PHC progress in relation to a set of SDG goals and UHC. It highlights issues of global coverage and financial protection in PHC including the challenges of addressing gender and gender equity.[6] The 2019 PHC monitoring report is a monitoring report on PHC, so reporting of at least some sex-disaggregated data was to be expected, but the way that these reports engaged with the data shows a level of engagement with men's health that was absent from the rest of the policy reports reviewed. The second is the WHO 2023 Global Accelerated Action for the Health of Adolescents (AA-HA!),[36] referred to here as the 2023 WHO Adolescent report. The WHO 2023 Adolescent report provides guidance to assist governments to identify national health priority needs of adolescents, and recommends how to address these through the planning, monitoring and evaluation of adolescent health and well-being.

The WHO 2019 PHC monitoring report and the WHO 2023 Adolescent report both noted that gender equity is an important guiding principle.[6, 36] Both reports also noted that women's health needs should be prioritised given the disproportionate needs associated with women's inequality in relation to men, as well as need to address sex-specific reproductive health needs of women. Despite the prioritising of women's health needs, both reports nevertheless take a relatively balanced approach to acknowledging and analysing the PHC needs of men alongside that of women.

To illustrate, extensive sex-disaggregated data on health conditions affecting both men and women is provided in both reports. This is accompanied with narrative statements to indicate where women and where men had a higher burden of disease. Both reports were explicit about defining gender-equity as applying to the health needs of both

women and men, and as shown below, one report noted this included gender-diverse individuals.[6]

> **Gender equity means fair treatment of men, women and gender-diverse individuals** according to their respective needs so that they can benefit equally from rights and opportunities. This may require equal treatment or different treatment. Equity is often the means to ensure equality.[6] (pg.78).

In describing their approach to gender inequity, the authors clarified that women's health inequity should be prioritized, given women's unique PHC needs for access to sexual, reproductive and maternal health care, and as primary caregivers of children.

> We clearly must go beyond country averages that mask service delivery failures leaving those worst-off behind. **The path to success starts with a solid commitment to focus on the most disadvantaged, beginning with women and girls.** [6] (pg.78)

Nevertheless, prioritizing women's health needs in PHC did not preclude the report from also identifying and engaging with the greater health risks of men in PHC. At different points in the report the authors spelled out the reasons why it was imperative to focus on men's increased health risks. This included discussion of how women's gender inequality (and associated social norms) may also be harming men's health.

Another unusual component of the WHO 2019 PHC monitoring report is that the focus on gender equity and gender responsiveness is made explicit in the structure of the report, as shown in the inclusion of a separate chapter on gender-responsiveness (see extract of the content page of the report in Box 3 below). The content page makes it clear that this chapter includes a subsection on women's health needs and on men's' health needs.[6] Both reports also applied a gender lens to analysing potential underlying reasons for gendered pattern of disease, including highlighting the need for gender-responsive strategies.

Box 3. Extract of Contents page of WHO 2019 PHC monitoring report[6]

The report authors advocated for the importance of having the 'right data' to enable a gender analysis of health inequities.

> **For the first time, the report focuses on gender issues, shedding light on how gender norms and power influence access to health services.** Having the right data, broken down in the right way, is giving us vital insights about who is being left behind and why, and highlighting where more investments are needed.[6] (pg. ii)

In summary, there was little to no engagement on men's health needs in most reports. However. two reports showed more extensive engagement with men's health needs by more explicitly highlighting gender inequities in PHC health needs for both women and men. The reports described how gender also influences access and quality of care at primary care level and highlighted the need for gender-responsive strategies for both genders. While both reports focussed on prioritizing of women's health, they also focused attention on areas where men have disproportionate health needs. In this way, the two reports provided unique examples of balancing the need to prioritise women's health needs while also considering priority health issues amongst men.

Health needs of men in PHC

As noted earlier, none of the reports reviewed provided data on gender-differentiated patterns on PHC access and utilisation of care and this constitutes a major gap in engaging with men's PHC needs. Nevertheless, in a few reports there was discussion of the burden of disease amongst men which shows recognition of the health needs of men. This is relevant to PHC as many health burdens can benefit from early and effective primary level prevention, health promotion, diagnostic and curative services. The engagement with men's health burden of disease found in in mainly two key reports, the WHO 2019 PHC report[6] and the WHO 2023 Adolescent report[36] is described in this section.

The WHO 2019 report identified health priorities that affect both women and men and that require sex-disaggregated data and analysis. These are infectious disease care (TB, HIV and HPV vaccine cover), and NCDs, with the latter including tobacco and alcohol use services, obesity, cancer (especially lung and prostate cancer for men) and mental health (especially mortality from suicide).[6] Child immunisation and care seeking for suspected pneumonia in children also are important services requiring sex-disaggregated and gender analysis, as these provide an indicator of the coverage of the health services required across different socio-demographic settings.[6] Similar male health priorities are identified in the WHO 2023 Adolescent report,[36] but with different configurations of services. Adolescent male health priorities are listed as being NCDs, and harmful alcohol use. The Adolescent report also highlighted health risks associated with injury, violence and self-harm (with suicide covered under the self-harm category).[36]

Men, infectious disease and PHC

In the 2019 WHO report, the authors provided data on infectious disease control (HIV and TB) to highlight that men with HIV tend to access care later than women resulting in late diagnosis and poor health outcomes.[6] Men have poorer engagement with care and poorer health outcomes than women along the full continuum of HIV care, from HIV diagnosis to linkage and engagement with care, and poor health outcomes.

- **Men with HIV tend to have fewer entry points into health services and to access care later, compared to women for HIV and TB**. This

> resulted in late diagnosis and poor health outcomes, including poorer treatment coverage and retention in care, poor treatment completion rates and higher mortality rates for HIV and TB.[6] (pg.73)

Despite the higher prevalence of TB among men (men and boys accounted for 64% of TB cases globally in 2017 - see Figure in Box 2), men were less likely to access TB care than women.[6] The detection and reporting rates were found to be lower for men in most WHO regions except Europe and the Americas. Men delayed seeking care and had lower treatment completion rates and worse health outcomes.[6] These gendered patterns of healthcare utilisation point to problems men may be experiencing in access to and utilization of PHC services, including late entry into care, and problems with staying in care and adherence to clinical treatment.

Men, non-communicable diseases and PHC

The second area of health risk reported for men in these reports is NCDs, with the highest proportion of deaths among men being from cardiovascular disease and cancers (especially from colorectal and stomach cancers). With respect to mental health needs, men are also at high risk of death by suicide. Key NCD risk factors include tobacco use, alcohol use and obesity. The 2019 PHC monitoring report noted that NCDs are the leading cause of death in men and detail the scope of the problem for high blood pressure and cancer.[6]

> **Noncommunicable diseases account for 70% of all deaths in men globally**, CVD and cancers accounting for 67% of the deaths (26). Nearly 24% of men over age 15 had high blood pressure in 2015, and 8.8% had high fasting blood glucose levels in 2014 (70, 71). Lung cancer is the most commonly diagnosed cancer is followed by prostate cancer and colorectal cancer for incidence and liver cancer and stomach cancer for mortality (31).[6](pg.72).

The report goes beyond describing the statistics on the burden of disease and offers a gender analysis of the underlying social, economic and political factors that are driving this gendered pattern of disease for men [6]. Here again, the WHO 2019 PHC monitoring report, compared to other reports reviewed, was unique for the detail in discussion of how gender affects men's health and their health seeking behaviour. For instance, the report provides a gender analysis on how social norms and economic factors may be driving the disproportionately high rates of NCD. It highlighted the multiple ways that gender norms of masculinity may be the result and stressors and risk factors to men's health, including harmful substance use, stressors associated with being a sole breadwinner, unemployment, and low control in job situations, as well as trauma from childhood abuse.

> **Rigid gender norms and harmful ideals of masculinity increase the risk of CVD and cancers in men.** Risk factors such as smoking and excessive drinking have been associated with masculine identities (60, 72). Men also experience more stress in settings where they are expected to be the sole breadwinner and in the workplace because of

> high demands or low control over their job (73). Unemployment or fear of unemployment may affect stress levels that in turn influence high blood pressure. As among girls, physical, sexual and emotional abuse among boys can elevate the risk of CVD when they become men (43).[6] (pg.72)

The report also noted how other social determinants may intersect with gender, resulting in further negative impact on the health of men in some settings. This was illustrated in reference to the example how a combination of factors operates to worsen the cancer mortality outcomes for Black men in the USA , due to limitations in access to diagnoses and treatment, as well as socioeconomic factors, including racial discrimination.[6]

Men, mental health and PHC

"Men's need for mental health services has been increasing, but men are less likely to access care, be diagnosed and receive treatment."

In some reports, mental health services are included as part of NCD services at the PHC level. The 2019 PHC monitoring report draws attention to increases in men's need for mental health services, as well as the fact that men are less likely to access care and be diagnosed and receive treatment. The report points to the dilemma of having a disproportionately high rate of men dying by suicide compared to women, even though more women attempt suicide than men.

The WHO 2019 PHC monitoring report highlighted gender disparities in mental health care for men, noting that "Men's need for mental health services has been increasing, but men are less likely to access care, be diagnosed and receive treatment." Here again, the 2019 PHC monitoring report offered an analysis of how gendered factors may be influencing the engagement of men in mental health services, including the likelihood of underdiagnosis of depression among males. For instance, the report noted that despite the high rates of suicide, men were less likely to be diagnosed with "internalizing" disorders such as depression, in part because these conditions do not conform to traditional gender role stereotypes about how men may be expressing emotional distress.[6] They continue that this "gender bias" on the part of health care workers may be limiting men's access to health care services.[6]

> **Several studies have found that despite having high rates of suicides, men are less likely to be diagnosed with internalizing disorders such as depression**, in part because these conditions do not conform to traditional gender role stereotypes about men's emotionality (77). **Gender bias in diagnosis and treatment for mental health conditions also influences men's access to appropriate services** (78, 79).[6] (pg.72)

Another mental health-related concern for boys and men is the high rate of childhood behavioural disorders, such as conduct disorder (CD), and the knock-on effect into adolescent and adult male well-being. Behavioural disorders are described as a set of disorders that are "characterized by repeated disruptive, aggressive or defiant behaviour that is persistent, severe and inappropriate for the adolescent's developmental level".[36] Boys and younger adolescent males are

disproportionately affected. These disorders can negatively influence the lives of adolescents in different ways, including disruption in their interactions with caregivers, peers and teachers. It was in the top five causes of adolescent morbidity in all WHO regions in 2019, regardless of sex or age group. The burden of these disorders is particularly high among 10- to 14-year-old males, for whom they were the leading cause of healthy years of life lost due to disability (or YLDs) in 2019.[36] PHC has a role to play in prevention, through detection and treatment of conduct disorder and the associated risk among adolescent boys, but the quality of access to PHC services for boys and men for these disorders remain unclear.

PHC and men's harmful use of alcohol

In the WHO 2019 PHC monitoring report, the higher burden among men of alcohol and tobacco use is reported as major NCD risk factors for early death and disability among men.[6] There are disproportionately high rates of alcohol and tobacco use among men compared to women.

> In 2016 among people over 15 years, **54% men and 32% women reported being current drinkers** and **34% men and 6% women reported smoking tobacco daily**.[6] (pg.52)

The vulnerability of young people to alcohol and drug use is a global concern across all country-income groups. The WHO 2023 Adolescent health report noted the high level of heavy episodic drinking among male adolescents 15-19 years old.[36]

> Worldwide, more than one quarter of all people ages 15–19 years were estimated to be current drinkers in 2016, amounting to 155 million adolescents. **In 2016 the prevalence of heavy episodic drinking among all adolescents ages 15-19 years**[48, 49] was 13.6%, which represents 45.7% of heavy episodic drinkers among those adolescents drinking any alcohol, **with males most at risk**.[36] (pg.63)

Reports also noted that some mental health risks among youth track into adulthood, resulting in social and mental health problems in later life. This underscores the importance of a life-course approach in PHC to limit the adverse effects of childhood disorders for later adult life. For instance, the WHO 2023 Adolescent report noted that alcohol and drug use in children and adolescents is associated with neurocognitive alterations, which can lead to behavioral, emotional, social and academic problems in later life.[36] This knock-on effect of youth vulnerability resulting in poor health in adulthood, was echoed in the WHO 2019 PHC report. The report noted that unhealthy behaviors of tobacco and alcohol consumption amongst male youth increased their risk of developing NCDs in later life [36]. By contrast, a gender analysis of underlying factors was absent from the WHO 2021 Global alcohol action plan, even though the action plan did provide figures on alcohol use as high as 84% for men, compared to 16% for women, and alcohol-related mortality figures three to five times higher for men than women.[32]

A related risk with harmful use of alcohol, is the associated risk of interpersonal violence. The WHO 2023 Adolescent report highlighted

that interpersonal violence is among the leading causes of death in adolescents and young people globally. This included disproportionately high rates of male victims, with most homicide victims being men and boys (81%), and with a higher burden in some LMIC settings.[38] Youth vulnerability is echoed in the WHO Injury report noting that being male, young and of low socio-economic status all increased the risks of injury, and of being either a victim or a perpetrator of violence.[33] PHC service, especially emergency care PHC, would have a key role to play in treating homicide victims and preventing death, but there were no indications in these reports, that PHC services have developed gender responsive strategies to address this inequity in male injury and death from violence.

One report, the WHO Injury report, explained the underlying factors influencing the distribution of risk for violence and injury. It identified a range of factors influencing injuries, including alcohol and substance use, but the analysis did not highlight the increased risks for males.[33] It also noted the intersection of gender with other social determinants such as age, socio-economic status and other economic, environmental, and institutional factors in risk of injuries but it does not make any reference to gendered distribution of these risks.

> **Risk factors and determinants common to all types of injuries include alcohol or substance use**; inadequate adult supervision of children; and broad societal determinants of health such as poverty; economic and gender inequality; unemployment; a lack of safety in the built environment, including unsafe housing, schools, roads and workplaces; inadequate product safety standards and regulations; easy access to alcohol, drugs, firearms, knives and pesticides; weak social safety nets; frail criminal justice systems; and inadequate institutional policies to address injuries in a consistent and effective manner, in part due to the availability of sufficient resources.[33] (pg.7)

Related to the issue of harmful use of alcohol and high risk of violence and injury among men, is the association with crime and imprisonment, and the overrepresentation of males in the prison population, compared to females. Health of the prison population is generally poorer than for people in the general population[50, 51, 52, 53] and access to quality PHC services may be limited.[53] Of note is that suicide is the leading cause of death in the European prison system, and NCDS are increasing, including mortality from CVD and cancer.[52] In the US prison system, over 60 percent of prisoners have a chronic physical condition, and more than 40 percent have mental health conditions.[53] Poor access to primary care services for prisoners in the US include missed PHC visits and unaffordable copayments. For example, over one third of US prisoners who required pharmacotherapy for a mental health condition at the time of their offense, had not received mental health prescriptions in prison.[50] In addition, people with a history of incarceration may have poorer access to PHC services once discharged, compared to people without a history of incarceration,[50-53] a pattern that would disproportionately affect men.

The UN 2023 Special edition SDG report highlighted a specific concern over global escalation of prison population and overcrowding, especially the increasing proportion of unsentenced detainees and the associated human rights abuses.[38] The SDG report noted that overcrowding

adversely affecting the health of prisoners, and indicated that countries needed to provide adequate space and resources "to promote rehabilitation, reduce recidivism, and ensure prisoner and societal well-being".[38] These patterns disproportionately affect men because most of the prisoners are men.

Men, PHC access and gender responsiveness

Barriers to PHC access and care

As mentioned earlier, the reports reviewed for this study contained no sex-disaggregated data on PHC coverage and utilization. However, two reports noted that gender differences not only affected burden of disease, but also access and utilization of primary care.[6, 36] The 2019 PHC monitoring report discussed the importance of recognizing the access barriers faced by men, and potential reasons for these barriers. The report noted that men are predisposed to certain health risks, often have poor access to health services and may be less willing to seek health care. For example, as shown earlier in the figure in Box 2, from this report, illustrated that despite higher TB prevalence of men globally, the detection and reporting rates of TB among men remained lower than that for women, which points to access and care barriers. While some of this predisposition is related to biological sex, other reasons are harmful masculine gender norms that limit health seeking, marketing of harmful practices to men (e.g., alcohol and smoking), as well as health system barriers that reduce men's willingness to access care. In their gender analysis, the authors acknowledged the privileged societal position of men, while also acknowledging the harmful effects of stereotypical male gender norms on the health of men.[6,]

> **While men continue to benefit from a greater degree of socio-economic power and privilege than women by virtue of their gender, men have higher mortality than women for 33 of the 40 leading causes of death** (24). Some of this has to do with sex-based factors. However, in addition, **restrictive gender norms including harmful notions of masculinity, combined with aggressive marketing of harmful products and practices to men, can increase men's risk-taking and decrease their willingness to engage with health services**.[6] (pg.71)

Further, the report highlighted health system barriers to men accessing PHC care, that result from health services being orientated to prioritising of maternal and child health services.

> The orientation of health systems towards maternal and child health services and gender stereotypes exclusively associating women with these services means that **men have fewer entry points to health services, reducing their overall access**.[6] (pg.71)

As mentioned earlier, there are reports of barriers to PHC access and care for men related to gender that result in underdiagnosis and treatment of depression in males, despite the disproportionately high male suicide

mortality rates, and that this may in part be due to bias amongst health care workers.[6]

Gender-responsiveness for men's health

While some reports referred to the need for interventions to address gender inequities, gender-responsiveness in interventions was mostly stated as a guiding principle. But, as mentioned earlier, where practical recommendations were made for gender responsiveness, these were usually to address women's health inequities related to, for example, increased attention to maternal health needs, cervical and breast cancer screening, and gender-based violence. Except for two reports mentioned earlier,[6, 36] there were no explicit gender-responsive recommendations made to address men's health needs in any of the reports.

The 2019 PHC monitoring report noted the importance of considering gender norms and gender-related social determinants of risks for men in global and national policies. The reasons for men's increased health risks and poor health outcomes include rigid gender norms and harmful notions of masculinity, as well as systemic factors such as commercially-driven motivations that target these gender norms for men (e.g. through smoking and alcohol advertising).[6] The reports noted that global and national policies often fail to consider these risks and underlying causes, and that this can result in a failure to develop effective gender-responsive approaches to address men's primary care needs.

> **Addressing masculinities and the social determinants of men's health is relatively neglected in global and national health policies** and hence, services and programmes fail to identify how best to reach men for their health needs which further reduces their access.[6] (pg.58)

Both the WHO 2019 PHC monitoring report, and the WHO 2023 Adolescent reports provided recommendations that are centered on the need for a gender mainstreaming approach to health service planning, intervention development and monitoring. Gender mainstreaming is an approach to health service delivery that is aimed at more effective ways of promoting gender equity, while avoiding perpetuating gender inequality and gender inequities. Recommendations include gender-transformative interventions to change social norms associated with harmful masculinities.

In the WHO Adolescent report, gender mainstreaming is defined as "a process of assessing the gender implications for both adolescent boys and girls of any planned action, including legislation, policies and programmes in all areas and at all levels".[36] This would involve a gender analysis of adolescents' needs and health programming, where the influence of gender norms and roles on both boys and girls are assessed, and the information used to design interventions that are specific and sensitive to the underlying gender and social determinants. The report advocates for adolescent health and well-being programmes to be gender specific (at minimum), and ideally, gender transformative.

A gender-transformative approach is described as one that addresses the causes of gender inequality, transforms harmful gender roles, norms and relations, and that promotes gender equality.[6] Examples of gender-

transformative interventions with boys and men are programmes that encourage them to question stereotypes of masculinity that are harmful to their health and to the health of women, and to encourage the adoption of healthier forms of masculine identity. Transformative programmes fostering healthier, more progressive or ''modern views of masculinity" are aimed at "encouraging kinder, gentler forms of masculinities".[36] This could include, for example, changing men's beliefs towards more equitable responsibilities for childcare, cooking and other domestic chores.

This recommendation to address harmful masculinities is echoed in the 2019 PHC monitoring report. The term "harmful masculinities" is explained further, including its negative effects on both gender equality and on men's health and wellbeing.[6]

> **Harmful masculinities** refer to a set of descriptive, prescriptive and proscriptive notions associated with men and boys that often include anti-femininity, achievement, adventure, risk, violence, and avoidance of the appearance of weakness. These cultural norms continuously connect men to the power and economic achievements that shape the hegemonic position of men. **Harmful masculinities have been described as adverse to equality and inclusion, but also as harmful to men's health and well-being**.[6](pg.78-9)

Importantly, recommendations for gender mainstreaming go beyond addressing gender norms of harmful masculinities and is also aimed at making health services and systems more equitable to all genders, including women, men, and gender-diverse people. This involves addressing gender equity issues across the various functions of health system, including in health information systems, health service design, in human resources and leadership in the PHC workforce, and more.[35] The WHO 2019 PHC monitoring report offered some concrete recommendations about how to make health services more responsive to male health needs, including reducing the stigma of health help-seeking, setting up male-specific clinics and men's participation in the antenatal care of partners.

"The WHO 2019 PHC monitoring report offered some concrete recommendations about how to make health services more responsive to male health needs."

> **Modes of delivery of services are important to improving men's access to services**. Combining services to **reduce stigmatization** or **setting up clinics that serve only men** can improve health access, utilization and outcomes. **Men's participation in their partner's antenatal care** can potentially familiarize men with health facilities, increase their entry points to health care and encourage them to use health care.[6] (pg.71)

The report also referred to evidence from a systematic review that increased pricing policies for tobacco had a greater positive effect on reducing smoking rates amongst young males.[6]

Gender mainstreaming requires the integration of gender in planning, programme delivery and monitoring. The 2019 PHC monitoring report offered a framework for integrating gender monitoring of universal access to care in PHC, which would be key to evaluating the extent to which the health services are addressing gender equity in access to care. Disaggregated data by sex and other social determinants would be an

essential requirement for measuring gender equity in health service access.[6]

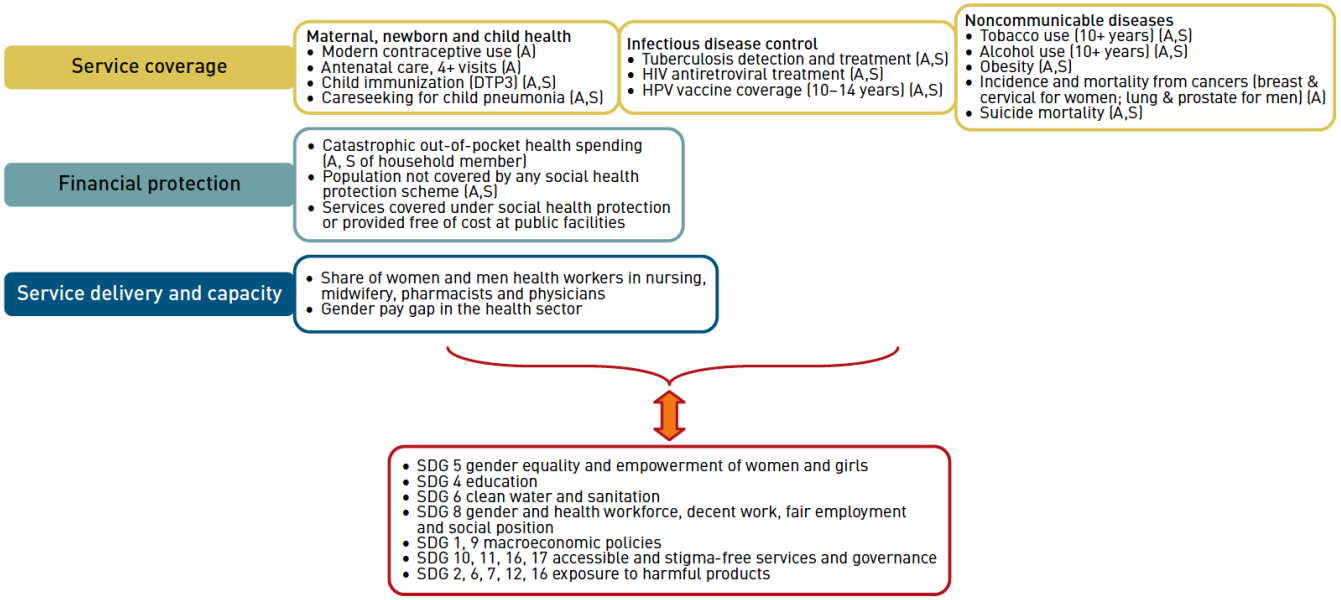
Gender mainstreaming would benefit from a framework to enable monitoring and responsiveness to gender equity in PHC services. Such a framework would need to include a prioritised PHC package of services that include not only the provision of sex-disaggregated data, but also bringing a gender lens to analysis and programme design to ensure gender responsiveness in addressing gender-differentiated disease burdens. The 2019 PHC monitoring report outlined a framework for integrating gender in UHC monitoring, one that can help to unpack and monitor inequities that are driven by gender and gender inequality.[6] An extract of the diagram of the framework is shown in Box 4 below. The comprehensive universal health coverage monitoring framework prioritised three broad areas of disease-focussed services, as shown in the extract of Figure 3.10, in Box 4 below.

Across all three areas, the monitoring framework indicates where age and sex-disaggregated data will be required to allow for gender equity to be monitored. Maternal, new-born and child health services are framed as primarily female health-focused, while infectious disease (HIV and TB) and NCDs are services where health risks for females and males are identified. Here the need for sex-disaggregated (and age-disaggregated) data is explicitly stated.[6] (See the "Note" at the bottom of the Figure 3.10 that indicate the 'S' in the diagram is for sex-disaggregated data).

In addition, both the WHO 2019 PHC monitoring report[6] and the WHO 2023 Adolescent report[36] recommended that the health services take a life course perspective in their approach to service delivery, to address the

Box 4. Integrating gender in the UHC monitoring framework[6]

FIGURE 3.10 **Integrating gender in the universal health coverage monitoring framework**



Note: A is age-disaggregated; S is sex-disaggregated.

vulnerabilities of youth, especially as there is evidence that certain health risks in adolescents have negative health impacts into adulthood.

To summarise, except for two WHO reports, one on PHC monitoring and one on adolescent health, there was little engagement with men's health issues across reports. There was a gap in data and information on gender inequities in PHC access and care. The two reports provided detail on gender inequities in the burden of disease for women and men and applied a gender lens to analysing the potential underlying causes, including reflections on the gendered factors influencing PHC access and care for men. There was also mention of the health and well-being of prisoners, where men are overrepresented. While gender equity was cited as a guiding principle across several reports, there was little to no application of this principle in terms of providing recommendations for gender responsive strategies, beyond advocating for a gender mainstreaming approach.

Discussion and Recommendations

Summary of findings

- Few reports provided sex-disaggregated data to show the gender distribution of disease, and none provided data on gendered patterns of access to and utilization of PHC. There was nevertheless widespread recognition of the importance of disaggregated data for analysing and addressing disparities associated with the social determinants of health and illness, including sex-disaggregated data for analysing gender equity.
- References to gender as a determinant of health and illness was common across reports, usually in the context of acknowledging the influence on health of a range of social determinants, including gender.
- While gender equality and gender responsiveness were considered important guiding principles, this was mostly interpreted as referring to gender inequities in women's health.
- Overall, there was little engagement with men's health needs across reports. Only 6/27 or 22% of the reports reviewed made mention of men's health alongside that of women, and only two of those reports (7% of all reports reviewed) engaged more explicitly with men's health needs.
- Two WHO reports (one on PHC monitoring and one on adolescent health) showed engagement with men's health needs by more explicitly highlighting gender disparities in PHC health needs for both women and men. These reports described the gendered distribution of risks and illness for both genders, applying a gender lens to analysing gendered patterns of disease, access to and use of primary care services, and acknowledging the need for gender-responsive services for both women and men. Even though both these reports prioritized women's health equity, their relatively balanced approach to gender analysis allowed for a level of engagement on men's health needs that was absent from other reports.
- There was reference to the need for attention to health and well-being of prisoners in one report especially given the global increase in unsentenced prisoners and overcrowding. This is of relevance as men are overrepresented in the prison population.
- There were few recommendations for gender-responsive interventions to address men's health needs across most reports.

Gender-mainstreaming was recommended as an approach to address gender equity in health services in a few reports, but with few PHC-based strategies to address inequity in the men's health.

Recommendations

Given the relative lack of substantive attention to questions of gender and men in these global PHC related policy documents, it is important to think more deeply about where the windows of opportunity might be for recognition of men's PHC needs in global policy and how best to take advantage of those windows of opportunity.

Evidence generation and use

Policy development requires current understanding among stakeholders of the nature, scale and impacts of the problem at hand, and this requires for appropriate evidence to be generated and for it to be used effectively in policy making.[54]

Build a robust, nuanced and diverse research evidence base about the problem

Gather evidence...

- Men are not a homogeneous group, and their health needs intersect with other social determinants in the same way as women's health needs do, including social variables such as age, ethnicity, economic status and more. Robust, nuanced, and diverse evidence is needed that recognizes the diversity of men's health needs, its intersection with other social determinants, and how it differs across developmental stages, to enable a life-course approach to PHC services. The life-course approach remains relevant in the context of gender-responsive, gender mainstreaming, and other approaches that explicitly consider gender.
- It is useful to draw on other sources of evidence on improving access to health care more generally, as much of this evidence may also be applicable to improving access for men. This includes harnessing lessons about the need for people-centred, holistic, continuous and responsive health care services, that also involves health user participation.[17, 19] Post-COVID pandemic health system responsiveness and interest in health system resilience is another opportunity for exploring the distinctive gendered patterns of disease and mortality associated with the COVID pandemic;[55] and to identify gender-responsive ways to address relevant prevention, health promotion, and health care utilisation for men for future epidemics.

Identify evidence gaps...

- Identify where there are gaps in research evidence on men's health priorities. For example, what health needs are neglected and what groups of men are neglected? Based on the absence of sex-

disaggregated data on PHC utilization identified in this review, there is need for more detailed evidence on gender-distribution of access to and utilization of primary care services.

- A review of literature on men and boys' access to healthcare in Australia showed gaps in evidence that might be applicable in other settings.[17] The review identified gaps in evidence on the health of young boys below secondary school going age. There were also gaps in evidence on marginalised groups of men (those with disabilities, socio-economically disadvantaged, and culturally and linguistically diverse backgrounds), and in areas where men are overrepresented (veterans and defence forces, and in the criminal justice system). The review found that there was also little research on men's health priority disease areas, such as certain NCDs (e.g. type 2 diabetes, coronary heart disease) and cancers (e.g., lung and bowel cancer). There were also gaps in research on the barrier of discontinuity of care across major life transitions (e.g., from childhood to adolescents to young adulthood and aging, as well as transition to fatherhood).[17]

Work to make this evidence base accessible to researchers and decision-makers

- Researchers, advocates, and policymakers need to have easy access to the best available evidence as evidence only becomes impactful if it is packaged and delivered strategically. This involves gathering evidence from different sources, including evidence from robust research and programme evaluations. It will require strategic packaging and dissemination of evidence beyond the typical journal article, to include for example policy briefs, policy dialogues, as well as social media engagement. Similar recommendations were captured in a review that informed the 2018 WHO European Men's health strategy[56] as shown in the extract in Box 5.

Box 5. Evidence support recommendations from the WHO 2018 European report on the health and well-being[56]

- Using disaggregated data (by gender, age and other social determinants) to inform policies and programmes,
- Promoting research and innovation on sex and gender differences in the use of medicines, service delivery and health promotion,
- Developing operational research on the ways in which gender causes different forms of risk-taking and health-seeking behaviour among boys and men from early childhood to adulthood, including how this this intersects with other social determinants, for example, socio-economic status.
- Promoting research on the health impact and the benefits of gender equality policies on the health and well-being of men.
- Developing tools and capacities for translating research and lessons learned from good practices into policy and programmes.

Policy options and linkages

Men's health policy development requires both new strategies and ongoing evaluation of policy options to address men's health.[54]

Consolidate and build from emerging best practices for men

- There is a large and growing body of evidence on what works for addressing men's health needs. Reviews of 'what works' for improving men's health and achieving men's health equity and technical papers in support of developing men's health strategies are all sources of best practice.[12-14, 19, 57, 58, 59] This evidence needs to be consolidated and translated as potential policy options for decision-makers to consider.
- More recently (2022), evidence of what works to reduce barriers to men's health access was reviewed, to inform the development of the Australian Charter for Men's Mental Health.[17] The evidence summarized in the extract in Box 6 below may be applicable to access and utilization of primary care more generally. The authors noted the importance of flexibility as success is more likely if intervention can appropriately balance guidance and structural changes, while tailoring strategies to "flexibly address specific needs of men and boys with content tailored to health vulnerabilities, cultural backgrounds, and life stage".[17]

Box 6. Extract of summarised evidence on 'what works' to reduce barriers to men accessing health care[17]

What works? Gateway consultations; brief interventions; participatory designs; going to where men or boys are; e-Health programs; peer support programs; family engagement in men's and boys' treatment (where appropriate); recognition of masculine strengths; responsiveness to cultural values; male-specific clinics; services offered at convenient times; clinician training for recognising and responding to male specific presentations; person-centred, goal-oriented, empathic, clear communication often with humour; and holistic services that address multiple determinants of health and wellbeing. For each of these strategies, evidence of varying strength exists for their potential success.

- Collaboration across and alongside men's health advocacy groups is needed for more complex and transferable solutions. Many of the ways in which policy might intervene to better support men's mental health are not specific to a particular disease or health programme. Developing solutions alongside advocates for other health problems is crucial for a feasible and effective gendered approach. Feasible policy solutions are ones that are transferable to similar settings, and 'scalable' within local and national contexts. Where there are multiple smaller interest groups each pitching for national men's health policy responses specific to their own population group or disease domain, this may result in a fragmented approach and draining of energy and synergy in advocacy for men's health.

Leverage the growing number of national and global men's health policies and advocates to develop integrated and holistic strategies

- This review did not identify any global PHC policies that are explicitly focussed on promoting men's health, but there are emerging regional and national policies, statement and practices that address men's health more thoughtfully. These policies may not all provide a comprehensive, globally applicable, or fully evidence-informed set of strategies, but they are an important place to start. Building on and consolidating early gains in a policy area is a critical way to save time and resources and build cross-project learning. There are several country-level examples of men's health policies and in 2018, the WHO European region published a men's health strategy covering their 53 member countries.[15]
- Policy solutions to address men's health needs in PHC would need to consider strategies at multiple levels from individual to organisational to societal. The European Men's Health Forum (EMHF) recommended a set of strategies on multiple levels, for improving men's use of primary care, based on consultations with several European countries between 2013 and 2015.[16, 60, 61, 62, 63, 64] A summary of action areas for policy solutions to improve men's health access to PHC based on European Men's Health Forum (EMHF) consultations in 2014 and 2015 appears in box 7 on page 42.

Alliances and opportunities for strengthening advocacy and political support

Political support is critical to move men up in the PHC policy agenda. Understanding and engaging with the political context is therefore important for policy development. There is a need to address political resistance and the persistent yet inaccurate notion of the "zero-sum game" – that wrongly assumes promoting men's health means taking resources from women's health. The policy context involves a set of external events, institutions and conditions in the political environment that can either close or open up opportunity for policy change.[54] Political support is also the most difficult aspect of developing health policies focused on men as it involves events, institutions and conditions that are outside of the immediate purview of academics and advocates working in specific policy problem areas. Researchers, academics, advocates, and policy makers need to pay attention to the broader political environment and making strategic use of both predicted and unpredicted situations to move men up in the PH policy agenda. This can include leveraging parallel policy development for women, or for men and other health issues, as well as building long-term coalitions and networks with individuals and institutions working on issues indirectly related to PHC.

Box 7. A summary of the EMHF's action areas for policy solutions[16, 60-64]

Individual

- Improve men's awareness of health and the role of health services from a young age. This includes changing harmful norms around masculinity to promote better health seeking behaviour.

Health service organisation

- Improve the way health services are organised to promote better uptake of health services and more effective and efficient management of care for all, including for males. This includes improved waiting periods, more responsive and effective health services that allows for more patient-centred health care, better inter-service co-ordination, effective clinical communication, and care, including appropriate knowledge of male health needs and male-specific services.
- Areas for actions include education of health care professionals about how gender influences how men present with mental health problems, the develop of male-friendly initiatives tailored to the values, customs and priorities of those groups of men most in need and promoting strengths-based approaches to men's mental health that build on positive aspects of traditional masculinity while supporting more health promoting norms of masculinity.

Structural

- Structural barriers to PHC access should be addressed such as those related to financial burden, proximity and transport, and convenience of operating hours. This includes taking health services to where the men are, such as in the workplace and leisure spaces, as well as targeted interventions for sub-groups of vulnerable men (such as in the military, prisons, migrants).

Leverage parallel policy development for women, or for men and other health issues.

- To promote policy for addressing equity in men's PHC needs, there is benefit in aligning with and leveraging existing global health goals, and health legislation and mandates around human rights, health equity and gender equity.
- Leveraging parallel global policy developments, may for example, include alignment with the call to 'leave no-one behind' in the UN 2030 SDG agenda and with WHO policies for UHC and for Integrated people centred PHC. The WHO 2019 PHC monitoring report, for example, noted the importance of the UN SDG principle of "Leaving no-one behind", when designing responsive health systems to address gender and other health inequities.[6]

> In the 2030 Sustainable Development Agenda, UN Member States **pledged to "leave no one behind." For health systems that means that countries should prepare inclusive and gender-responsive national health strategies that consider wider dimensions of inequality**, such as wealth, ethnicity, education, geographic location and sociocultural factors and implement them within a human rights framework.[6] (pg.74.)

- Policy alignment for addressing men's health equity can also be done with parallel effort to address women's health equity, including promoting women's equality. For instance, the 2018 WHO European region "Strategy on the health and well-being of men" argued for making gender equality a priority for men and for men's health.[15] It notes that addressing women's gender inequality is key to attaining many of the SDGs and that engagement of men in promoting gender equality is needed, to the benefit of the health of both genders. The report highlighted areas for men's involvement in promoting gender equality, including more involvement in child and family care, and actions for prevent gender-based violence. The report noted that greater involvement of men in promoting gender equality would also reduce health risks for men.

> "**Engaging men in gender equality includes learning from positive experiences, transforming patterns of care** (including self-care, parenting, care of family and unpaid care), and **engaging men in action to prevent gender-based violence and improve sexual and reproductive health. Many of these activities would lead not only to greater gender equality but also to a reduction in exposure to risk factors**.[15] (pg.7)

Build long-term coalitions and networks with individuals and institutions working on issues indirectly related to primary health care

- Making an effective and sufficiently rapid response to changes in the broader political environment requires much more than ad hoc efforts to link across sectors, campaigns and interest groups when a policy opportunity arises. Long-term coalition building is required, that is rooted in a shared understanding of mutual interests and lessons that can be shared across domains. This will enable policy entrepreneurs to better take advantage of unexpected developments to advance men's health equity up the global and national PHC policy agenda.
- Key action areas for politicians to consider in policy to address men's health are noted in the WHO European region report that informed their men's health strategy.[56] Action areas are: strengthening governance for the health and well-being of men, making gender equality a priority for men's health, making health systems gender responsive, improving health promotion, building on a strong evidence base, and importantly, ongoing monitoring and reporting.[56]
- Strategies for politicians and policymakers to consider include gender mainstreaming actions in the management and organisation of PHC

services. A Spanish sub-national health strategy provided guidance for integrating gender into the PHC approach and suggested that cross-cutting criteria for gender mainstreaming in PHC.[65] These are the use of inclusive language, peer working groups, gender analysis of health problems, and applying a gender perspective in programming and programme evaluation,[65] criteria that could be applied to shape gender-responsive global PHC policy on men's health.

Organisations for advocacy

Based on reports identified and reviewed here, the WHO and its regional offices, together with partner organisations are key organisations to engage with to advocate for increased focus on the gender disparities, and more specifically, to advocate for gendered approaches that address male equity in health. Key partner organisations would be United Nations and associated groups in relation to supporting the SDGs. PHC is a broad area, and advocacy could be focused on multiple areas. A key area is to advocate for strengthening a comprehensive PHC approach that includes the values of holistic and equitable health, disease prevention, health promotion, treatment, and care. In addition, advocacy could be focused on strengthening universal access to quality care at PHC level for men, for priority health conditions. Here again WHO is a key stakeholder, but also through other intergovernmental and non-governmental conditions that focus on NCDs, infectious disease, mental health, addressing harmful substance use and prevention of violence and injury, as well as advocacy for health systems strengthening. PHC policy directives also need to take a life-course approach, so this involves policy advocacy organisations that address strengthening the PHC approach to health for children, adolescents, adults, and the elderly. Other organisations of interest include UNICEF, NCD alliance, OECD, UN, UNAIDS. Also, professional associations representing clinicians key to PHC, such as the World Organisation of Family doctors (WONCA), whose mission is to foster high standards of care in general practice/family medicine including gender equity, and the International Pharmaceutical Federation (FIP), a global body of pharmacists who work closely with WHO to advance the role and impact of pharmacy services. Given the disproportionately high levels of male prisoners, organisations advocating for prison health can directly benefit the health of men. Finally, organisations advocating for health systems strengthening of PHC platforms, could be partners in advocating for integrating gender-equity across PHC delivery platforms.

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