Becton Dickinson; honoraria for lectures, presentations, or educational events from Novo Nordisk, AstraZeneca, Sobi International, Pfizer, Becton Dickinson, Ipsen, and Ecosense; and support for attending meetings and travel from Ipsen. NK reports grants from the Novo Nordisk Foundation and the Karen Elise Jensen Foundation, administered by her institution; honoraria from Novo Nordisk paid to her institution; and support for attending meetings and travel from Ipsen.

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1 Marchesini G, Petta S, Dalle Grave R. Diet, weight loss, and liver health in nonalcoholic fatty liver disease: Pathophysiology, evidence, and practice. *Hepatology* 2016; **63:** 28392.
2 Vali Y, Wonders K, Lee J, et al. Non-invasive tests in metabolic dysfunction-associated steatotic liver disease: the LITMUS prospective multicentre diagnostic accuracy study.. *Lancet* 2026; **408:** 1850–65.
3 Vali Y, Lee J, Boursier J, et al. Biomarkers for staging fibrosis and non-alcoholic steatohepatitis in non-alcoholic fatty liver disease (the LITMUS project): a comparative diagnostic accuracy study. *Lancet Gastroenterol Hepatol* 2023; **8:** 714–25.
4 Hardy T, Wonders K, Younes R, et al. The European NAFLD Registry: a real-world longitudinal cohort study of nonalcoholic fatty liver disease. *Contemp Clin Trials* 2020; **98:** 106175.
5 Mózes FE, Lee JA, Selvaraj EA, et al. Diagnostic accuracy of non-invasive tests for advanced fibrosis in patients with NAFLD: an individual patient data meta-analysis. *Gut* 2022; **71:** 324243.
6 Foroutan F, Weiss J, Mayer M, et al. Discriminating clinical prediction models: how outcome incidence and decision thresholds shape clinical utility and apt AUROC values. *J Clin Epidemiol* 2026; **1:** 112293.
7 Han JW, Kim HY, Yu JH, et al. Diagnostic accuracy of the fibrosis-4 index for advanced liver fibrosis in nonalcoholic fatty liver disease with type 2 diabetes: a systematic review and meta-analysis. *Clin Mol Hepatol* 2024; **30:** S147–58.
8 Diaz LA, Ajmera V, Arab JP, et al. An expert consensus Delphi panel in metabolic dysfunction- and alcohol-associated liver disease: opportunities and challenges in clinical practice. *Clin Gastroenterol Hepatol* 2026; **24:** 633–45.
9 Shaheen A-A, Baguley E, Swain MG, et al. Diabetes and obesity reduce FIB-4 accuracy in MASLD referral pathways. *JHEP Reports* 2026; **8:** 101735.
10 Lindvig KP, Thorhauge KH, Hansen JK, et al. Development, validation, and prognostic evaluation of LiverPRO for the prediction of significant liver fibrosis in primary care: a prospective cohort study. *Lancet Gastroenterol Hepatol* 2025; **10:** 55–67.
11 Graupera I, Thiele M, Castera L, et al. Prevalence of liver fibrosis in the general population (the LiverScreen project): a multinational European cohort study. *Lancet* 2026; **407:** 1448–58.

Men's health: recognising and responding to the problems

See **Series** pages 1866, 1881, and 1899
See **Viewpoint** page 1912

The authors of *The Lancet*'s Series on men's health[1–3] provide a genuinely world-scale picture of the issues. Their approach links biological with social process, and emphasises intersectional perspectives. The Series papers offer valuable case studies, and a suite of proposals to move health policy in new directions.

Research about men in the gender order goes back to the heyday of social role theory in the mid-20th century in the Global North, when the idea of a "male role", complementary to a "female role", became common. The Women's Liberation movement turned the sex-role concept into a critique of the oppression of women, and during the 1970s this impulse led to critiques of a rigid sex role for men. During the 1980s and 1990s social-scientific research on men and masculinities moved beyond the "role" model to address social practices, gender structures, violence, and embodiment. Researchers found multiple patterns of masculinity, and gendered hierarchies among men and boys, as well as between men and women.[4] The field has diversified, with a growing volume of research coming from the Global South.[5]

The research soon found practical applications, including men's health, with researchers in the 1970s warning "the male sex role may be dangerous to your health".[6] By the 2000s, there were comprehensive conceptual and programmatic discussions of men's health.[7] There was also a troubling political twist. In the late-20th-century backlash against feminism, selected statistics of mortality, morbidity, stress, and incarceration were used to present men as the victims of the gender order. A leading writer in this genre declared that "men are the disposable sex"[8] and today the misogynist manosphere reproduces these arguments.[9]

The discourse of men's health has sometimes been presented as a remarkable new insight. But there is a long history of official and medical concern. For instance, during World War 1 the discovery that about half the British male population were unfit for front-line service by 1917 due partly to poor living and working conditions, chronic diseases, malnutrition, and other factors provoked dismay among professionals, policy makers, and the military.[10] Since then health issues among men have from time to time attracted public debate, such as violence, rates of smoking, heart disease, and sexual conduct.

The third paper in this *Lancet* Series by Sarah J Hawkes and colleagues speaks of men's health suffering "policy neglect" and "institutionalised silence".[3] We caution that where there is no formal men's health policy, it need not imply that men with

power are actually neglecting men's health. Implicit men's health agendas and patriarchal priorities can be found in a range of mainstream professional fields such as in surgery and occupational health.[11,12] Surgery is a specialty with one of the lowest representations of women; institutionalised discrimination, enacted through a male-dominated culture and work environments unresponsive to family responsibilities, systematically excludes women.[11] Meanwhile, until the late 20th century, occupational health policy and research were essentially "gender-blind" and largely oblivious to women's workplace fatalities, injuries, diseases, and ill-health.[12] Men's interests have shaped medical services for women too, in ways now visible in obstetric violence on a global scale.[13] The health workforce itself has been powerfully shaped by gender inequality. For generations, it can be argued, these facts gave excellent reasons not to formalise men's interests across the health field.

Crucially, women's health and men's health are not equivalent concepts.[14] The policy field of women's health was formed by social movements attempting to increase women's control over their own health care, with a large component of local activism such as refuges, women's health centres, and underground networks such as those concerned with access to abortion. These forms of activism responded to women's health concerns as lived social realities arising from such experiences as domestic violence. Women's resistance was central to the definition of the field; women's health was created as a form of political redress for marginalisation and disempowerment arising from gender dynamics.[15] This perspective continues in feminist activism around violence against women and children; abortion, contraception, and other reproductive health and rights; and women-centred care.

The men's health policy field, by contrast, has been mainly constituted by technocratic reasoning drawing on sex-based margins of difference in population-level health statistics. We think a sophisticated version of this reasoning can be found in aspects of the second Series paper by James W F Catto and colleagues about global men's health epidemiology within an intersectional framework.[2]

The concept of gender itself is at stake here. We understand gender as an embodied historical process

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operating across a wide field of social relations, generating inequalities of material benefit, power, recognition, and sexuality. Gender relations have shown a relentless push towards hierarchy and division, most often subordinating women. This dynamic creates a common political interest among large groups of men in relation to women, now amplified by misogynist politics. It also shapes inequalities among men and boys, well shown in evidence of the clustering of health conditions among marginalised groups of men.[1]

We therefore question whether the expansion of a special-purpose men's health research, policy, and implementation apparatus is the best way to go. Should we instead be building on the experience of women's health movements, and support a comparable activism among groups of men who make large contributions to those margins of ill-health and death?

Such organising from below already occurs; here we highlight three examples from Australia. Gay men in Sydney responded to the deadly HIV/AIDS crisis in the 1980s with "one of the most profound changes of practice ever found in the social science and public health literature",[16] including personal changes in sexual practice, relationships, and knowledge and sustained community-based action in safe-sex education, peer support, and winning government funding.[16] Worker militancy by some large blue-collar unions in the construction industry

has made considerable gains in workplace health and safety within the last generation. For example, when worksites reach 35°C all construction workers must leave to prevent heat stress.[17] Meanwhile, Indigenous men, who have the poorest health outcomes in Australia, are working with the National Aboriginal Community Controlled Health Organisation and local Aboriginal and Torres Strait Islander communities to run their own initiatives towards bettering their health.[18]

Many places have such initiatives. Still needed are resources at scale, and strong links from grass-roots activism to research and policy making. Deep and lasting change to improve health outcomes for men requires, above all, drive and direction from the groups most profoundly impacted by current conditions.

RC receives author royalties for books some of whose topics relate to this Comment, from Polity Press, the University of California Press, Oxford University Press, Melbourne University Publishing, Bloomsbury, Sage, Informa, and Monash University Press. TS receives author royalties from Cambridge University Press and Oxford University Press. RC has received lecture fees from Sydney Writers Festival, Attorney-General's Department, Western Sydney University, Big Picture Education, Global 5050, and the University of New England; and has received travel funding from the University of New England and Global 5050. The funders had no role in the writing of this Comment or in the decision to publish.

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1 Tolhurst R, Egid BR, Mavhu W, et al. Men's health: an intersectional and multilevel framework for understanding syndemic patterns of health. *Lancet* 2026; **408:** 1866–80.
2 Catto JWF, Thomson RM, Griffith DM, et al. A global men's health epidemiology within an intersectional framework. *Lancet* 2026; **408:** 1881–98.
3 Hawkes SJ, Katikireddi SV, Buse B, et al. Charting a course to men's health and wellbeing: applying a lens of power and politics to improve men's health outcomes. *Lancet* 2026; **408:** 1899–911.
4 Kimmel MS, Hearn J, Connell R, eds. Handbook of studies on men and masculinities. Sage, 2005.
5 Loureiro J, ed. Men and masculinities in the Global South: a Southern perspective. Vernon Press, 2026.
6 Harrison J. Warning: the male sex role may be dangerous to your health. *J Soc Issues* 1978; **34:** 65–86.
7 Schofield T, Connell R, Walker L, Wood J, Butland DL. Understanding men's health and illness: a gender-relations approach to policy, research, and practice. *J Am Coll Health* 2000; **48:** 247–56.
8 Farrell W. The myth of male power: why men are the disposable sex. Simon & Schuster, 1993.
9 Hawkes S, Buse K. Reframing the manosphere: a public health response to a commercial ecosystem. *Lancet* 2026; **408:** 1912–16.
10 Clare RJ. "Fit to fight?" How the physical condition of the conscripts contributed to the manpower crisis of 1917-18. *J Soc Army Historical Res* 2016; **94:** 225–44.
11 Lech GE, Goulart LB, Alves CH, Aguiar CP, Moraes LBL, Brandão GR. Gender bias in surgery: a systematic review of qualitative studies. *Am J Surg* 2025; **242:** 115974.
12 Walter AL, Faue E. In the shadow of tragedy: Jeanne M Stellman and the work of the women's occupational health resource center. *J Women's Hist* 2022; **34:** 93–114.
13 Hakimi SJ, Allahqoli L, Alizadeh M, et al. Global prevalence and risk factors of obstetric violence: a systematic review and meta-analysis. *Int J Gynaecol Obstet* 2025; **169:** 1012–24.
14 Schofield T. What does "gender and health" mean? *Health Sociol Rev* 2002; **11:** 29–38.
15 Norsigian J. *Our Bodies Ourselves* and the women's health movement in the United States: some reflections. *Am J Public Health* 2019; **109:** 844–46.
16 Kippax S, Connell R, Dowsett G, Crawford J. Sustaining safe sex: gay communities respond to AIDS. Falmer Press, 1993.
17 Fatima SH, Rothmore P, Giles LC, Peng B. Impacts of hot climate conditions on work, health, and safety in Australia: a case study of policies in practice in the construction industry. *Safety Sci* 2023; **165:** 106197.
18 National Aboriginal Community Controlled Health Organisation. Men's Health, Our Way—Let's Own It. 2022. https://www.naccho.org.au/mens-health-our-way-lets-own-it/ (accessed Oct 16, 2026).

Men's Health 1

Men's health: an intersectional and multilevel framework for understanding syndemic patterns of health

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Lancet 2026; 408: 1866–80

See **Series** pages 1881 and 1899

See **Comment** page 1796

This is the first in a **Series** of three papers about men's health

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Men occupy a privileged position within gender power relations: the male body has been the default reference point for biomedical research and therapeutic development (with the historical exclusion of women from medical trials), and men dominate health services leadership and exercise well documented medical misogyny. Yet despite their privileged position, many aspects of men's health outcomes are neglected and undertheorised because they are not examined through an intersectional gender lens. Although consideration of gender and masculinity is important for understanding men's health, research thus far has focused predominantly on men's harmful health behaviours, overemphasising individual determinants of health, and a deficit-based approach. Little attention has been paid to the influence of structural determinants of men's health risks and vulnerabilities, or the gender-specific health outcomes of worsening social and economic inequalities. In this first paper of a *Lancet* Series on men's health, we present a conceptual framework for understanding men's health from an intersectional perspective, highlighting how structural, social, and commercial determinants of health, intersectionality, and syndemic theory can be combined to analyse men's health at different socioecological levels. We illustrate the framework using four selected case studies that show how the health outcomes of marginalised men are influenced by complex interactions. We provide a working definition of men's health that reflects existing literature and builds on the conceptual framework and case studies. Promotion of gender justice and health equity requires moving beyond one-dimensional approaches that construct men as problematic individuals, and towards better understanding and action on the broader set of power systems and structural determinants underpinning men's health.

Introduction

Men's health is characterised by paradox. Men occupy a privileged position within gender power relations and the (able, White) male body has been the default reference point for biomedical research and therapeutic development, which are associated with the historical exclusion of women from clinical trials,[1] domination of health services leadership by men, and well documented medical misogyny.[2] Simultaneously, modern, colonial, and postcolonial health programming has tended to focus on women's reproductive health and been oriented towards women as the assumed primary carers of children.[3] This focus has led to multiple exclusions from health systems, such as of men and women minoritised by race, ethnicity, gender expression, sexuality, class, or disability, and of women's health needs beyond reproduction. Despite the structural advantages men have relative to women, and with some heterogeneity across contexts and age ranges, analysis of Global Burden of Disease data from 1990 to 2023 shows that male life expectancy and disability-adjusted life-years have generally been worse than those of female individuals across most contexts,[4] particularly for disadvantaged and minoritised male patients (see the second paper in this Series[5]).

Explorations of men's health have thus far prioritised the discussion of gender, masculinities, and men's harmful behaviours, often treating men as a homogenised group and taking a deficit-based approach that overemphasises individual determinants of health.[6,7] The influence of structural and systemic determinants of

Key messages

- The paradox of men's health—that men are privileged in gendered power relations, but their life expectancy and disability-adjusted life-year outcomes are generally poor compared with those of women—remains underexplored, and gender mainstreaming efforts have rarely explicitly included men's health.
- Much of the existing research on men's health has focused on hegemonic masculinities in isolation and paid insufficient attention to the influence of other intersecting systems of power and structural, social, and commercial determinants on men's health outcomes (explored in more detail in the second paper of this Series).
- We present a conceptual framework for understanding men's health that integrates structural, social, and commercial determinants of health with intersectionality and syndemic theory to show how the health experiences of marginalised men are shaped by complex interactions at different socioecological levels. We illustrate key aspects of the framework with four case studies, selected on the basis of their representation of different geographical locations, health conditions, and manifestations of men's marginality.
- Across different global contexts, historical and ongoing social and economic marginalisation and precarity interact with hegemonic masculinities to create clusters of poor health and wellbeing outcomes for groups of men disadvantaged by class, race, nationality, disability, and gender expression, sexuality, or both.
- Coordinated action at multiple levels on multiple systems of power is needed to address the determinants of men's health and ultimately achieve gender justice and health equity for all (explored in more detail in the third paper of this Series).

men's life chances, health risks, and vulnerabilities (including racism, colonialism, poverty, and climate change) have been largely overlooked; although this dynamic is also present for women, approaches that consider how gender and structural determinants interact for men have been particularly absent. In addition to overlooking the heterogeneity among men, there has also been a failure by policy makers to discuss positive aspects of masculinity or manhood and the role that men can play in improving everyone's health.[8–10]

Furthermore, little attention in terms of research, policy, and programming has been paid to men's health despite available evidence of poor outcomes.[10–12] Although national governments and policy makers are slowly beginning to recognise men's health as an important issue,[13] only a few regional or global bodies have included men's health in their agendas (see the third paper in this Series[14]). This recognition comes at a time when the well established notion of gender as a key driver of health is under attack, and much of the progress and infrastructure supporting the health of women and girls is being dismantled.[15,16] This recognition also coincides with a societal rise in the presence and acceptance of harmful ideals of masculinity that are associated with men's poor health, gender-based violence, and gender inequities and injustice, including social mobility.[17–19]

Building on the *Lancet* Commission on gender and global health, we frame men's health (inclusive of trans men; panel 1) within a gender justice approach, which encompasses "universal rights in relation to health equity and gender equality", "recognises the diversity of needs and experiences, [and] calls for the inclusion of all people".[20] Gender justice is not a zero-sum game, whereby efforts to improve men's health must be at the expense of tackling women's oppression. To this framing, we add the WHO definition of health equity, which emphasises that health is a fundamental human right that is achieved only when everyone can attain their full potential for health and wellbeing.[25] Using Rowlands' model of power,[26] we acknowledge the need to end men's power over women and we argue that men also stand to benefit from gender justice, because patriarchy intersects with other structural forces to harm everyone's health, including men's. We use the concept of hegemonic masculinity: the form of masculinity that is culturally dominant in a given setting and characterised by patriarchal dominance of men over women and other less powerful men who do not live up to idealised notions of masculinity.[27–29] Since the publication of Connell's work popularising this term more than 30 years ago,[28] an important and expanding body of research has critiqued hegemonic masculinities and men's approaches to embodying these ideals, including recognition of the multiple or mosaic expressions of masculinities, in part shaped by other intersecting aspects of identity in any given context.[30–34]

Gender mainstreaming efforts, which have sought to systematically include a consideration of gender in policy and practice over the past 25 years, have rarely included men's health explicitly.[35–37] No agreed-upon definition of men's health exists,[38] in global, regional, non-governmental organisation, and national policy reports that focus on the health of men or elsewhere.[39–41] Many gender and health frameworks have included men and

Panel 1: Gender, sex, and diversity of intersecting male identities

In line with the 2025 *Lancet* Commission on gender justice and global health,[20] in this Series, we use the term gender to refer to the structure of social relations and practices that are organised in relation to reproductive bodies, which creates hierarchies of power and influences the distribution of resources within societies. We use the term men to refer to all adults who self-identify as such, recognising that the field of men's health should encompass a diversity of masculinities and male gender expression, including trans men. We use the term sex to refer to biological characteristics associated with sexual reproduction, chromosomal genotypes, hormones, and physical characteristics. The term is also used to classify bodies in a binary manner as either male or female. We therefore use the term male when classification has been done on the basis of biological sex, as has often been the case in data collection (including government administrative systems and the Global Burden of Diseases, Injuries, and Risk Factors Study). We recognise the complexities and challenges of attributing observed differences between individuals or populations to gender, sex, or both, and use the original terminology of published studies, which might lead to variation in usage across the Series. Sexuality should be seen as distinct from gender and we use the term sexuality to refer to an individual's sexual orientation, expression, and identity. Using an intersectional framework enables investigation of the complex expressions of power, privilege, and penalty associated with different masculine identities,[21] with cisgenderism being an important oppressive process for analysis in relation to men's health, alongside racism, classism, ableism, heterosexism, and other systems of power.[22] Intersectional theory highlights that expressions and experiences of masculinity and manhood are uniquely constructed at the intersection of multiple identities, including class, race, gender, sexuality, and ability in specific cultural contexts; however, as highlighted in *The Lancet*'s 2016 Series on transgender health, population-level data with which to monitor the health of transgender men and women are scarce.[23] Routine health surveillance in most countries does not assess gender identity as an equity stratifier and in many countries, stigma, punitive laws, and misunderstanding discourage many people from making their transgender status known or accessing health care.[24] Efforts must be made by the global health community to address this gap and fully engage the heterogeneity of men's identities in the journey towards gender justice and health equity.

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masculinities, but often as the dominant reference group; most were not designed to help monitor, understand, or address men's health. Furthermore, although structural determinants are inadequately attended to in both men's and women's health, the nuances of gender in relation to men's health are particularly overlooked and the idea that gender might not operate the same way in men's health as it does in women's health is rarely considered. Few of these frameworks are equipped to look beyond hegemonic masculinities alone to consider how men's social, political, and economic power does not necessarily translate to better health.

Men's health remains undertheorised, neglected, and inadequately funded,[42] with many health researchers, professionals, and policy makers unaware of existing work.[43] This situation has implications for men's health and wellbeing, as well as for families, caregivers (who are usually women), communities, and economies.[1] Although intersectionality is acknowledged in existing frameworks, the frameworks do not sufficiently focus on how hegemonic masculinities intersect with other social stratifiers to affect uniquely vulnerable subgroups of men, or the fact that hegemonic masculinities are not exhaustive of the ideals men draw from or seek to embody.[8,9,44] Continuing to emphasise the role that gender plays in everyone's health outcomes is important at a time of anti-gender push-back,[45] as is highlighting the gendered negative outcomes of worsening social and economic inequalities, including contributions to conflict.[39]

This Series aims to explore the paradox of men's health with an intersectional lens, to unpack the concomitant privilege and penalty that shape men's health outcomes through social and structural determinants. In this first paper in the Series, we present a conceptual framework for understanding men's health from an intersectional perspective that builds on existing theories, using selected case studies to illustrate how the health of different groups of men is shaped by intersecting systems of power, and propose a definition of men's health. In the second paper in this Series,[5] we review the patterns of health outcomes of men in comparison with those of women, as well as between different groups of men, and present evidence on social and structural drivers that lead to outcomes unevenly patterned by age, demographic characteristics, and global location across different groups of men.

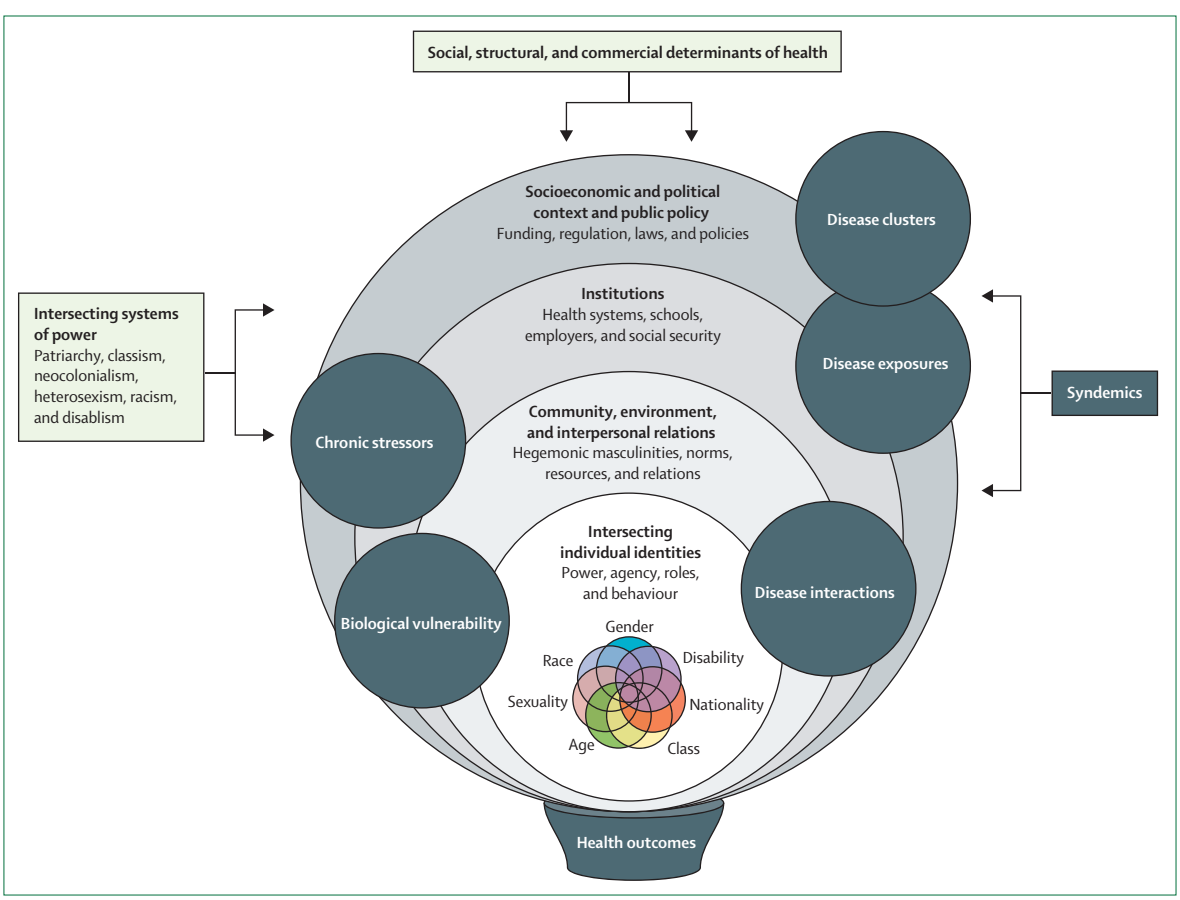

Figure: **A conceptual framework for men's health**
This framework draws on social, structural, and commercial determinants of health, intersectionality theory, and syndemic theory.

Finally, in the third paper in this Series,[14] we offer a theoretically informed analysis of the inattention to men's health and propose evidence-informed recommendations for promoting action to improve men's health.

A conceptual framework for men's health

Drawing on the discussions and critiques presented thus far and a narrative review of the literature (appendix p 1), we outline a conceptual framework that brings together social, structural, and commercial determinants of health,[46] intersecting systems of power,[47,48] and syndemic theory[49] to analyse men's health at different socioecological levels (figure).[50]

Socioecological models highlight how individuals are embedded in and influenced by systems at multiple levels.[50] Our framework identifies social, structural, and commercial determinants that shape health outcomes for men at four levels, all of which include the operation of power through intersecting systems: socioeconomic and political context (including public policy); institutions; community, environment, and interpersonal relations; and the individual level, which includes individual identity, agency, roles, and behaviour.

Intersectional theory recognises that multiple (ie, class, gender, political, religious, and sociocultural) systems of power intersect with hegemonic masculinity to create simultaneous disadvantages and privileges for groups of men on the basis of their positions within axes of social inequality.[51–53] This theory shapes our framework by showing how determinants of men's health are pervaded by interacting systems of power at all levels. For example, at the level of socioeconomic and political context, the forces of racism, capitalism, neoliberalism, neocolonialism, and patriarchy, among others, influence economies through flows of capital.[54] These forces also shape public policy on immigration and migrant entitlements,[55] and patriarchy simultaneously shapes political discourse, including political violence, which is often a key influence shaping the lived realities of marginalised men.

At the institutional level, health systems in many contexts are shaped by patriarchy, class, casteism, and racism and designed around women's reproductive biology and socially ascribed roles as carers. For example, primary health care, particularly in systems stripped back to essential health-care packages, is focused particularly on pregnancy and child health,

See Online for appendix

	Social, structural, and commercial determinants of health	Intersectionality	Syndemic theory
Men's vulnerability to pulmonary tuberculosis in the context of economic precarity in Africa	Poverty, precarious employment, and fragile health systems, shaped by neocolonialism and neoliberalism, underpin men's occupational exposure and susceptibility to tuberculosis.	Urban men in low-income, informal employment are faced with high occupational exposure to tuberculosis and the uncertainty of a daily wage creates systemic barriers to health care. Hegemonic masculinities emphasising men's income-earning responsibilities encourage prioritisation of work over health care.	Exposure to air pollution, alcohol and tobacco use, malnutrition, and chronic stress exacerbate biological susceptibility to tuberculosis and other respiratory diseases, which negatively interact with comorbidities such as HIV and silicosis, worsening health outcomes.
Cancer and heart disease risk among racially minoritised men with low income in North America	Legacies of slavery and colonisation, including residential segregation policies, generate stressful community and environmental conditions, resulting in Black and Indigenous men living in communities with reduced access to health-promoting resources or affordable, high-quality health-care options. These men face greater exposure to toxic and other health-harming factors (eg, toxic waste, fast food restaurants, liquor stores, etc) compared with their White counterparts.	Hegemonic masculinities intersect with commercial determinants (eg, racially and gender-targeted tobacco and alcohol marketing) to drive harmful health behaviours that increase cancer risk.	Cancer and heart disease are the most common causes of death, which cluster with chronic liver disease due to high tobacco and alcohol use, high access to carcinogenic, unhealthy food, and poor access to nutritious food.
Men's mental health in the context of conflict and forced displacement in the Middle East and north African region	Structural forces, including global economic pressures, neoliberal policies, patriarchal norms, and sectarian divides, create social fragility and conflict. Family-centric aid structures, perceptions of women's vulnerability, and institutional discrimination exclude men and exacerbate chronic stress.	Displaced men can have high mental health burdens. Single men receive little social support, and those who are unable to work and support their families suffer gender role strain. Racism and xenophobia in host countries impede social integration and contribute to health services under-use.	Multiple mental health conditions, including depression, post-traumatic stress disorder, and substance abuse disorders, interact negatively. Aggression and self-harm emerge as harmful coping behaviours, as does smoking, which increases non-communicable disease risk. Poor health-care access worsens previous health conditions.
Men's health and wellbeing during the COVID-19 pandemic in urban informal settlements in Bangladesh	Discriminatory global and national policies, weak governance and legal structures, and persistent wealth inequality undermine social protection and service delivery in informal settlements. Hegemonic masculinities and economic precarity interact to create chronic stressors and men resort to harmful coping strategies (eg, gambling, violence, or addiction).	Men with low income living in informal settlements faced pressure to provide for their families in the context of increasing constraints on livelihoods and violent enforcement of COVID-19 lockdowns by local authorities.	Poor environmental conditions, substandard housing, limited employment, gendered expectations and harmful coping strategies negatively interact to impact men's mental health. Low-paid, intensive, and informal manual labour also put men at risk of worsening existing mental health and other health conditions, including COVID-19.

Table: **Case studies illustrating the conceptual framework**

staffed primarily by women, and culturally oriented towards women as the primary carers of children, the sick, and older people.[3,56] Primary health care thus functions to socially exclude some women (eg, postmenopausal and trans women) and most men, who often perceive health services as female spaces.[57,58] Broader institutional systems, such as education systems, tend to consolidate hegemonic masculinities[17,59] and class, racial, and ethnic discrimination.[60]

At the community level, context-specific gender norms, including hegemonic masculinities, are usually harmful to boys and men as well as women and girls, and are consolidated through social media exposures, interacting with the inequitable distribution of resources and a toxic physical and social environment for many.[17,61,62] Repeated exposure to patriarchal hegemonic ideals, through social media or across community and family spaces, worsens stress and other harms to mental health.[63]

All these determinants intersect to create disease exposures that, along with individual vulnerabilities arising from interactions between chronic stressors and male biology, produce poor health outcomes for men. The framework we present here draws on syndemic theory, which takes a biosocial approach and explores how social, environmental, and disease-related factors interact synergistically in various and consequential ways.[49,64] This theory helps to explain why groups of disadvantaged men in particular socioeconomic, political, and cultural contexts are vulnerable to specific disease exposures and adverse interactions, which leads to clustering of diseases. For example, men who have sex with men have an elevated risk of both HIV transmission and mental ill health in ways that reinforce each other, particularly in contexts of community sexual prejudice shaped by patriarchal heteronormativity, underpinned by legal and institutional discrimination, and exacerbated by racial, ethnic, and class inequalities.[65,66] Poor health outcomes for men in turn contribute to poor social and economic environments and communities, for example by reducing productivity in the workforce, creating caring burdens (predominantly for women and girls), and increasing the risk of intimate partner violence.[67]

Illustrating the conceptual framework

The framework emphasises the importance of understanding how intersections between gender and other systems of power determine health outcomes for men, particularly men who are minoritised because of classism, neocolonialism, racism, heterosexism, ableism, or other oppressive processes. Here, we present four case studies that synthesise existing research to illustrate key aspects of the framework, selected on the basis of their representation of different geographical locations, major health conditions contributing to the gender gap in health outcomes (as discussed in the second paper in this Series[5]), and manifestations of men's marginality. Intended to be illustrative of the range of intersecting determinants of men's health globally rather than an exhaustive review of the literature, case study contributors identified additional literature relevant to the topic from their own experience and expertise, reflecting diverse geographical locations, social positionalities, and disciplines.

The table summarises how the case studies illustrate different elements of the conceptual framework.

Men's vulnerability to pulmonary tuberculosis in the context of economic precarity in Africa

This case study illustrates how the interaction of global and national economic policies, institutional health system biases, and gendered norms creates precarity and environmental exposures that shape the vulnerability to tuberculosis of men with low income and limit their access to diagnosis and treatment, ultimately creating disproportionate risk of tuberculosis and poor outcomes.

Men bear the brunt of tuberculosis incidence in Africa[68,69] and face systemic barriers to tuberculosis prevention and care.[70] Of the 2·62 million people who developed tuberculosis in the WHO African region in 2024, more than 1·35 million were men (alongside approximately 926 000 women and 337 000 children), with more than one in four men missing tuberculosis diagnosis and treatment. Tuberculosis thrives where poverty, precarious employment, and fragile health systems intersect. Men with low income, who are disproportionately represented in unstable, high-exposure jobs such as mining, transportation, and manual urban work, often face cumulative disadvantages across structural, institutional, and community levels.[71]

Overcrowded urban informal settlements (which accommodate more than 50% of people living in cities across Africa)[72] and poorly ventilated social settings and workplaces amplify airborne transmission of tuberculosis, and indoor air pollution from biomass fuels compounds pulmonary damage.[73] Tuberculosis-associated occupational hazards are widespread in male-dominated employment sectors;[74,75] for example, in Kenya, drivers and touts working in enclosed and poorly ventilated *matatus* (buses) have high rates of tuberculosis exposure.[76] Normative gender expectations of men as providers and scarce employment opportunities push most men into informal employment.[77] Men who rely on daily contracts for physically demanding but unlucrative work must act fit, even when they are unwell,[60] and prioritise work over health care to avoid shortfalls in income and food for their families.[78] Where men's workplace tuberculosis care programmes exist, they rarely make use of worker led structures of self-organisation, whether formal or informal.[79,80]

In low-income urban and peri-urban settings, hegemonic masculine norms valorising toughness, self-reliance, and risk taking interact with economic stress to produce harmful coping behaviours.[81] Alcohol and

tobacco use are often seen as markers of manhood or strategies to manage psychosocial stress and chronic cough, yet they exacerbate vulnerability to tuberculosis infection and progression to disease.[82] Moreover, many men perceive sickness and care seeking as emasculating and resort to what are known as paracetamol masculinities[83]—ie, using over-the-counter medication to suppress tuberculosis symptoms, sustain themselves, and avoid ridicule.[84,85]

Health-care delivery systems in many low-income countries prioritise maternal and child health services, rendering men's health needs invisible. Fear of stigma, long waiting times, indirect costs of travel, and lost wages deter men from seeking care in formal health facilities.[86] User-fee regimes, stock-outs, and weak diagnostic referral systems widen gendered access gaps, contributing to diagnostic delays and sustained community transmission.[87,88]

These structural and behavioural factors cluster with malnutrition, chronic stress, and comorbidities, such as HIV and silicosis, to produce syndemic conditions that accelerate tuberculosis morbidity and mortality among men.[68] The vicious cycle of tuberculosis-related morbidity and premature mortality reduces household income and social participation, deepens economic precarity, and constrains national productivity.[89] At a societal level, the health costs of male vulnerability to tuberculosis are borne not only by families but by entire health systems struggling with preventable disease burdens.[90,91]

Cancer and heart disease risk among racially minoritised men with low income in North America

This case study shows how power systems of racism and classism intersect with hegemonic masculinities and commercial determinants of health to drive risky health behaviours and limit access to high-quality health services, leading to inequitable non-communicable disease outcomes for minoritised men.

In North America, coronary heart disease and cancer remain by far the leading causes of death for men.[92,93] These diseases are also the largest contributors to the gender gap between men and women in terms of causes of death: in the USA, the number of deaths from heart disease and cancer were 204·4 per 100 000 population and 165·3 per 100 000 population for men and 126·8 per 100 000 population and 124·1 per 100 000 population, respectively, for women.[92] These outcomes are not equally patterned among men, with higher cancer and cardiovascular mortality rates in Black men compared with their White counterparts.[94,95]

In the USA, the legacy of slavery and racism interacts with contemporary public policy to create stressful community-level social and environmental conditions for Black American men.[96,97] A key example is the impact of widespread racial residential segregation, stemming from historical discriminatory policies such as redlining, which devalued areas with large Black, low-income, or foreign-born populations by ranking them as unsuitable for mortgage lending.[98] This practice led to disinvestment in these neighbourhoods and deliberate constraints on where racially minoritised populations could live, resulting in stark racial inequities in home ownership, wealth, education, employment, transportation, and environmental pollution that are still observed today.[99] Combined with the influence of hegemonic masculinity, which idealises stoicism, strength, and risk taking, and gender norms of culturally appropriate coping behaviours, these conditions increase the likelihood that men will engage in harmful health behaviours that increase the risk of both cancer and heart disease, such as smoking, alcohol or drug use, and overeating, in an attempt to cope with the stressors of daily life.[100]

Shaped by race-based residential segregation and other aspects of structural racism, commercial determinants of health play a substantial role in the patterning of non-communicable disease outcomes in Black and Indigenous men. Smoking is a major contributor to lung cancer, the leading cause of cancer deaths among men in the USA.[92] For decades the tobacco industry has targeted Black American communities, and Black men in particular, by advertising more heavily in stores with customers who are mostly Black American and by using price promotions to increase sales.[101] Menthol cigarette use is highly concentrated among Black American smokers—approximately 85%, compared with around 39% among smokers overall—a pattern widely attributed to decades of aggressive marketing by tobacco companies and associated with higher nicotine dependence, lower cessation success, and disproportionate smoking-related health burdens compared with non-menthol cigarette use.[102–104]

The influences of structural racism and private-sector interests have also shaped health outcomes for American Indian and Alaska Native men, particularly regarding the crisis-level threats of chronic liver disease and cirrhosis.[93,105] The epidemic of alcohol-related problems among many Native North American communities can be traced back to colonial legacies of European arrival and the role of alcohol in frontier society,[106,107] maintained by targeted marketing of alcohol towards men in Indigenous communities and the loss of traditional support networks, which leads to disproportionate use of alcohol as a response to stress, psychological strain, and depressive symptoms.[108]

Black American and Indigenous men in North America face particularly limited access to timely, high-quality care.[109] The history of harm and anti-Black racism in health-care institutions, including misdiagnosis and subjection to unethical research masked as health care, has led to distrust and low health care-seeking rates in these populations.[110,111] Black American men have the highest incidence and mortality rates of colorectal cancer of any ethnic group in the USA,[112] but particularly low uptake of colorectal cancer

screening, due to the interplay between traditional masculine norms, racism, and medical mistrust.[113,114] Black American cancer survivors receive most of their outpatient care from informal family caregivers, the majority of whom are women.[115] As in many contexts around the world, this reliance on women's unpaid and domestic care work restricts women's economic empowerment, embeds traditional gender roles, and creates substantial physical and mental strain for women.[116] Despite coverage gains between 2019 and 2023, Black American men (as well as Hispanic, American Indian and Alaska Native, and Native Hawaiian or Pacific Islander men) are more likely to be uninsured compared with their White counterparts in the USA, reflecting more limited access to affordable health coverage options due to ongoing racial disparities in employment and income.[117]

Mental health of men displaced by conflict in the Middle East and north African region

This case study illustrates how the poor mental health of displaced men from the Middle East and north African (MENA) region is shaped by the interaction between the global political economy and regional conflict, hegemonic masculinities, and public policies on migration and entitlements of asylum seekers and refugees, all of which lead to institutional exclusion.

The health needs of displaced men are often overlooked, with the vast majority of refugee studies focusing on women;[118] however, displaced men face a range of gender-specific physical and psychological challenges. Many of these challenges stem from trauma, torture, forced conscription, and sexual violence, which might be more common than recognised,[119] especially against men who have sex with men and trans men.[120] Mental ill health is particularly pronounced: a 2024 meta-analysis in the MENA region estimated that 42% of displaced people have depression and 45% have post-traumatic stress disorder (PTSD).[121] For men in particular, psychological distress is exacerbated by economic insecurity, unstable housing, visa uncertainty, underemployment, and loss of social status, all of which can erode identity and self-worth.[122]

Multiple forces have driven conflict and mass displacement in the past decade across the MENA region, which hosted 3·2 million refugees and asylum seekers at the end of 2024.[123] Deeply entrenched patriarchal and neocolonial power structures have contributed to wars and repression in many countries in the MENA region, including Syria and Yemen, where national regimes and militias exploit patriarchal norms and sectarian divides to maintain power through violence.[124,125] Global geopolitics and neoliberal policies create economic pressures that exacerbate social fragility; for example, international financial institutions have promoted austerity measures that have impoverished large segments of society in Syria and Egypt.[126–128]

Single men are frequently excluded from institutional responses to displacement, such as emergency housing schemes and health and social services, due to restrictive laws and gendered assumptions.[128–130] Many men avoid clinics or non-governmental organisations due to stigma or fear of being viewed as security risks,[130] driven by gendered media narratives that portray lone men as suspicious or dangerous.[128] Access to health care for displaced populations is often limited by legal, financial, linguistic, and cultural barriers,[131] and displaced men are substantially less likely than displaced women to seek help, especially for mental health conditions, due to fears of retraumatisation, mistrust of clinicians and psychotropic medications,[132] cultural stigma, and concerns about jeopardising employment opportunities.[133]

Within communities, displacement can disrupt gender roles, which can leave men who formerly identified as providers and protectors feeling emasculated and frustrated.[134] In many host states, refugees are barred from formal work, a constraint that hits men especially hard, as seen among Syrian men in Jordan, Lebanon, and Egypt who face ongoing fear and humiliation tied to their diminished status.[135] Unresolved emasculation often drives harmful coping behaviours, such as substance use, aggression, or domestic violence, and fuels identity loss, mental health decline, and ongoing risky behaviours.[136,137]

Men—particularly young men—are more likely than women to sustain conflict-related injuries that lead to disability,[138] and men with disabilities face elevated risks of acute harm during armed conflicts.[139] Many veterans accumulate disability-related debts because of health expenses and loss of wage income, embedding poverty, debility, and precarity, which negatively impact all aspects of health.[140]

A study published in 2020 shows that approximately one-third of displaced men have overlapping mental health conditions that cluster and reinforce one another.[126] These issues form a feedback loop: untreated trauma and PTSD can lead to alcohol or drug use, which increases the risk of violence or self-harm and further isolates men and deepens their distress.[141] Young men are particularly vulnerable to this loop due to high trauma exposure, unemployment stress, and risk of addiction.[126] Displaced men are also at heightened risk of non-communicable and infectious diseases; a study in Greek refugee camps found that male Afghan refugees made up a disproportionate share of respiratory tract infection cases compared with female Afghan refugees.[142] Sex-based inequalities can be exacerbated by heightened tuberculosis risk in conditions of displacement and overcrowding,[143] and an increase in coping behaviours such as smoking leads to cardiovascular diseases and cancers. This syndemic burden underscores how the neglect of displaced men contributes to their poor health, social marginalisation, and economic exclusion, undermining both individual wellbeing and broader integration efforts.

Men's health and wellbeing during the COVID-19 pandemic in urban informal settlements in Bangladesh

This case study highlights how, for disadvantaged men in informal settlements in Dhaka, Bangladesh, vulnerabilities and health risks are shaped by the interaction between global and national economic strategies, trade policies, and hegemonic masculinities, all of which were exacerbated during the COVID-19 pandemic.

Neoliberal reforms, including privatisation, reduced state spending, and strict budgets, promoted by the World Trade Organisation, The World Bank, and the International Monetary Fund, have combined with global economic downturn to deepen poverty and economic precarity in Bangladesh, which is highly loan dependent. Human Rights Watch reports that austerity measures linked to the International Monetary Fund have harmed jobs and social services, with an estimated 36 million Bangladeshis living in poverty and highly vulnerable to inflation, job losses, illness, and climate shocks in 2025.[144] Discriminatory national policies, weak governance, insufficient accountability, persistent inequality, and tax evasion undermine social protection and health service delivery, with people with low income in urban areas most affected.

Rapid urbanisation and rising inequality have created an estimated 5000 informal settlements in Dhaka that house approximately 4 million people. Land is commodified, which drives up housing costs beyond the reach of people with low income in urban areas. This intense competition for urban space has led to frequent evictions and growing unhealthy physical and social environments due to overcrowding, open waste disposal, poor drainage, crime, and gang violence.[145,146]

At the beginning of the COVID-19 pandemic in early 2020, national lockdowns, following WHO guidelines, meant that all industries, businesses, and schools closed, which led to severe job and income losses, particularly in informal settlements.[147] More than 1900 global brands cancelled or delayed US$3·7 billion in orders from Bangladeshi factories, causing massive job and income losses with little global accountability,[148] with the unemployment rate for people older than 15 years rising from 3·35% in 2023 to 3·65% in 2024.[149]

Hegemonic masculinities put pressure on men living in informal settlements to provide economically for their families;[150] however, these men are often constrained by little to no education, few skills, and unstable, low-paid work, mainly in the informal sector (including transport, construction, street vending, domestic labour, and factories). These jobs are risky and largely unprotected. The unemployment rate in two informal settlements in Dhaka in 2021 was 36·34%.[151] Approximately 85% of people employed in Bangladesh work in the informal sector, where exclusion from national labour laws leaves them without legal protection or social security.[149] Boys from families with low income are disadvantaged in education compared with girls in the same situation, with 74% of boys aged 15–19 years having some secondary schooling compared with 83% of girls, due to having to work to support the family.[152]

Whereas analyses have found that the COVID-19 pandemic worsened women's positions in Bangladesh, men with low income particularly experienced negative effects.[153] Qualitative studies of young men's experiences show high rates of anxiety and depression in the context of pressure to provide for their families, lost jobs, daily wage work, police violence in enforcing lockdowns, and food insecurity, with many using smoking and drinking as coping strategies.[154] Once lockdowns were lifted, men faced particular pressure to resume livelihoods, effectively being forced to choose between risking COVID-19 infection and starvation for themselves and their families. Male individuals had a higher infection rate than female individuals, and more confirmed (67%) and fatal (65%) cases were among male individuals than female individuals in Bangladesh (33% *vs* 35%).[153]

At the onset of the COVID-19 pandemic, higher rates of negative effects on mental health were reported among men than women (although later in the pandemic, higher rates of depression and anxiety were reported among women compared with men).[153] In many cases, men's poor mental health is tied to their perception of failing to embody gendered roles.[155] Failing to provide and frustrated with their lives, men can turn to negative coping strategies, such as gambling, drinking, or joining gangs, that threaten their health, as well as the health and wellbeing of their families. Intimate partner violence against women increased during the COVID-19 pandemic,[153] exacerbated by commercial drivers such as the expanding sex work industry and the prevalence of pornography in a context of little sex education, which reinforce hegemonic masculinities that valorise male sexual violence and exacerbate male anxieties in relationships.[156] Masculine norms of showing what they might see as strength and suppressing emotions discourage men from seeking psychological support.[157] Furthermore, the urban primary health-care system predominantly focuses on maternal and child health and family planning and does not explicitly include men.[158]

Discussion

Existing approaches to understanding men's health tend to focus either on gender and masculinities or on other drivers of health inequalities between men, rather than looking at how these two concepts intersect. The framework proposed here brings together intersectional theory; social, structural, and commercial determinants of health; and syndemic theory across different socioecological levels. We have explained the relationship between these concepts with examples focused on important contributors to men's poor health outcomes across different global contexts, to show the need for continued engagement with men's health and to underscore several important cross-cutting themes.

First, harms to men's health are shaped by interactions between global, regional, and national policies that drive increasing economic precarity and class inequalities.[159] Trade and economic policies, including recent reductions in development assistance in the USA and parts of Europe, might exacerbate economic precarity in low-income and middle-income countries, particularly where aid reductions constrain public provision of health, social protection, or other essential services.[160,161]

Second, men with low income, racially minoritised men, and otherwise marginalised men have poor geographical and financial access to high-quality education, health care, and humanitarian aid due to discriminatory norms that influence institutional policy in areas such as health care, urban planning, and development.[162–164] This situation is often exacerbated by gendered assumptions that underpin policy and practice, which equate women with vulnerability and commonly exclude men.[39] Gender justice requires that vulnerabilities of both women and men are recognised, resources are allocated to meeting their needs, and service provision is inclusive and accessible to all.

Third, risks to men's health in physical and occupational environments are underpinned by insufficient environmental regulatory powers and labour protections. These risks are felt more acutely by people who are politically and socially marginalised, which highlights the role of environmental injustice[165] (ie, exposure to environmental hazards and the social, political, and economic processes that shape intersectional vulnerabilities) in contributing to many poor health outcomes for men.[166] Commercial promotion of tobacco, alcohol, and pornography to marginalised men, often drawing on hegemonic masculinity,[167] contributes to a harmful social environment, together with social discrimination and interpersonal and community-level violence. Furthermore, when structural forces disrupt patriarchal gender roles, men often develop anxiety and depression or engage in unhealthy coping mechanisms due to gender role strain, whereby men perceive they are failing to live up to gendered expectations, such as providing for their families.[168] It does not follow, however, that inequitable gender roles and harmful hegemonic masculinities should be maintained or protected. Redistribution of gendered power within households and the cultivation of positive, equitable masculinities are important to achieve gender justice, but they are less likely to be achieved without concomitant action to tackle men's oppression and marginalisation across other axes of power. For example, analyses in South Africa have linked men's resistance to gender-transformative initiatives—those programmes and policies that actively examine, challenge, and change the root causes of gender inequality—to the lack of attention to the class and race disadvantages faced by men within these initiatives.[169]

Fourth, risks and vulnerabilities are mediated by the unique social positions of men within power systems, including aspects of identity such as gender (beyond the male–female binary), age and life course stage, education, citizenship, race, ethnicity, ability or disability, and class, which shape opportunities for agency, including occupations and incomes.[31] The often harmful and restrictive masculine norms associated with hegemonic masculinities contribute to the continuation of patriarchal power structures, which, although reproducing privilege for some men, create multiple harms for many others marginalised through interconnected systems of oppression, as well as women and people of other genders. Heterosexism and ableism are particularly underexplored as drivers of men's poor health.

Building on insights from the conceptual framework and case examples, here we propose a working definition of men's health adapted from the literature,[170–172] which we utilise across this series (panel 2).

Our analysis and working definition shows that promoting men's health, health equity, and gender justice requires sustained action across all systems of power and at multiple levels—global, national, and community—including within institutions across different sectors and a wide range of societal stakeholders. Key to this action are strategic alliances between advocacy coalitions of men, women, and people of other genders to challenge economic, social, and political inequalities, including but not limited to hegemonic masculinities that are harmful to all genders, to improve health for all (see the third paper in this Series[14]). Our case studies illustrate how the clustering of men's poor health outcomes has negative consequences for the women and children in their families and communities, including through vicious cycles of poor mental health and harmful coping strategies, such as alcohol, tobacco, and drug use, which exacerbate violence, divert family resources, and contribute to community and wider conflicts.[39] Such cycles generate caring burdens within families,[67] communities, and health systems and inhibit economic and human development.

Gender-transformative approaches that challenge gender inequalities should not reflect a zero-sum concept

Panel 2: **Working definition of men's health**

Men's health refers to a field of research, policy, practice, and men's lived experiences of health and wellbeing that examines how biological factors, social positioning, and the distribution of power and resources shape patterns of health, illness, and mortality among men. Men's health focuses on how exposure to risk and capacities to mitigate and respond to risk are patterned and clustered, and on access to health services and the social, structural, political, and commercial determinants that produce unequal health outcomes across diverse groups of men, differentiated by biology, identity, experience, and context.

of gender justice; they should benefit men as well as women by creating more equitable relationships, in which men's power over women might be reduced, but their opportunities for power within, and for power with (from Rowlands' model of power[26]) women allies and those of other genders against oppressions might be increased.[173] Efforts to foster more positive masculinities need to engage with the multiple intersecting power systems that shape men's health in specific social, political, cultural, and historical contexts. This engagement is crucial for shifting the focus on men's health solely at the level of harmful individual behaviours to encompass the role of structural, social, and commercial determinants and systems of power in sustaining and producing multiple vulnerabilities (sometimes simultaneously with the exercise of privilege and power) that lead to poor health outcomes. Interventions need to move beyond deficit-based biomedical approaches that focus on masculinities as barriers or risks, and towards more holistic, strengths-based models that recognise and embrace people's (including men's) local cultures, resources, and skills as crucial assets in health-care provision.[174–176] This move includes supporting the many positive contributions men make to family and community health,[177] and the use of dialogue and equity-focused participatory approaches with the aim of developing more inclusive and equitable services.

The application of syndemic theory in our framework enables us to highlight how the clustering of health conditions in marginalised populations of men (eg, cancer and heart disease in Black American men, or PTSD and substance misuse in displaced men) is driven by the harmful social conditions in which these populations live.[49] Combining syndemics with intersectional approaches highlights the role of power systems in driving concentrated health disadvantage at the population level,[178] as well as how these systems produce chronic stressors that intersect with biological vulnerabilities to create health outcomes, as illustrated by men's vulnerability to tuberculosis in the context of economic precarity in Africa. Together, this conceptual view can help in guiding policy makers and practitioners to identify what types of interventions matter—those that enhance individual and community resilience, leverage the strengths of marginalised groups of men, and explicitly address the full range of social inequities and broader structural determinants that shape men's health.[66,179] Application of the framework will generate learnings about the complex interactions between systems of power at different socioecological levels and the implications for gender justice and health equity that are useful for informing strategic advocacy and tailored interventions to improve men's health.

Conclusion

The changing geopolitical order, ongoing and new conflicts, economic protectionism, and cuts to international aid mean that analysis and action for social justice—including gender justice and health equity—are urgent. This Series paper shows how the paradox of men's health stems from the way hegemonic masculinities, which privilege men in gender power relations but also create multiple harms for all genders, intersect with other social characteristics and systems of power in complex ways to affect men's health outcomes. By presenting the analysis from an intersectional perspective across different geographical locations, conditions, and groups of marginalised men, we emphasise the need to move beyond one-dimensional approaches that focus on individual men's behaviours to better understand, analyse, and act on the broader set of power structures and social determinants that underpin men's health.

Contributors

Conceptualisation: RTo , BRE, WM, and ST. Funding acquisition: RT, ST, and SFR. Identifying relevant literature: RTo, BRE, FF, DG-S, IJ, AAM, SFR, BR, RTh, RMT, CU, ST. Literature search and case study methodology: RTo, BRE, WM, ST. Project administration: RTo, BRE, WM, and ST. Writing of the original draft: RTo, BRE, FF, DG-S, DMG, IJ, AAM, SFR, BR, RTh, CU, and ST. Review and editing: RTo, BRE, WM, JWFC, FF, DMG, SJH, IJ, SVK, AAM, SFR, BR, RTh, RMT, CU, and ST.

Declaration of interests

RTo, BRE, SFR, and ST were supported by funding from the UK Research and Innovation (UKRI) Global Challenges Research Fund Accountability for Informal Urban Equity Hub: a UKRI Collective Fund award with award reference ES/S00811X/1. ST, SFR, WM, and RTo were supported with funding from Gender Equity and Antimicrobial Resistance, funded by the Department of Health and Social Care's Fleming Fund using UK aid/MottMacDonald (grant number FF152 558). ST is a part-time UKRI–Foreign, Commonwealth & Development Office (FCDO) Senior Research Fellow in Gender (2024-2027, payment to the institution), and the views expressed in this publication are those of the authors and not necessarily those of UKRI–FCDO or any other funder. ST has received payments and travel expenses from the Wellcome Trust. RTo is supported by funding from the Canadian International Development Research Centre and UK FCDO for Urban Transformative Research for Adaptation to Climate Change in Informal Settlements (grant number 110642-001). JWFC has received a grant from Roche (to their institution); consulting fees or honoraria from Astellas, AstraZeneca, BMS, CG Oncology, Roche, Ferring, Janssen, Johnson and Johnson, Medscape, Pfizer, and Merck; support for attending meetings from Janssen; has participated on the External Advisory Boards for the PROMOTE trial (University of Oxford, UK), the Bespoke trial (University College London Hospitals, UK), and the CISTO trial (Bladder Cancer Advocacy Network, USA); has played a leadership/fiduciary role with Fight Bladder Cancer UK and Weston Park Cancer Charity; and is Director of the Sheffield National Institute for Health and Care Research (NIHR) Clinical Research Facility. DMG declares National Institute on Minority Health and Health Disparities funding for Fathers and Children Exercising Together (FACEiT) & Black Health Block & Quit and Screen Project - Supplement to University of Arkansas for Medical Sciences P50, US Department of Defense funding for Impact of Online Prostate Cancer Information on Health Disparities, Movember Foundation funding for Rooted & Rising Collective: Movember Foundation Accelerator Program for Young Black Men; payment for lecture for Men's Health World Congress, National Maternal Health Innovation Symposium, University of Minnesota's 8th Annual Research Ethics Day Conference, Community Engagement Grand Rounds (University of Texas Southwestern Medical Center), 13th Annual Health Equity & Social Justice Conference, Annual Public Health Conference Promoting Health Equity, Speaker Series University of Arkansas for Medical Sciences (Center for Research, Health and Social Justice),

Promoting Father Engagement to Enhance Baby's Brain Health Development (School of Public Health, University of Texas), Equity ECHO Series—The Ethics of Doing Research with Communities (University of New Mexico Health Science Center), Partners for Advancing Health Equity (P4HE) webinar (Tulane School of Public Health and Tropical Medicine), Curtis Center Health Equity Seminar at University of Michigan, Black Health & Wellness Speaker Series at University of Pittsburgh, Health Equity: From Lens to Science series at University of California, Workshop at Rutgers University, Precision Prevention, Early Detection, and Interception of Cancer Special Conference at American Association for Cancer Research; member of Global Men's Health Advisory Committee (Movember Foundation) and Men's Health Network, Chair of Global Action on Men's Health. SJH declares grants to Global 50/50 from the Gates Foundation and Co-Impact; consulting fees from Elsevier Research Cultures Board and the Swedish Government Research Funding Board; payment or honoraria from the Swiss National Science Foundation (paid to Global 50/50); has participated on an advisory board with WHO as chair of Data Safety and Monitoring Board trial; and is a UK Government-appointed Commissioner and Chair of the Awards Policy Committee for the Commonwealth Scholarship Commission. SVK was supported by funding from the European Research Council (949582), the Medical Research Council (MRC; MC_UU_00022/2), and the Scottish Government Chief Scientist Office (SPHSU17); has received reimbursement from the MRC to attend grant panel meetings; and is an unpaid member of Obesity Action Scotland. BR, RTh, and CU were supported by funding from UK aid Leaving No One Behind; transforming Gendered pathways to Health for TB Research Programme Consortium. RMT received a Wellcome Trust Research Award for Health Professionals (218105/Z/19/Z), the NIHR Development Award (co-primary investigator; NIHR154243), the NIHR Researcher-Led Award (co-investigator; NIHR168008), and a Public Health Scotland award (Safer Drugs Consumption Facility Evaluation – Baseline Data Collection). All other authors declare no competing interests.

Acknowledgements
We thank Vittoria Lutje who supported the literature search.

References

1 Bennett JC. Inclusion of women in clinical trials—policies for population subgroups. *N Engl J Med* 1993; **329:** 288–92.
2 Merone L, Tsey K, Russell D, Nagle C. Sex inequalities in medical research: a systematic scoping review of the literature. *Womens Health Rep* 2022; **3:** 49–59.
3 Morgan R, Ayiasi RM, Barman D, et al. Gendered health systems: evidence from low- and middle-income countries. *Health Res Policy Syst* 2018; **16:** 58.
4 Chang AY, Johnson EK, Bolongaita S, et al. From sex differences to sex inequalities in life expectancy: a cross-country observational benchmarking analysis. *PLoS Med* 2025; **22:** e1004828.
5 Catto JWF, Thomson RM, Griffith DM, et al. A global men's health epidemiology within an intersectional framework. *Lancet* 2026; **408:** 1881–98.
6 Affleck W, Carmichael V, Whitley R. Men's mental health: social determinants and implications for services. *Can J Psychiatry* 2018; **63:** 581–89.
7 Hoy S. Beyond men behaving badly: a meta-ethnography of men's perspectives on psychological distress and help seeking. *Int J Mens Health* 2012; **11:** 202–26.
8 Griffith DM. "Healthy masculinities are mosaics": comment on Di Bianca and Mahalik (2022). *Am Psychol* 2023; **77:** 333–35.
9 Valdez LA, Jaeger EC, Garcia DO, Griffith DM. Breaking down machismo: shifting definitions and embodiments of Latino manhood in middle-aged Latino men. *Am J Mens Health* 2023; **17:** 15579883231195118.
10 Shand T, Evoy C. Out of focus: the representation of men in regional and global sexual and reproductive health policy. Global Action on Men's Health, 2024.
11 Leon NH, Colvin CJ. No man's land: how men are considered in global primary health care policy. Global Action on Men's Health, 2021.
12 Leon NH, Colvin CJ. Absent-minded: the treatment of men in global mental health policy. Global Action on Men's Health, 2024.
13 Irish Department of Health. National men's health action plan: heathy Ireland - men (HI-M) 2024–28: working with men in Ireland to achieve optimum health and wellbeing. Irish Department of Health. 2024. https://www.drugsandalcohol.ie/42274/1/national-men-s-health-action-plan-2024-2028.pdf (accessed June 5, 2026).
14 Hawkes S, Katikireddi SV, Buse K, et al. Charting a course to men's health and wellbeing: applying a lens of power and politics to improve men's health outcomes. *Lancet* 2026; **408:** 1899–911.
15 Hawkes S, Buse K, Clark JP, et al. When the rules are rewritten, strengthen the coalition for gender justice. *Lancet* 2026; **407:** 929–31.
16 Ignatiou N. UK and international aid cuts are fuelling a worldwide health crisis for women and girls. *BMJ* 2025; **390:** r1902.
17 Domingue BW, Cislaghi B, Nagata JM, et al. Implications of gendered behaviour and contexts for social mobility in the USA: a nationally representative observational study. *Lancet Planet Health* 2019; **3:** e420–28.
18 Shakya HB, Domingue B, Nagata JM, Cislaghi B, Weber A, Darmstadt GL. Adolescent gender norms and adult health outcomes in the USA: a prospective cohort study. *Lancet Child Adolesc Health* 2019; **3:** 529–38.
19 Roberts S, Jones C, Nicholas L, Wescott S, Maloney M. Beyond the clickbait: analysing the masculinist ideology in Andrew Tate's online written discourses. *Cult Sociol* 2026; **20:** 459–83.
20 Hawkes S, Sy EA, Barker G, et al. Achieving gender justice for global health equity: the *Lancet* Commission on gender and global health. *Lancet* 2025; **405:** 1373–438.
21 Wojnicka K. Intersectionality and masculinities studies, go together like a horse and carriage. *Int J Masculinity Stud* 2024; **19:** 111–15.
22 Bowleg L, Malekzadeh AN, AuBuchon KE, Ghabrial MA, Bauer GR. Rare exemplars and missed opportunities: intersectionality within current sexual and gender diversity research and scholarship in psychology. *Curr Opin Psychol* 2023; **49:** 101511.
23 Reisner SL, Poteat T, Keatley J, et al. Global health burden and needs of transgender populations: a review. *Lancet* 2016; **388:** 412–36.
24 Lo S, Horton R. Transgender health: an opportunity for global health equity. *Lancet* 2016; **388:** 316–18.
25 WHO. Health equity and its determinants. World Health Organization, 2021.
26 Rowlands J. Empowerment examined. *Dev Pract* 1995; **5:** 101–07.
27 Connell RW, Messerschmidt JW. Hegemonic masculinity: rethinking the concept. *Gend Soc* 2005; **19:** 829–59.
28 Connell RW. Masculinities. Cambridge: Polity Press, 1995.
29 Courtenay WH. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Soc Sci Med* 2000; **50:** 1385–401.
30 Creighton G, Oliffe JL. Theorising masculinities and men's health: a brief history with a view to practice. *Health Sociol Rev* 2010; **19:** 409–18.
31 Evans J, Frank B, Oliffe JL, Gregory D. Health, illness, men and masculinities (HIMM): a theoretical framework for understanding men and their health. *J Men's Health* 2011; **8:** 7–15.
32 Efird CR, Griffith DM. Structural advantage and White men's health and well-being. *Am J Public Health* 2026; **116:** 1156–64.
33 Lohan M. How might we understand men's health better? Integrating explanations from critical studies on men and inequalities in health. *Soc Sci Med* 2007; **65:** 493–504.
34 Robertson S, Williams B, Oliffe J. The case for retaining a focus on "masculinities" in men's health research. *Int J Mens Health* 2016; **15**: 52–67.
35 Cornell M. Men's health policies: long overdue. *Bull World Health Organ* 2025; **103:** 515–16.
36 Griffith DM. Gender health equity: the case for including men's health. *Soc Sci Med* 2024; **351** (suppl 1)**:** 116863.
37 Hankivsky O, Hunting G. From gender mainstreaming towards mainstreaming intersectionality. In: Morrow M, Hankivsky O, Varcoe C, eds. Women's health in Canada. University of Toronto Press, 2022: 186–208.
38 White A, Connell R, Griffith DM, Baker P. Defining "men's health" towards a more inclusive definition. *Int J Mens Soc Community Health* 2023; **6:** e1–9.

39 Percival V, Thoms OT, Oppenheim B, et al. The *Lancet* Commission on peaceful societies through health equity and gender equality. *Lancet* 2023; **402:** 1661–722.

40 Pan American Health Organization. Masculinities and men's health in the Caribbean. Pan American Health Organization, 2023.

41 Pan American Health Organization. Masculinities and health in the region of the Americas. Pan American Health Organization, 2019.

42 Horton KC, White RG, Houben RMGJ. Systematic neglect of men as a key population in tuberculosis. *Tuberculosis* 2018; **113:** 249–53.

43 Ruane-McAteer E, Gillespie K, Amin A, et al. Gender-transformative programming with men and boys to improve sexual and reproductive health and rights: a systematic review of intervention studies. *BMJ Glob Health* 2020; **5:** 10.

44 Curry TJ. The man-not: race, class, genre, and the dilemmas of Black manhood. Temple University Press, 2017.

45 Griffith DM. Men's health, population health, and President Trump 2.0: 5 years after George Floyd. *Int J Mens Soc Community Health* 2025; **8:** 1–4.

46 Heller JC, Givens ML, Johnson SP, Kindig DA. Keeping it political and powerful: defining the structural determinants of health. *Milbank Q* 2024; **102:** 351–66.

47 Crenshaw KW. Mapping the margins: intersectionality, identity politics, and violence against women of color. In: The public nature of private violence. Routledge, 1994: 93–118.

48 Bowleg L. When Black+ lesbian+ woman≠ Black lesbian woman: the methodological challenges of qualitative and quantitative intersectionality research. *Sex Roles* 2008; **59:** 312–25.

49 Singer M, Bulled N, Ostrach B, Mendenhall E. Syndemics and the biosocial conception of health. *Lancet* 2017; **389:** 941–50.

50 Bronfenbrenner U. Toward an experimental ecology of human development. *Am Psychol* 1977; **32:** 513–31.

51 Cho S, Crenshaw KW, McCall L. Toward a field of intersectionality studies: theory, applications, and praxis. *Signs (Chic)* 2013; **38:** 785–810.

52 Griffith DM. An intersectional approach to men's health. *J Men's Health* 2012; **9:** 106–12.

53 Bowleg L, Del Río-González AM, Holt SL, et al. Intersectional epistemologies of ignorance: how behavioral and social science research shapes what we know, think we know, and don't know about U.S. black men's sexualities. *J Sex Res* 2017; **54:** 577–603.

54 Onyango Ouma S. Neo-colonialism, global economic structures, and Africa's development: rethinking dependency and economic sovereignty. In: Onyango Ouma S, ed. Indigenous systems, colonialism, colonial legacies, and Africa's economic challenges: why is Africa failing? Cham: Springer Nature, 2025: 179–98.

55 Misra S, Kwon SC, Abraído-Lanza AF, Chebli P, Trinh-Shevrin C, Yi SS. Structural racism and immigrant health in the United States. *Health Educ Behav* 2021; **48:** 332–41.

56 Hay K, McDougal L, Percival V, et al. Disrupting gender norms in health systems: making the case for change. *Lancet* 2019; **393:** 2535–49.

57 Skovdal M, Campbell C, Madanhire C, Mupambireyi Z, Nyamukapa C, Gregson S. Masculinity as a barrier to men's use of HIV services in Zimbabwe. *Global Health* 2011; **7:** 13.

58 Beia T, Kielmann K, Diaconu K. Changing men or changing health systems? A scoping review of interventions, services and programmes targeting men's health in sub-Saharan Africa. *Int J Equity Health* 2021; **20:** 87.

59 Renold E. Learning the 'hard' way: boys, hegemonic masculinity and the negotiation of learner identities in the primary school. *Br J Sociol Educ* 2001; **22:** 369–85.

60 Ohba A. Do low-cost private school leavers in the informal settlement have a good chance of admission to a government secondary school? A study from Kibera in Kenya. *Compare* 2013; **43:** 763–82.

61 Kågesten AE, Kabiru CW, Maina B, German D, Blum RW. 'Inexperienced'? Patterns in romantic and sexual experiences among urban poor early adolescents in Nairobi, Kenya. *Cult Health Sex* 2018; **20:** 1299–316.

62 Weber AM, Cislaghi B, Meausoone V, et al. Gender norms and health: insights from global survey data. *Lancet* 2019; **393:** 2455–68.

63 Dhoest A. From manosphere to mainstream: representations of masculinity on TikTok. *Int J Commun* 2025; **19:** 20.

64 Griffith DM, Holliday CS, Enyia OK, Ellison JM, Jaeger EC. Using syndemics and intersectionality to explain the disproportionate COVID-19 mortality among Black men. *Public Health Rep* 2021; **136:** 523–31.

65 Operario D, Sun S, Bermudez AN, et al. Integrating HIV and mental health interventions to address a global syndemic among men who have sex with men. *Lancet HIV* 2022; **9:** e574–84.

66 Quinn KG. Applying an intersectional framework to understand syndemic conditions among young Black gay, bisexual, and other men who have sex with men. *Soc Sci Med* 2022; **295:** 112779.

67 Oram S, Fisher HL, Minnis H, et al. The *Lancet Psychiatry* Commission on intimate partner violence and mental health: advancing mental health services, research, and policy. *Lancet Psychiatry* 2022; **9:** 487–524.

68 WHO. Global tuberculosis report 2025. World Health Organisation, 2025.

69 Rickman HM, Phiri MD, Feasey HRA, et al. Sex differences in the risk of *Mycobacterium tuberculosis* infection: a systematic review and meta-analysis of population-based immunoreactivity surveys. *Lancet Public Health* 2025; **10:** e588–98.

70 Chikovore J, Pai M, Horton KC, et al. Missing men with tuberculosis: the need to address structural influences and implement targeted and multidimensional interventions. *BMJ Glob Health* 2020; **5:** e002255.

71 Ugwu C, Kolawole G, Ringwald B, Bimba J, Squire SB, Wingfield T. Adapting health systems to men's realities: an intersectional exploration of men's barriers to TB care in Nigeria's peri-urban communities. *SSM Health Syst* 2026; **6:** 100188.

72 UN Habitat. World cities report 2020: the value of sustainable urbanization. United Nations Settlement Programme, 2020.

73 Fullerton DG, Bruce N, Gordon SB. Indoor air pollution from biomass fuel smoke is a major health concern in the developing world. *Trans R Soc Trop Med Hyg* 2008; **102:** 843–51.

74 Ahimbisibwe I, Tumusiime C, Muteebwa L, Mupere E, Andia Biraro I. Prevalence of pulmonary tuberculosis among casual labourers working in selected road construction sites in central Uganda. *PLoS One* 2024; **19:** e0304719.

75 teWaternaude JM, Ehrlich RI, Churchyard GJ, et al. Tuberculosis and silica exposure in South African gold miners. *Occup Environ Med* 2006; **63:** 187–92.

76 KELIN, Stop TB Partnership. Tuberculosis: a gender assessment in Kenya. KLEIN, 2018.

77 UN. The Sustainable Development Goals report 2024. United Nations, 2024.

78 Kerkhoff AD, Mwamba C, Pry JM, et al. A mixed methods study on men's and women's tuberculosis care journeys in Lusaka, Zambia-implications for gender-tailored tuberculosis health promotion and case finding strategies. *PLOS Glob Public Health* 2023; **3:** e0001372.

79 Daniels J, Medina-Marino A, Glockner K, Grew E, Ngcelwane N, Kipp A. Masculinity, resources, and retention in care: South African men's behaviors and experiences while engaged in TB care and treatment. *Soc Sci Med* 2021; **270:** 113639.

80 The Light Consortium. Putting people first: a participatory study with TB healthcare workers and policymakers in Nairobi, Kenya. The Light Consortium. 2024. https://light.lstmed.ac.uk/sites/default/files/content/centre_page/attachments/LIGHT%20Kenya%20PAR%20Booklet%20150x150mm.pdf (accessed Sept 2, 2026).

81 Mavhu W, Dauya E, Bandason T, et al. Chronic cough and its association with TB-HIV co-infection: factors affecting help-seeking behaviour in Harare, Zimbabwe. *Trop Med Int Health* 2010; **15:** 574–79.

82 Bates MN, Khalakdina A, Pai M, Chang L, Lessa F, Smith KR. Risk of tuberculosis from exposure to tobacco smoke: a systematic review and meta-analysis. *Arch Intern Med* 2007; **167:** 335–42.

83 Mwiine AA, Twinomugisha BK. National study on men, masculinities and the sexual and reproductive health and rights (SRHR) realisation in Uganda. Gayaza: Center for Health, Human Rights and Development, 2024.

84 Chikovore J, Hart G, Kumwenda M, Chipungu GA, Corbett L. 'For a mere cough, men must just chew Conjex, gain strength, and continue working': the provider construction and tuberculosis care-seeking implications in Blantyre, Malawi. *Glob Health Action* 2015; **8:** 26292.

85 Chikovore J, Hart G, Kumwenda M, Chipungu GA, Desmond N, Corbett L. Control, struggle, and emergent masculinities: a qualitative study of men's care-seeking determinants for chronic cough and tuberculosis symptoms in Blantyre, Malawi. *BMC Public Health* 2014; **14:** 1053.

86 Krishnan L, Akande T, Shankar AV, et al. Gender-related barriers and delays in accessing tuberculosis diagnostic and treatment services: a systematic review of qualitative studies. *Tuberc Res Treat* 2014; **2014:** 215059.

87 Kumwenda M, Desmond N, Hart G, et al. Treatment-seeking for tuberculosis-suggestive symptoms: a reflection on the role of human agency in the context of universal health coverage in Malawi. *PLoS One* 2016; **11:** e0154103.

88 Muttamba W, Omongot S, Najjingo I, et al. Using intersectional gender analysis to identify challenges in tuberculosis care at four health care facilities in Uganda. *Infect Dis Poverty* 2024; **13:** 2.

89 Meghji J, Gregorius S, Madan J, et al. The long term effect of pulmonary tuberculosis on income and employment in a low income, urban setting. *Thorax* 2021; **76:** 387–95.

90 Horton KC, Sumner T, Houben RMGJ, Corbett EL, White RG. A Bayesian approach to understanding sex differences in tuberculosis disease burden. *Am J Epidemiol* 2018; **187:** 2431–38.

91 Silva S, Arinaminpathy N, Atun R, Goosby E, Reid M. Economic impact of tuberculosis mortality in 120 countries and the cost of not achieving the Sustainable Development Goals tuberculosis targets: a full-income analysis. *Lancet Glob Health* 2021; **9:** e1372–79.

92 Griffith DM, Heilman BP, Gilgoff JN, et al. The real face of men's health: 2025 United States report. Movember Institute of Men's Health, 2025.

93 University of British Columbia, Sinclair N. The real face of men's health: 2025 Canadian report. Movember Institute of Men's Health, 2025.

94 Islami F, Arias G, Lee D, et al. American Cancer Society's report on the status of cancer disparities in the United States, 2025. *CA Cancer J Clin* 2026; **76:** e70045.

95 Kyalwazi AN, Loccoh EC, Brewer LC, et al. Disparities in cardiovascular mortality between Black and White adults in the United States, 1999 to 2019. *Circulation* 2022; **146:** 211–28.

96 Thorpe RJ Jr, Kennedy-Hendricks A, Griffith DM, et al. Race, social and environmental conditions, and health behaviors in men. *Fam Community Health* 2015; **38:** 297–306.

97 Gilbert KL, Ray R, Siddiqi A, et al. Visible and invisible trends in Black men's health: pitfalls and promises for addressing racial, ethnic, and gender inequities in health. *Annu Rev Public Health* 2016; **37:** 295–311.

98 Krieger N, Wright E, Chen JT, Waterman PD, Huntley ER, Arcaya M. Cancer stage at diagnosis, historical redlining, and current neighborhood characteristics: breast, cervical, lung, and colorectal cancers, Massachusetts, 2001–2015. *Am J Epidemiol* 2020; **189:** 1065–75.

99 Aaronson D, Hartley D, Mazumder B. The effects of the 1930s HOLC "redlining" maps. *Am Econ J Econ Policy* 2021; **13:** 355–92.

100 Jackson JS, Knight KM. Race and self-regulatory health behaviors: the role of the stress response and the HPA axis in physical and mental health disparities. In: Schaie KW, Carstensen LL, eds. Social structures, aging, and self-regulation in the elderly. New York: Springer, 2006: 189–239.

101 Lee JG, Henriksen L, Rose SW, Moreland-Russell S, Ribisl KM. A systematic review of neighborhood disparities in point-of-sale tobacco marketing. *Am J Public Health* 2015; **105:** e8–18.

102 Gardiner PS. The African Americanization of menthol cigarette use in the United States. *Nicotine Tob Res* 2004; **6** (suppl 1)**:** S55–65.

103 US Food and Drug Administration. Scientific review of the effects of menthol in cigarettes on tobacco addiction: 1980–2021. Centre for Tobacco Products, Food and Drug Administration. 2022. https://www.fda.gov/media/157642/download (accessed Sept 3, 2026).

104 Mendez D, Le TTT. Consequences of a match made in hell: the harm caused by menthol smoking to the African American population over 1980–2018. *Tob Control* 2021; published online Sept 16. https://doi.org/10.1136/tobaccocontrol-2021-056748.

105 Million D, Pete D. We are peoples: reclaiming Native health. In: Ford CL, Griffith DM, Bruce MA, Gilbert KL, eds. Racism: science & tools for the public health professional. APHA Press, 2019: 47–64.

106 Frank JW, Moore RS, Ames GM. Historical and cultural roots of drinking problems among American Indians. *Am J Public Health* 2000; **90:** 344–51.

107 Eisenkraft Klein D, Shawanda A. Bridging the commercial determinants of Indigenous health and the legacies of colonization: a critical analysis. *Glob Health Promot* 2024; **31:** 15–22.

108 Stewart SH, Sherry SB, Comeau MN, Mushquash CJ, Collins P, Van Wilgenburg H. Hopelessness and excessive drinking among Aboriginal adolescents: the mediating roles of depressive symptoms and drinking to cope. *Depress Res Treat* 2011; **2011:** 970169.

109 Nelson A. Unequal treatment: confronting racial and ethnic disparities in health care. *J Natl Med Assoc* 2002; **94:** 666–68.

110 Griffith DM, Mason MA, Rodela M, et al. A structural approach to examining prostate cancer risk for rural southern African American men. *J Health Care Poor Underserved* 2007; **18** (suppl)**:** 73–101.

111 Griffith DM, Bergner EM, Fair AS, Wilkins CH. Using mistrust, distrust, and low trust precisely in medical care and medical research advances health equity. *Am J Prev Med* 2021; **60:** 442–45.

112 Augustus GJ, Ellis NA. Colorectal cancer disparity in African Americans: risk factors and carcinogenic mechanisms. *Am J Pathol* 2018; **188:** 291–303.

113 Rogers CR, Mitchell JA, Franta GJ, Foster MJ, Shires D. Masculinity, racism, social support, and colorectal cancer screening uptake among African American men: a systematic review. *Am J Mens Health* 2017; **11:** 1486–500.

114 Rogers CR, Rogers TN, Matthews P, et al. Psychosocial determinants of colorectal cancer screening uptake among African-American men: understanding the role of masculine role norms, medical mistrust, and normative support. *Ethn Health* 2022; **27:** 1103–22.

115 Schwartz K, Beebe-Dimmer J, Hastert TA, et al. Caregiving burden among informal caregivers of African American cancer survivors. *J Cancer Surviv* 2021; **15:** 630–40.

116 Revenson TA, Griva K, Luszczynska A, et al. Gender and caregiving: the costs of caregiving for women. In: Revenson TA, Griva K, Luszczynska A, et al, eds. Caregiving in the illness context. London: Palgrave Macmillan, 2016: 48–63.

117 Hill L, Ndugga N, Artiga S, Damico A. Health coverage by race and ethnicity, 2010–2023. May 4, 2026. https://www.kff.org/racial-equity-and-health-policy/health-coverage-by-race-and-ethnicity/ (accessed May 4, 2026).

118 Affleck W, Selvadurai A, Sikora L. Underrepresentation of men in gender based humanitarian and refugee trauma research: a scoping review. *Intervention* 2018; **16:** 22–30.

119 Chynoweth SK, Buscher D, Martin S, Zwi AB. Characteristics and impacts of sexual violence against men and boys in conflict and displacement: a multicountry exploratory study. *J Interpers Violence* 2022; **37:** NP7470–501.

120 Edström J, Dolan C, Shahrokh T, David O. Therapeutic activism: Men of Hope Refugee Association Uganda breaking the silence over male rape in conflict-related sexual violence. Brighton: Institute of Development Studies, 2016.

121 Zabarra M, Obtel M, Sabri A, El Hilali S, Zeghari Z, Razine R. Prevalence and risk factors associated with mental disorders among migrants in the MENA region: a systematic review and meta-analysis. *Soc Sci Med* 2024; **357:** 117195.

122 Colic-Peisker V, Tilbury F. Refugees and employment: the effect of visible difference on discrimination. Centre for Social and Community Research, Murdoch University, 2007.

123 Executive Committee of the High Commissioner's Programme. Update on UNHCR operations in the Middle East and north Africa. Office of the UN High Commissioner for Refugees. 2025. https://www.unhcr.org/sites/default/files/2025-03/MENA-92-SC-English.pdf (accessed June 6, 2026).

124 Solomon H, Tausch A. Beyond patriarchy: gender, Islam and the MENA region. In: Solomon H, Tausch A, eds. Arab MENA countries: vulnerabilities and constraints against democracy on the eve of the global COVID-19 crisis. Singapore: Springer Singapore, 2021: 153–66.

125 Berti B, Paris J. Beyond sectarianism: geopolitics, fragmentation, and the Syrian civil war. *Strateg Assess* 2014; **16:** 21–34.

126 Nosè M, Tarsitani L, Tedeschi F, et al. Association of traumatic events with levels of psychological distress and depressive symptoms in male asylum seekers and refugees resettled in Italy. *BMC Psychiatry* 2020; **20:** 576.

127 Solfrank M, Nikendei C, Zehetmair C, Friederich H-C, Nagy E. The burden of substance use and (mental) distress among asylum seekers: a cross sectional study. *Front Psychiatry* 2023; **14:** 1258140.

128 Brun D. Men and boys in displacement: assistance and protection challenges for unaccompanied boys and men in refugee contexts. CARE, 2017.

129 International Rescue Committee. Vulnerability assessment of Syrian refugee men in Lebanon. Lebanon: International Rescue Committee, 2016.

130 International Rescue Committee. Unmarried and separated Syrian refugee men in Lebanon struggle to get aid, face exploitation and feel 'less of a man' study finds. Jan 19, 2016. https://www.rescue.org/uk/press-release/unmarried-and-separated-syrian-refugee-men-lebanon-struggle-get-aid-face-exploitation (accessed Dec 18, 2025).

131 Gil-González D, Carrasco-Portiño M, Vives-Cases C, Agudelo-Suárez AA, Castejón Bolea R, Ronda-Pérez E. Is health a right for all? An umbrella review of the barriers to health care access faced by migrants. *Ethn Health* 2015; **20:** 523–41.

132 Mezey G, Thachil A. Sexual violence in refugees. In: Bhugra D, Craig T, Bhui K, eds. Mental health for refugees and asylum seekers. Oxford Academic, 2010: 234–62.

133 Byrow Y, Pajak R, McMahon T, Rajouria A, Nickerson A. Barriers to mental health help-seeking amongst refugee men. *Int J Environ Res Public Health* 2019; **16:** 2634.

134 Syam H, Venables E, Sousse B, Severy N, Saavedra L, Kazour F. "With every passing day I feel like a candle, melting little by little." experiences of long-term displacement amongst Syrian refugees in Shatila, Lebanon. *Confl Health* 2019; **13:** 45.

135 Suerbaum M. Becoming and "unbecoming" refugees: making sense of masculinity and refugeeness among Syrian refugee men in Egypt. *Men Masculinities* 2018; **21:** 363–82.

136 Harvey C, Garwood R, El-Masri R. Shifting sands: changing gender roles among refugees in Lebanon. London: ABAAD Resource Centre for Gender Equality, Oxfam GB, 2013.

137 Çarpar MC, Göktuna Yaylaci F. Forced migration as a crisis in masculinity: a sociological approach to refugee men's remasculinization strategies in Turkey. *J Refug Stud* 2021; **34:** 3846–70.

138 Daw MA, El-Bouzedi AH, Dau AA. Trends and patterns of deaths, injuries and intentional disabilities within the Libyan armed conflict: 2012-2017. *PLoS One* 2019; **14:** e0216061.

139 Priddy A. Academy briefing no 14: disability and armed conflict. Geneva Academy of International Humanitarian Law and Human Rights, 2019.

140 Aciksoz SC. Sacrificial limbs: masculinity, disability, and political violence in Turkey. University of California Press, 2020.

141 Fomiatti R, Pienaar K, Savic M, Keane H, Treloar C. Improving understandings of trauma and alcohol and other drug-related problems: a social research agenda. *Int J Drug Policy* 2023; **121:** 104198.

142 Scales SE, Park JW, Nixon R, Guha-Sapir D, Horney JA. Disease burden among refugees in camps on mainland Greece, 2016-2017: a retrospective cross-sectional study. *BMC Public Health* 2023; **23:** 1715.

143 Boyd AT, Cookson ST. TB control in humanitarian emergencies: lessons from the Syria displacement crisis. *J Clin Tuberc Other Mycobact Dis* 2019; **14:** 31–35.

144 The World Bank. Bangladesh - poverty and equity assessment: navigating the road to prosperity. Washington DC: World Bank Group, 2025.

145 Rashid SF. Poverty, gender and health in the slums of Bangladesh: children of crows. London: Routledge, 2024.

146 Rahaman MA, Kalam A, Al-Mamun M. Unplanned urbanization and health risks of Dhaka City in Bangladesh: uncovering the associations between urban environment and public health. *Front Public Health* 2023; **11:** 1269362.

147 Rashid SF, Theobald S, Ozano K. Towards a socially just model: balancing hunger and response to the COVID-19 pandemic in Bangladesh. *BMJ Glob Health* 2020; **5:** e002715.

148 Preetha SS, Islam Z. Bangladesh: 1931 brands have delayed cancelled $3.7bn worth of orders from garment factories during COVID-19. June 29, 2020. https://www.business-humanrights.org/en/latest-news/bangladesh-1931-brands-have-delayed-cancelled-37bn-worth-of-orders-from-garment-factories-during-covid-19/ (accessed Jan 6, 2026).

149 Statistics and Informatics Division, Bangladesh Ministry of Planning. Labour force survey 2024 final report. Bangladesh Bureau of Statistics. 2024. https://bbs.gov.bd/pages/files/6a608a53a1eaf8d1868d0ae0 (accessed Sept 7, 2026; in Bangla).

150 James-Hawkins L, Naved RT, Cheong YF, Yount KM. Multilevel influences on depressive symptoms among men in Bangladesh. *Psychol Men Masc* 2019; **20:** 104–14.

151 Hasan MZ, Rabbani MG, Ahmed MW, et al. Assessment of socioeconomic and health vulnerability among urban slum dwellers in Bangladesh: a cross-sectional study. *BMC Public Health* 2024; **24:** 2946.

152 Streatfield AJ, Rahman MM, Khan S, et al. What shapes attitudes on gender roles among adolescents in Bangladesh. *Front Public Health* 2023; **11:** 1121858.

153 Sarker MR, Rouf Sarkar MA, Alam MJ, Begum IA, Bhandari H. Systems thinking on the gendered impacts of COVID-19 in Bangladesh: a systematic review. *Heliyon* 2023; **9:** e13773.

154 Sajid E. Police enforce social distancing through humiliation, harassment. The Business Standard, March 27, 2020. https://www.tbsnews.net/coronavirus-chronicle/coronavirus-bangladesh/police-enforce-social-distancing-through-humiliation (accessed Jan 15, 2026).

155 Fast D, Bukusi D, Moyer E. The knife's edge: masculinities and precarity in East Africa. *Soc Sci Med* 2020; **258:** 113097.

156 Rashid SF, Desai S, Kumar R. Situating sex, gender, and health in south Asia. In: Sivakami M, Bhushan A, Rashid SF, Khan KS, eds. Handbook on sex, gender and health: perspectives from south Asia. Singapore: Springer, 2024: 3–23.

157 Robertson S, Gough B, Robinson M. Masculinities and health inequalities within neoliberal economies. In: Walker C, Roberts S, eds. Masculinity, labour, and neoliberalism: working-class men in international perspective. Springer, 2017: 311–34.

158 Vandello JA, Wilkerson M, Bosson JK, Wiernik BM, Kosakowska-Berezecka N. Precarious manhood and men's physical health around the world. *Psychol Men Masc* 2023; **24:** 1–15.

159 Carbonell J. From provider to precarious: how young men's economic decline fuels the anti-feminist backlash. April 9, 2025. https://www.epc.eu/publication/From-provider-to-precarious-How-young-mens-economic-decline-fuels-th-63effc/ (accessed April 9, 2025).

160 Jimu C. The precarious future of HIV and AIDS programs in Zimbabwe following international funding freeze: impact and strategic interventions. *J Epidemiol Glob Health* 2025; **15:** 79.

161 UN. US aid cuts will make world 'less healthy, less safe and less prosperous': Guterres. Feb 28, 2025. https://news.un.org/en/story/2025/02/1160646 (accessed Feb 28, 2025).

162 Yearby R. Racial disparities in health status and access to healthcare: the continuation of inequality in the United States due to structural racism. *Am J Econ Sociol* 2018; **77:** 1113–52.

163 Pottie K. Health equity in humanitarian emergencies: a role for evidence aid. *J Evid Based Med* 2015; **8:** 36–38.

164 Young K. Exclusive humanitarianism: policy recommendations for genuine inclusion of persons with disabilities in humanitarian action. *Int Rev Red Cross* 2023; **105:** 396–415.

165 Schlosberg D. Defining environmental justice: theories, movements, and nature. Oxford University Press, 2007.

166 Brehm HN, Pellow DN. Environmental justice: pollution, poverty and marginalized communities. In: Harris PG, ed. Routledge handbook of global environmental politics. Routledge, 2022: 348–61.

167 Lyons AC, Kersey K, Emslie C, Dimova E, Burrows A. Digital alcohol marketing and gender: a narrative synthesis. *Drug Alcohol Rev* 2024; **43:** 1361–87.

168 Levant RF. Research in the psychology of men and masculinity using the gender role strain paradigm as a framework. *Am Psychol* 2011; **66:** 765–76.

169 Ratele K. Working through resistance in engaging boys and men towards gender equality and progressive masculinities. *Cult Health Sex* 2015; **17** (suppl 2)**:** S144–58.
170 Robertson S, Kilvington-Dowd L. Masculinity and men's health disparities: conceptual and theoretical challenges. In: Griffith DM, Bruce MA, Thorpe RJ, eds. Men's health equity: a handbook. New York: Routledge, 2019: 10–26.
171 Bardehle D, Dinges M, White A. What is men's health? A definition. *Gesundheitswesen* 2016; **78:** e30–39 (in German).
172 Griffith DM, Bruce MA, Thorpe RJ. Introduction. In: Griffith DM, Bruce MA, Thorpe RJ, eds. Men's health equity: a handbook. New York: Routledge, 2019: 3–9.
173 Barker G, Ricardo C, Nascimento M, Olukoya A, Santos C. Questioning gender norms with men to improve health outcomes: evidence of impact. *Glob Public Health* 2010; **5:** 539–53.
174 Chilisa B, Major TE, Khudu-Petersen K. Community engagement with a postcolonial, African-based relational paradigm. *Qual Res* 2017; **17:** 326–39.
175 An TL, Waling A, Bourne A. Men and masculinities studies in Vietnam: a brief review. *Sociol Compass* 2022; **16:** 15.
176 Seidler ZE, Benakovic R, Wilson MJ, et al. Approaches to engaging men during primary healthcare encounters: a scoping review. *Am J Mens Health* 2024; **18:** 15579883241241090.
177 Chung H. Shared care, father's involvement in care and family well-being outcomes: a literature review. Government Equalities Office, Women and Equalities Unit, UK Government, 2021.
178 Tsai AC. Syndemics: a theory in search of data or data in search of a theory? *Soc Sci Med* 2018; **206:** 117–22.
179 Ferlatte O, Salway T, Trussler T, Oliffe JL, Gilbert M. Combining intersectionality and syndemic theory to advance understandings of health inequities among Canadian gay, bisexual and other men who have sex with men. *Crit Public Health* 2018; **28:** 509–21.

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Men's Health 2

A global men's health epidemiology within an intersectional framework

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Males have lower life expectancies and greater disability-adjusted life-years (DALYs) than females, and particularly poor outcomes are seen among males in marginalised contexts. In this paper, we provide an epidemiological overview and highlight the intersectional nature of men's health. We analyse mortality and DALYs data from the 1990–2023 Global Burden of Diseases, Injuries, and Risk Factors Studies to illustrate our intersectional framework and draw attention to how health varies in men and to show key themes. Conditions that contribute most to the poor health of males include non-communicable diseases (eg, cardiovascular diseases and cancers), substance use, suicide, injuries (eg, road traffic incidents and interpersonal violence), and respiratory infections (eg, tuberculosis and COVID-19). Although cardiovascular disease and cancer make the largest contributions to men's higher mortality rates, determinants of health such as violence and war, migration, economic stagnation, and labour market changes due to automation and new technologies will disproportionally affect their health in the future. Injuries, violence, and other external morbidity causes often occur at a young age and in unequal distributions across the sexes, making a large contribution to DALYs. Although biology plays a role, the pattern of many diseases contributing to health differences reflects the intersection of health behaviours, shaped by patriarchy, ideas of masculinity, and structural drivers (including commercial determinants of health); many of these are preventable. Although improvements in some health behaviours are seen, exceptions occur in marginalising social conditions (eg, incarcerated men, men experiencing homelessness, men with mental illnesses, men with substance use disorders, men with low income, men who have sex with men, and those who are gender non-conforming). Multiple data sources detail men's shorter life expectancies and the drivers compared with women, but going beyond sex disaggregation remains challenging and is an urgent priority for research and health monitoring.

Lancet 2026; 408: 1881–98

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This is the second in a **Series** of three papers about men's health

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Introduction

In this second paper of the Men's Health Series, we review patterns of men's health and examine the intersecting systems of power that contribute to them. Our approach to men's health is to analyse data and inform health promotion efforts to complement,[1] rather than compete with, efforts to promote the health of other genders.[2] We summarise some key contributors to sex differences in mortality and disability-adjusted life-years (DALYs) using The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2023 and draw attention to the differences among men. We build on our conceptual framework[1] and, given the limitations of GBD data, draw on published epidemiological data and conduct new illustrative secondary analyses of data to show the syndemic patterns arising from multilevel and intersectional determinants. Throughout this paper we use the terms men and male in line with the panel on gender, sex, and diversity of intersecting male identities in the first paper in the Series.[1]

As detailed,[1] there are stark intersectional inequalities in men's health, shaped by individual-level, community-level, institutional-level, and policy-level determinants that affect chronic stressors and biological vulnerability. For an individual, the patriarchy and masculine ideals are some of the factors that shape health in complex, often contradictory ways, reflecting power, agency, roles, and behaviours. Power shapes risk exposure and health behaviours (eg, smoking, substance use, gambling, and firearm possession). Agency can lead to positive health behaviours through a sense of control and autonomy,[3] whereas lack of agency (perhaps through unemployment, displacement, incarceration, dependency, or lack of kinship) leads to poor health profiles through

Key messages

- Differences in life expectancies and disability-adjusted life years (DALYs) exist between males (especially in marginalised contexts) and compared with females; these reflect intersectional inequalities and the gaps are either persisting or increasing in most countries
- Conditions contributing to the greatest health differences (quantified using DALYs) between males and females include non-communicable diseases (ie, cardiovascular diseases and most cancers), liver failure, suicide and injuries (including road traffic incidents, falls, and violence), and respiratory infections (eg, tuberculosis and COVID-19)
- Poor health outcomes are often concentrated among marginalised and minoritised men, many of whom are experiencing intersecting social disadvantages
- The absence of of intersectionally disaggregated data currently limits systematic and comprehensive analyses, the understanding of which are needed to inform programmes and practices and develop robust approaches to improve men's health

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See Online for appendix

Panel 1: Smoking in Bangladeshi men—an intersectional analysis

Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy is a quantitative approach to exploring intersectionality. We analysed nationally representative cross-sectional data on male youth (aged 15–24 years) in Bangladesh to examine how smoking behaviour varies across multiple and intersecting social positions. In addition, we studied the association between masculinity norms and smoking (the Gender Role Conflict Scale was used to capture alignment with masculine stereotypes [appendix pp 14–15]). Intersectional strata were constructed by cross-classifying three social variables: education (primary or less, secondary, and tertiary), occupation (agriculture and fisheries, skilled labour, services, and students), and household income (low and middle to high), yielding a multidimensional matrix of social positions, with four very small intersectional groups (less than ten individuals) excluded from analyses. We fitted a multilevel model considering each individual as being nested within one of 20 intersectional groups, with a binary variable of current smoking as the outcome. The prevalence of smoking in each intersectional group was then estimated from the model. The intersectional groups with the highest and lowest prevalence were inspected. We then assessed if masculinity norms (tertiles) were additionally associated with smoking. Predicted smoking prevalences ranged from 22% to 67%, illustrating systematic differences in smoking across socio-economic combinations (appendix p 15). Inspection of the ranked intersectional strata reveals substantial inequalities in smoking (table 1). The lowest prevalences were consistently observed among students, particularly those with a low income. In contrast, the highest smoking risks were concentrated among men in higher-income households regardless of education level and occupation.

health-harming behaviours, delayed help-seeking, low treatment adherence, and directly through psychosocial stress.[4–7] Intersectional analyses using data from Bangladesh illustrate how health behaviours differ across different groups of men, shaped by intersecting axes of identity (panel 1).

Men often view themselves through financial roles, physical strength, and leadership roles, and conflicting prioritisations can lead to poor health behaviours. Men in the UK visit their general practitioners (GPs) less often than women, and this difference is greatest for those aged 16–60 years and those in underserved communities, possibly reflecting financial priorities, a lack of gender-responsive services, and masculine norms of stoicism and self-reliance in providers and patients.[8] As health becomes a higher priority or as men feel more vulnerable (eg, those older than 75 years, those with chronic health problems, and those on medication), differences in health care use between different groups of men and between men and women disappear.[9] Communities, environments, and relationships shape health through regional, geographical, societal, and cultural factors. For example, interpersonal relationships are fundamental to men's health—stable relationships, including marriage and cohabitation,[10] are beneficial to men, regardless of country and age.[11,12] The benefits from marriage are usually greater for men than women, reflecting the complexities and nuances of the influence of gender on health.[13] Societal inequalities can be harmful for many men. For example, Indian people within lower castes (such as the Shudra and Dalit castes) have higher mortality rates (odds ratio [OR] 1·72 [1·23–2·41] for both sexes) across their entire life compared with those in higher castes,[14] and consequently have lower life expectancies (60·32 years for men in scheduled castes *vs* 66·09 years for other men).[15] This difference in life expectancy is greater than the difference between religions in India,[15] and reflects avoidable factors (such as smoking and treatable infections), economic and social inequalities, and lack of health care.[14,16–18] British civil servants of low occupational grade experience more rapid health deterioration after retirement, resulting in a physical-age gap of 8 years compared with higher-grade retirees.[19] Displacement and migration can result in a loss of social connections and social status and a loss of access to health care, and can lead to mental health disorders.[13]

At the institutional level, education has a profound impact on health, being consistently linked to improvements in nearly all health outcomes, including mortality.[20] However, the proportion of boys enrolling in and completing secondary and tertiary education has declined since the 1990s, and is lower than the equivalent proportion of girls.[21] It should also be noted that girls continue to face substantial barriers accessing secondary and tertiary education, particularly in low-income countries. Learning poverty rates, defined as being unable to read and understand a simple text by age 10 years, are higher for boys than girls in nearly all countries worldwide. However, these poorer educational outcomes are not experienced equally among boys. For example, in the Nordic countries, girls with a Nordic background have the best outcomes, followed by girls with a migrant background, boys with a Nordic background, then boys with a migrant background.[22] There are repeated concerns that educational systems are not helping all boys thrive, particularly those with social disadvantages, potentially setting up generations of men to go on to experience lifetimes of poor health. Differences in men's educational trajectories between countries with high educational rank (eg, South Korea and Denmark) and falling standards (eg, the USA) account for some observed population-wide differences in health, independent of national wealth.[23] Perhaps more so than the health and education systems, the justice system is designed for men and supposed to be

gender-neutral,[24] but nevertheless men's health is neglected. There are more than 11·5 million people living in prison worldwide, around 90% of whom are men.[25] People who are incarcerated have high rates of mental health disorders, infectious diseases (eg, HIV, Hepatitis B and C, and tuberculosis), and many chronic diseases.[26] These findings reflect the links between reasons for incarceration (such as substance use) and poor health practices within prisons and social determinants of health (eg, there are high rates of incarceration in men experiencing homelessness, minoritised ethnicities, economically deprived men, and men with mental health disorders).[27,28] Systematic reviews show that around 9% of men who are incarcerated in high-income countries (HICs) attempt suicide in prison;[29] men at highest risk of attempting suicide include those with suicidal ideation or who have previously self-harmed, those kept in solitary confinement, and those experiencing victimisation or poor social support. Immediately after release from prison, high rates of preventable deaths occur from alcohol or drug overdose, suicide, and cardiovascular disease,[30] highlighting the need for preventative strategies (and opportunity for improving society and public health and safety).

Life expectancy and DALYs

Differences in life expectancies for men and women emerged during the 19th century and have widened since.[31] This difference is often the result of preventable or modifiable factors (appendix pp 2, 17).[1,32–35] Health patterns by sex can nuance mortality or life expectancy data. Although male individuals tend to have higher mortality rates, female individuals face greater morbidity, particularly from chronic autoimmune, musculoskeletal, and mental health conditions, as well as maternal, sexual, and reproductive risks.[36,37] Overall, male individuals face a higher illness burden: in 1990, global DALYs were 18% higher among males than females, and although this gap has narrowed slightly, it remained 16% higher in 2023 (figure 1; appendix pp 4–10).[36,38] The sex difference is more pronounced for age-standardised death rates, rising from 36% to 38% between 1990 and 2023, with a sharp increase seen during the COVID-19 pandemic (appendix p 18). Mortality and morbidity rates are improving faster for female individuals than for male individuals. Males are at greater risk of dying from infectious and non-communicable diseases and external mortality (injuries and violence) than females (appendix p 19).[39] Although risks vary by region and socioeconomic status, the higher disease burden in males is consistent across most countries and age groups (country-specific results are in the appendix [pp 20–29]).[36]

Sex and gender differences in disease and illness vary by health outcome and context.[36,38] Previous analysis of GBD data has highlighted how poorer health outcomes for male individuals compared with female individuals strongly reflects gender-related factors (as indicated by external causes of death), rather than being due to sex differences.[40] The differences are consistent over time and across most causes, particularly for deaths

	Education	Income, Bangladeshi taka	Occupation	N	Prevalence (95% CI)
Bottom five lowest risk strata					
1	Secondary	≤25 000	Students	4133	22·0% (18·1–26·5)
2	Primary or less	≤25 000	Students	217	28·5% (23·8–33·8)
3	Secondary	>40 000	Students	1776	30·6% (25·6–36·0)
4	Tertiary	≤25 000	Students	619	35·5% (30·1–41·3)
5	Primary or less	>40 000	Students	49	42·6% (36·8–48·7)
Top five highest risk strata					
16	Primary or less	≤25 000	Skilled or industrial	423	57·9% (51·8–63·7)
17	Primary or less	>40 000	Agricultural or fisheries	119	60·1% (54·2–65·8)
18	Secondary	>40 000	Skilled or industrial	144	63·9% (58·1–69·4)
19	Primary or less	>40 000	Skilled or industrial	136	64·0% (58·2–69·4)
20	Secondary	>40 000	Agricultural or fisheries	114	67·2% (61·6–72·3)

Adding masculinity norms to the regression model showed that masculinity was strongly associated with smoking and displayed a clear dose–response relationship.

Table 1: **Highest and lowest ranking strata for predicted smoking prevalence**

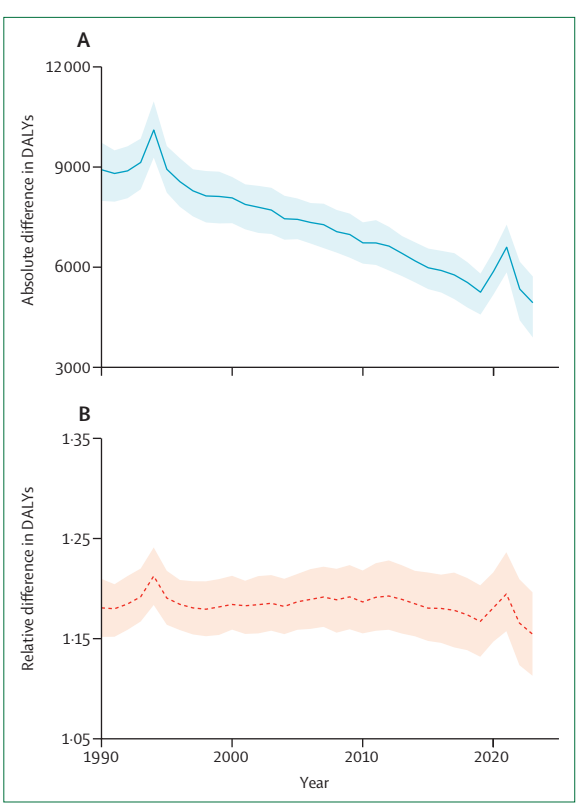
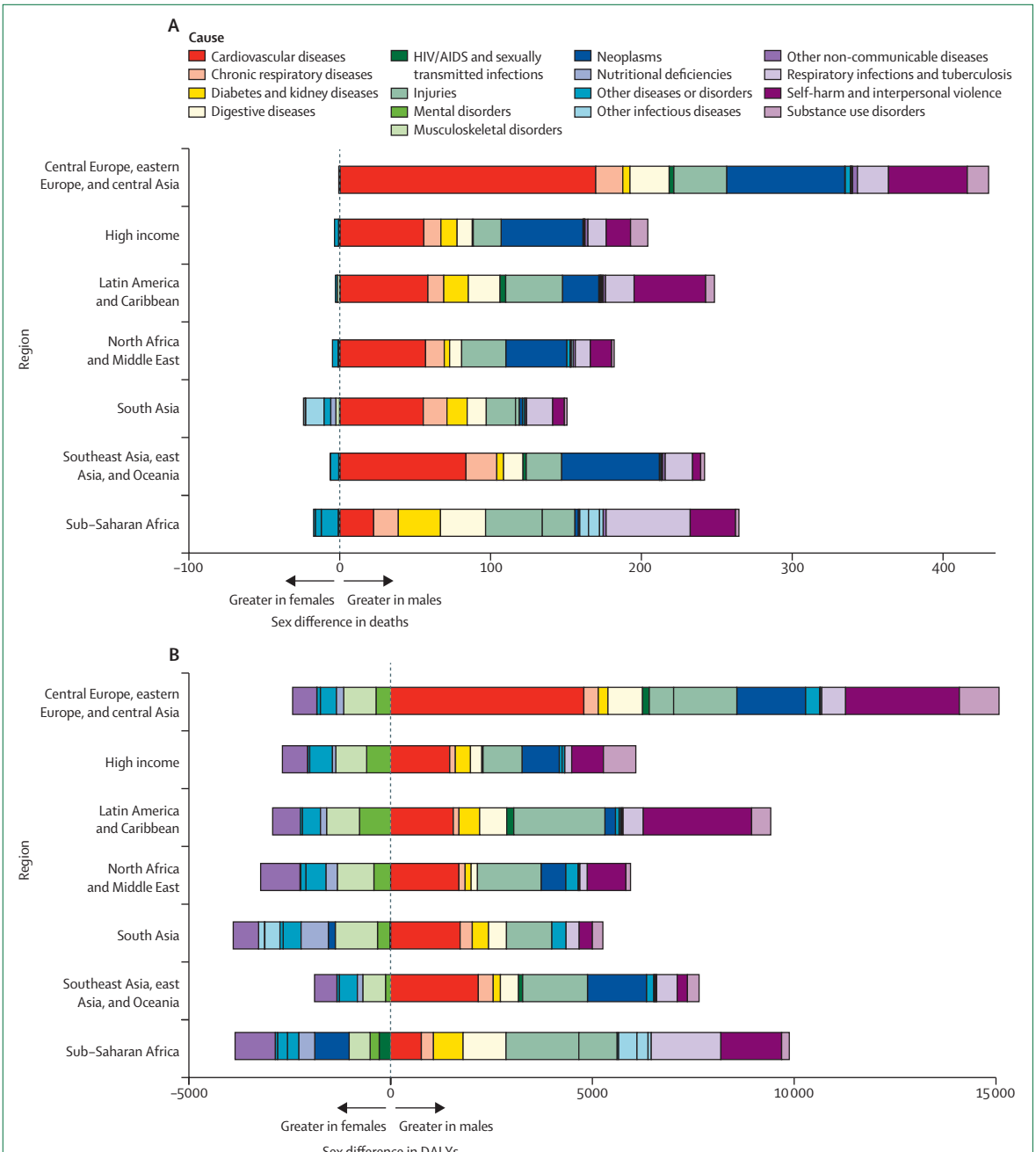


Figure 1: **Trends in absolute sex difference (A) and relative ratio (B) in DALYs over time per 100 000 population**
Data are from The Global Burden of Diseases, Injuries, and Risk Factors Study, 2023. Data are from the Global Burden of Disease Collaborative Network . Shading represents 95% CIs. DALY=disability-adjusted life-year.

For more on the **Global Burden of Disease Collaborative Network data** see https://vizhub.healthdataorg/gbd-results/

(figure 2).[41] The gap in outcomes between males and females is largest in central Europe, eastern Europe, and central Asia; sub-Saharan Africa; and Latin America and the Caribbean (gaps are at least twice as high in these regions than in North America, western Europe, and Australasia). Although there has been an encouraging reduction in the absolute gap over time (appendix pp 20–24), the increase in the comparative DALY burden suggests that improvements are slower for males.

Presenting the data in this way allows us to build on previous analyses to identify causes of higher disease burden in males compared with females, as well as regional differences among male individuals.[42] From 1990 to 2023, the primary causes of global sex death



For more on the **Global Burden of Disease Collaborative Network data** see https://vizhub.healthdata.org/gbd-results/

Figure 2: **Age-standardised death (A) and DALY (B) rates between males and females in 2023, stratified by region**
Cause to the left of the zero indicate diseases that have a higher burden in females, causes on the right are those with a higher burden in males. Presented as the sex difference in age-standardised rates of deaths and DALYs per 100 000 population for each GBD level 2 cause, stratified by GBD region. Data are the Global Burden of Disease Collaborative Network. DALY=disability-adjusted life-year. GBD=The Global Burden of Diseases, Injuries, and Risk Factors Study.

differences were non-communicable diseases (eg, cardiovascular disease, cancer, and diabetes), external causes (eg, suicide, road traffic injuries, falls, and interpersonal violence), communicable diseases (eg, respiratory infections, tuberculosis, HIV/AIDS, and hepatitis), and substance use (eg, alcohol-related and drug-related harms). The largest contributors to mortality and DALY sex differences were cardiovascular disease (1959 additional male DALYs per 100 000 population in 2023), accidental injuries (1651 additional male DALYs per 100 000 population), cancer (711 additional male DALYs per 100 000 population), and self-harm and interpersonal violence (including conflict and terrorism; 857 additional male DALYs per 100 000 population).

Gendered patterns for mental health conditions are complex. Suicide rates are higher in men than women, and suicide is a leading cause of death for men younger than 50 years, particularly in HICs where neuropsychiatric disorders, genetic risk, substance use, and stressful life events are key risks.[43,44] However, females tend to live longer with chronic mental health conditions than males, resulting in more mental illness DALYs (figure 2).[36] Careful consideration for explanations of these differences, including potential limitations in diagnostic practice, is crucial to developing solutions.[1,45]

As illustrated by our framework,[1] gender differences in health-related behaviours are context-dependent and culture-dependent (panel 2; appendix pp 25–29).[34,46] For example, in addition to access to testing and treatment, patterns of HIV infection and treatment in men vary considerably based on criminalisation of homosexuality; the patriarchy; and how cultural and gender norms value

Panel 2: Sports betting

Online sports betting is a rapidly rising health problem that disproportionately affects younger men, those in minority ethnic groups, and those most economically disadvantaged, and is contributing to financial and relationship stresses, binge drinking, and poor mental health.[163–165] Although sports betting is particularly prevalent in Australia, the UK, and the USA, rapid growth has been seen in low-income and middle-income countries.[166] The rise of sports betting reflects ease of access to gambling apps and websites, government policies (either to facilitate gambling or inaction to prevent problem gambling) and addictive, real-time betting options. The American Gaming Association reported commercial revenues increased by 8·7% (to $71·5 billion) between 2024 and 2025.[167] The steepest rises were for sports betting (17·4%, to $15·0 billion) and iGaming (eg, online slots and table games on casino websites; 28·3%, to $9·1 billion), compared with traditional gambling (2·8% rise).

Advertising and social media influence many men to start gambling.[168–171] In the USA, nearly half of men aged 18–49 years use online sportsbook accounts.[163] Systematic reviews report that men (49·1% [95% CI 45·5–52·6]) are more likely to gamble than women (37·4% [32·0–42·5]), are more likely to do risk gambling (associated behavioural symptoms or adverse personal, social, or health-related consequence; 11·9% [8·2–16·5] *vs* 5·5% [2·5–8·5] for women), and are more likely to be problematic gamblers (2·5% [0·9–3·0] *vs* 1·0% [0·5–1·8] for women).[168] Men enter gambling-related treatments at younger ages than women.[172] Young males and adolescent males, those in minoritised ethnic groups (especially indigenous populations), and those most socially and economically disadvantaged appear particularly vulnerable due to gambling's ease of availability, the use of digital money (and a disconnect with real world money), the use of gendered marketing that positions gambling as an integral part of engaging with sports and within male-bonding (through shared gambling experiences), and messaging that successful gamblers advance their social status among peers.[168,173,174]

The financial consequences of problem gambling are clear. Federal Reserve Bank of New York estimates that sports betting legalisation led to a ten-fold rise in sportsbook spending and a subsequent rise in credit delinquency (eg, missed or defaulted loan payments).[175] This financial effect was most dramatic in individuals younger than 40 years and is associated with other signs of excessive debt (eg, debts sent to collection agencies and bankruptcies).[176] There is spillover from territories that allow sports betting into neighbouring ones that do not, creating a double hit in that these regions have to deal with the consequences of gambling without the additional tax revenues (which paradoxically increases pressure to legalise sport betting further). In recognition of these financial consequences, in July, 2025, the US state of Illinois introduced a tax for online wagers (25 cents for the first 20 million wagers, and 50 cents thereafter).[177] In the following months there was a 13·7–16·6% reduction in the number of wagers in Illinois, although individual bet values increased.[167] In other countries, regulators have prohibited marketing that targets young individuals or sharing personal data that could be used by gambling companies for marketing.[166]

The health consequences of problem gambling take longer to emerge and are more nuanced, as it can co-exist with other health conditions or substance abuse. High-severity problem gamblers have poorer diets, do less exercise, are more likely to smoke, and have poorer general health, than low-severity or non-problem gamblers.[178] Alcohol consumption appears highest in low-severity gamblers, suggesting the importance of the context (eg, gambling in alcohol-focused locations). Longitudinal studies suggest there are higher premature mortality rates in problem gamblers (1·5-fold rise for men) compared with non-problem gamblers and non-gamblers, and that the difference is greatest in those aged 20–49 years (4·6-fold rise);[179] in this study by Karlsson and Håkansson, one third of deaths were from suicide, with a history of depression being the strongest risk factor.

masculinity, discrimination, and confidentiality concerns.[47] In South Africa, circumcision rates (in light of HIV prevention) range from 13 to 86%,[48] reflecting differing ideas of masculinity by rural and urban settings, ethnicity (eg, Hehe-speaking and Bena-speaking people do not traditionally practice circumcision), beliefs (eg, fear of pain or delayed healing, shame and embarrassment from older men undergoing circumcision next to younger men, and fear of enforced sexual abstinence), health-care availability, and an individual's wealth.[49] Similarly, gendered differences in many cancer outcomes reflect regional and cultural patterns in health behaviours combined with structural factors.[50] Men living with housing and financial insecurity are less likely to attend colorectal cancer screening and colonoscopy than those without such insecurities, and therefore have fewer screen-detected cancers.[51] For example, within the USA, screening adherence is associated with many factors, including race and ethnicity; insurance coverage; and food, housing, employment, and transport insecurity.[1,52] Differences in rates among men attending screenings are lowest for lung cancer, perhaps reflecting risk factor awareness (eg, smoking), impressions of disease severity, or the social acceptability of this cancer (eg, compared with bowel or male breast cancer).[53]

The impact of collective violence, such as war and conflict, is particularly gendered, as explained in the first paper in this Series (appendix pp 19–24).[54] In conflict zones, such as those in Rwanda and Syria, women have outlived men by more than 10 years, despite facing substantial challenges including displacement and gender-based violence.[1] Differences in life expectancy can widen in contexts of health inequalities and adversity, highlighting the importance of examining how social, political, and environmental factors intersect to influence health outcomes for men and women.

Cardiovascular diseases

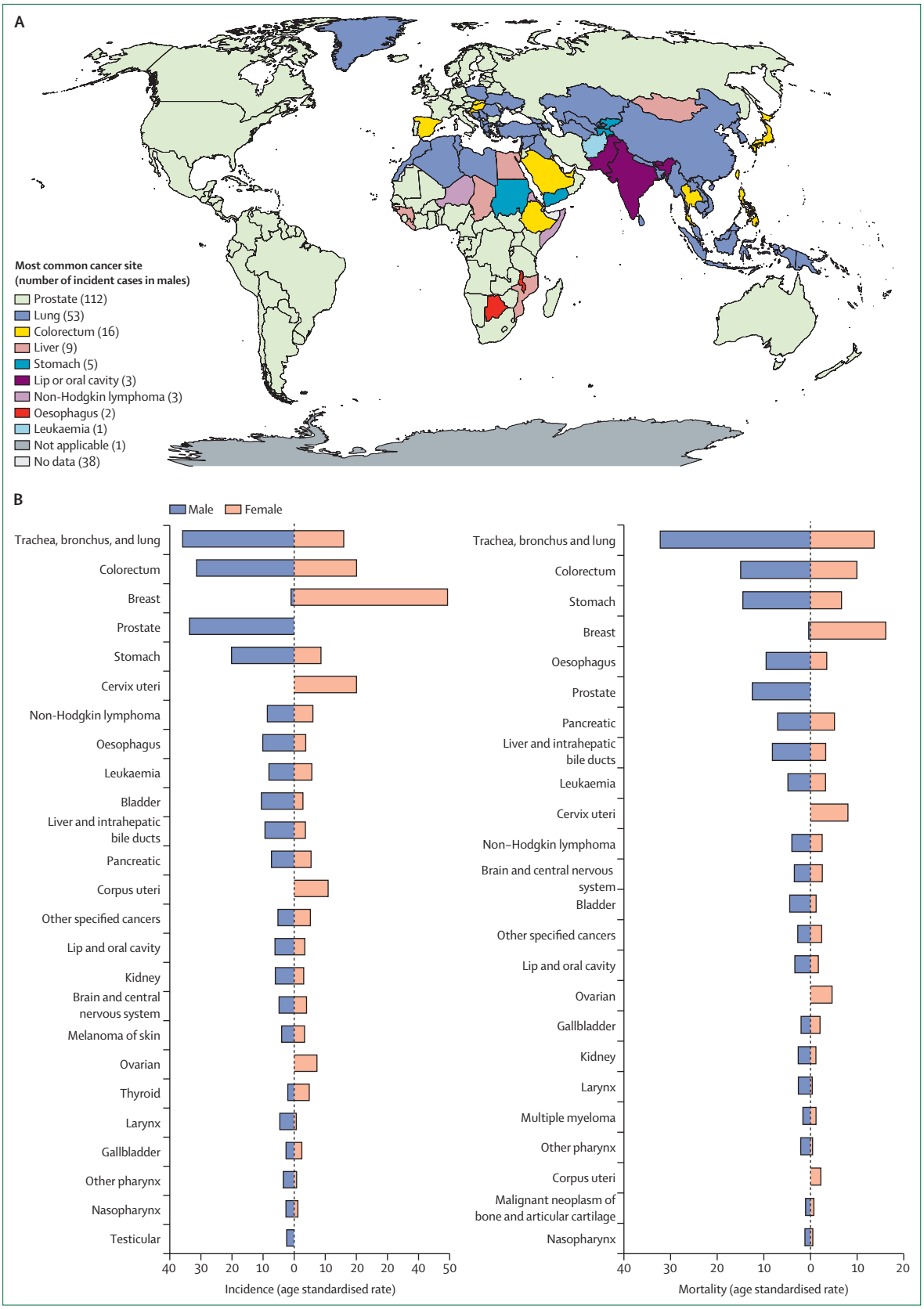
Cardiovascular diseases make the largest contribution to excess mortality and DALYs in males (figure 2). In 2023, there were 10·8 million cardiovascular disease deaths among males (compared with 10·1 million for females), including ischaemic heart disease (5·5 million), ischaemic stroke (1·8 million), and haemorrhagic stroke (2·3 million).[38] Although biological factors contribute to this elevated risk,[55,56] social determinants of health are also important.[1] The exact biological pathways underpinning sex differences are poorly understood and evidence can be contradictory. For example, the relative importance of testosterone in contributing to excess cardiovascular disease in men is debated,[57] especially since it probably plays a small role compared with other major factors (such as tobacco, ultra-processed foods, and alcohol) that are underpinned by commercial determinants.[58–60]

Gender roles, relations, and identities are important and interact with the structural and commercial determinants to shape the substantial differences in health behaviours and outcomes in men and women.[1,56] These differences have varied over time and across the world—for example, sex differences in smoking prevalence have narrowed substantially in the USA, with higher rates in older females than older males in recent years.[61] Similarly, changing patterns of cigarette use have led to a higher prevalence in adolescent girls than boys in HICs, although vaping and e-cigarette use is increasing in both.[62] Smoking patterns vary dramatically by nation.[63] In many HICs, smoking rates are declining in men, although it remains common among those living in marginalising conditions, potentially driven by chronic stressors, as highlighted in our framework in the first paper in this Series.[64] For example, high smoking prevalences are reported for incarcerated men, men experiencing homelessness, men with mental illness, men with substance use disorders, and men with low income.[65,66] Several other cardiovascular disease risk factors were more common in males than females in the GBD 2023 study, including alcohol use, unhealthy diets, and hypertension (appendix pp 17, 25–29). As with smoking, these risks vary considerably between diverse male populations.

Inequalities in cardiovascular disease also exist among men, and might reflect underlying structural inequities experienced by marginalised and minoritised groups. Men in marginalised and minoritised groups might have limited access to health care, which amplifies social disadvantage to negatively affect health,[1] and heightens cardiovascular disease risk factors. For example, there is a higher incidence of (overall and poorly controlled) hypertension among Black Americans in the USA compared with other ethnicities, and cardiovascular disease is more common among South Asian people in the UK compared with those of European ancestry, partly due to higher prevalence of diabetes.[67,68] However, patterns of cardiovascular disease across sex and gender and race and ethnicity are complex. For instance, despite Black women having a higher prevalence of hypertension than Black men in the USA,[68] younger age groups of Black women have a lower incidence of stroke than younger Black men.[69]

Cancer

In 2023, 13·7 million male individuals were diagnosed with cancer, compared with 12·2 million female individuals.[70] Variations in population, structural, and commercial determinants affect cancer patterns (figure 3; appendix pp 11–13).[1] Although prostate cancer is globally the most common male cancer (prevalence is particularly high in men of African descent),[71] lung cancer is the most common in much of Asia, probably reflecting tobacco use,[70] and lip and oral squamous cell carcinoma is the most common in India, Sri Lanka, and Pakistan, probably reflecting tobacco smoking, chewing of smokeless tobacco products (eg, gutka or paan



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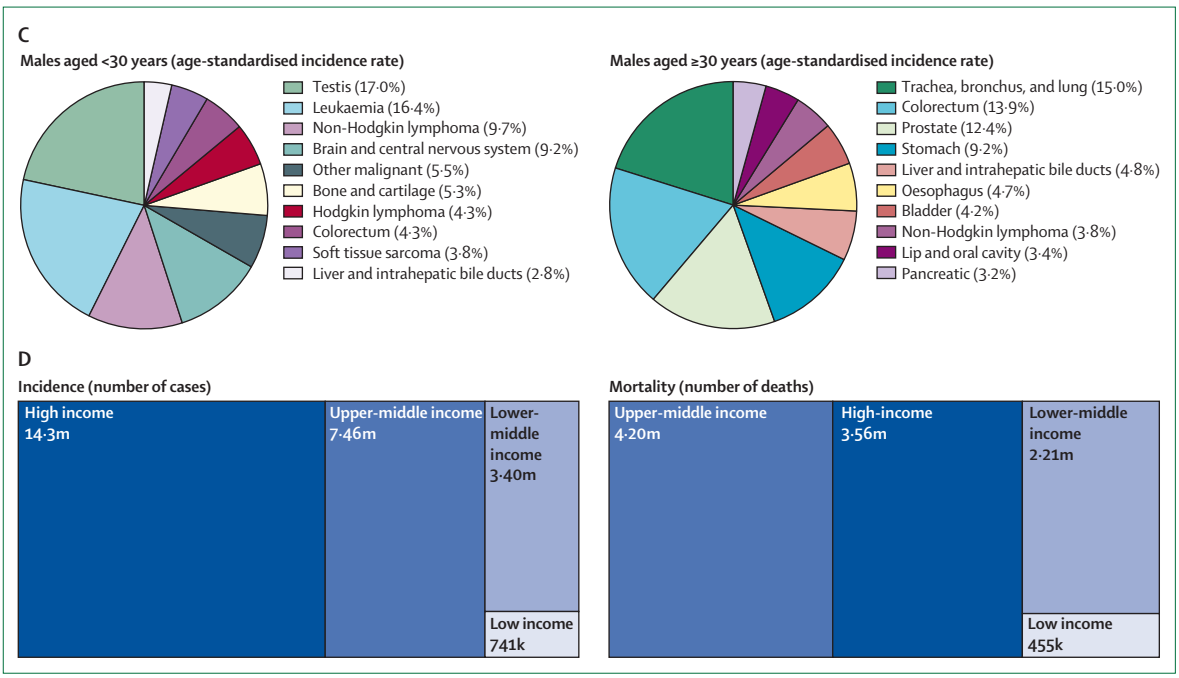

Figure 3: **Patterns of cancer in males in 2023**
(A) Map of the most common cancers in males. (B) Tornado plots showing the most common cancers (incidence and mortality), ranked by age-standardised rates and sorted by global numbers, for males and females. (C) The ten most common cancers (incidence) in males (aged <30 years *vs* ≥30 years). (D) Tree plot of cancer incidence and mortality (numbers of cases), according to the Human Development Index. Data are from the Global Burden of Disease Collaborative Network.

For more on the **Global Burden of Disease Collaborative Network data** see https://vizhub.healthdata.org/gbd-results/

masala), betel-quid chewing, challenges to oral hygiene, alcohol use, and viral infections.[72] The risks of lip and oral squamous cell carcinoma are highest in men within lower castes, reflecting cultural practices shaped by structural drivers. Alcohol and tobacco consumption rates are falling in men across India (12% reduction for both from 2016 to 2021), but their use is falling more slowly in men who are less affluent or within lower castes—tobacco use prevalence changed from 62% to 63% between 2000 and 2012 in the least affluent households versus 44% to 37% in the most affluent households.[73,74] The tobacco industry's use of advertising with high profile personalities and news network coverage to undermine tobacco control legislations helps create these structural drivers.[75,76] In keeping with these trends, men from lower castes also have more lung, stomach, and oesophageal cancers than men from higher castes.[77,78] In sub-Saharan Africa, immunosuppression from HIV infection combined with endemic human herpesvirus 8 make Kaposi Sarcoma common in male individuals.[79] The Asia-Pacific region accounts for 75% of the global deaths from hepatocellular carcinoma, reflecting chronic hepatitis B and C, steatotic liver disease, and alcohol-associated liver diseases.[80] Vaccination programmes are expected to reduce hepatocellular carcinoma incidence.[80] Cancer patterns vary with age (appendix p 31); in men younger than 30 years, testicular cancer, leukaemia, lymphoma, and cancers of the central nervous system account for most cancers (figure 3). In shared anatomical sites, men have a greater incidence of all cancers compared with women, except for thyroid, breast, gallbladder, and anal cancers.[70,81]

Males are also at greater risk of dying from cancer (11·4% lifetime risk) than females (8·0% risk, figure 3; appendix p 30).[70,82] Lung cancer is the leading cause of cancer death among men,[83] and the largest differences in survival for men compared with women are from leukaemia[84] and cancers of the pharynx and upper digestive tract, liver, skin, bladder, and kidney.[85] These findings suggest that there are behavioural (eg, smoking and alcohol consumption), environmental, or biological differences. In central Africa and central America, prostate cancer is the most common cause of cancer mortality, reflecting limited availability of effective treatments, biological risks, and low rates of early detection using Prostate Specific Antigen (PSA) testing.[71] Cancer prognosis is poor in many low-income and middle-income countries (LMICs), reflecting geographical distributions, types of cancers (poor survival rates from lip and oral cancer in South Asia, Kaposi Sarcoma in East Africa, and hepatocellular carcinoma in southeast Asia), and availability of treatments. Regardless of an individual's risk, men often exhibit longer delays than women before seeking help, and there are fewer cancer screening programmes for men.[86–90] The global cancer burden in males is expected to almost double by 2050 (appendix p 32), faster than the rise for females, and the rise is expected to be greatest in LMICs.

There are large inequalities in risks of and outcomes from cancer among men. Men who are marginalised (ie, pushed to the margins of society with limited access to resources, power, and influence) or minoritised (ie, made less powerful because of systemic oppression)[1] tend to fare worse than those who do not face these structural disadvantages. For example, Black American and native Hawaiian men have higher risks of lung cancer than White, Latino, and Asian men,[91] which might partly be due to differential exposure to structural racism,[92,93] cultural differences,[91] and commercial interests, such as targeted advertising (eg, menthol cigarettes targeted to Black Americans).[94] Transgender people and other members of the LGBTQ+ community have specific risks from cancer through smoking, alcohol use, and high-risk sexual activity,[95,96] potentially driven by stress arising from their minoritised status within many societies.[97,98] Engagement with health care can be difficult due to service design, stigma, and discrimination (eg, databases inaccurately recording sex so that transgender men miss their cervical smears) and a lack of medical education.[99–101] Incarcerated males have increased risks of cancer compared with the general male population, and quality of care in prisons is often poor.[26] People in prisons face specific challenges regarding control and choice,[96,102] communication barriers (eg, low health literacy, fear, lack of confidentiality regarding their medical consultations and decisions, and difficulty attending appointments), and restricted autonomy (eg, lack of control regarding treatment choices and adherence).[103] Men experiencing homelessness are at high risk for cancer (particularly respiratory, colorectal and urological) through behaviours, chronic infections, and limited access to affordable housing and health care.[104,105] Mental health issues, addiction, low health literacy, institutional fear, and limited health care access also pose barriers to medical engagement and lead to lower survival rates than matched populations.[96,105]

External causes

In 2023, there were an estimated 3·3 million deaths in male individuals from external causes (eg, trauma, interpersonal violence, road traffic incidents, and suicide), compared with 1·6 million in female individuals.[38] Since these deaths often occur at a young age, they make a large contribution to DALYs. Alcohol and other drugs are often contributory factors for many external death causes, reflecting their role in an individual's power in many societies (for instance, smoking and high alcohol consumption can elevate social status).[106–108] This link highlights the need to address commercial determinants of health, targeted marketing, and harmful consumption. Alcohol is a major driver of accidental deaths, intimate partner violence, and community violence.[109,110] External causes of death are often socially patterned, with characteristics such as socioeconomic position, race and ethnicity, and sexual or gender minority status shaping the distribution of external causes of death.

Interpersonal violence refers to violence between family and intimate partners or community violence.[111] While harms from interpersonal violence are largely experienced by women and children, community violence might result in a larger disease and mortality burden (although under-reporting of violence hampers data collection). For both interpersonal and community violence, men are more likely to be the perpetrators than women. Most victims of community violence are also men (panel 1), and it is likely that gay, bisexual, and transgender men experience a higher prevalence of both physical and sexual violence. Still, more high-quality data are needed to explore this phenomenon in different settings.[112] Competition over scarce resources and breakdown of social relationships and trust within communities can create the conditions for cycles of violence. Familial features (such as larger familial size, stress, and unwanted pregnancies) predict interpersonal violence.[113] Interpersonal violence is the most common cause of death in young men in Latin America and is concentrated in geographical hotspots.[114] Within these hotspots in Brazil, cumulative poverty (OR 1·33 [95% CI 1·20–1·46]) and poverty into early adulthood (1·35 [1·11–1·64]) predict future violence and homicide,[115] although causality is uncertain.[116]

Collective violence, perhaps best exemplified by wars, might increase over the coming years through many factors, including the effects of the climate change emergency.[117] The impacts of war are strongly gendered: men remain more likely to be involved directly in armed conflict, experience higher mortality risks, and have high rates of mental health disorders; in contrast, women and girls often face specific severe consequences of war, such as sexual trauma, and greater indirect impacts of war, such as those arising through infrastructure collapse, forced displacement, and disease outbreaks.[1,54,118,119]

Suicide is a major contributor to the lower life expectancy of males, with an estimated 536 000 deaths worldwide in 2023, compared with around 231 000 in females.[38] The higher male suicide burden contrasts with the higher rates of formally diagnosed mood disorders (largely comprising depression and anxiety) among women. There are specific subgroups of men who experience higher suicide risk: Indigenous men, men experiencing social and material deprivation, men with low education levels, men experiencing a chronic physical or mental illness, men with adverse childhood events, men in contact with the criminal justice system, and older men (panel 3).[120,121] Some drivers of suicide appear more important for men than women. For example, recessions are associated with increased male suicide, even during recessions in more recent years when sex differences in employment have diminished (panel 4).[122] Although suicide attempts are more common in women than men, men tend to use more

Panel 3: Suicide in older men

Suicide prevention strategies combine population-based interventions, which include restricting access to means (such as removing ligatures in institutional settings), and targeted approaches informed by intersectional analyses to focus on people at high risk.[44] Groups at high risk include people who have self-harmed, which affects 16 million persons worldwide. The subsequent 1-year suicide rate after self-harming is at least 20-fold higher than the suicide rate for the general population.[180] Longitudinal studies have reported that 1·6% of people with clinical self-harm diagnoses went on to die from suicide within the next 12 months and 3·9% died within the next 5 years.[181] Self-harm is therefore one of the strongest individual-level risk factors in psychological autopsy studies.[182]

A recent UK study reported that, compared with women, men have a three-fold increased risk of death from suicide after self-harm.[180] This risk is even higher in older men—in men aged 55 years and older, the incidence rate of suicide in 12 months after self-harm was 1873 per 100 000 people, compared with 111 per 100 000 in women aged 15–24 years. On a population level, despite there being many more presentations in younger women, the absolute number of deaths in older men was 40% higher than in these younger women.

Two implications arise. First, underlying causes of suicide deaths in older men need addressing through a public health approach. Reducing access to means in the community should consider factors that are more concentrated in men, including gun ownership, gambling, and alcohol use. There is new evidence that increasing unit pricing for alcohol has reduced deaths in Scotland,[183] which has also been reported in the USA and Switzerland for suicide specifically.[184] Associations between self-harm and suicidal thoughts with gambling are consistent and strong,[185] and recent research using population registers in Norway found a five-fold increased risk of suicide mortality in people with diagnosed gambling disorders.[186] Chronic stressors are important, particularly modifiable ones such as physical health problems and factors relating to employment and relationship stability. Community-based initiatives that foster stronger interpersonal relationships and mitigate loneliness are likely to play a role. In some countries, the effects of drug misuse, chronic unemployment, and weaker social networks are thought to be important in explaining the high suicide rates in older adult men.

A second implication is that risk stratification for suicide risk in vulnerable populations, including older men who self-harm, is an important way to allocate resources for further treatment and management of suicide risk in an evidence-based way, improve the consistency and quality of prognostic assessment in this population, and highlight modifiable risk factors.[187] Guidelines in some countries, including England, recommend that everyone presenting to hospital with self-harm is assessed and treated using the same clinical approach. As there is a 17-fold difference between older men and the most common group presenting to hospital (younger men), this approach potentially overlooks the new evidence that risk stratification is possible and accurate in this population.[188,189] Further, this approach overlooks the contribution that a more personalised assessment has made in other parts of medicine for vulnerable populations, such as cardiovascular risk calculators in people with diabetes,[190] atrial fibrillation,[191] or hypertension.[192] From an ethics perspective, not prioritising according to risk threatens to indirectly discriminate against older men, who already experience inequalities in access to mental health care.[193]

lethal methods. For example, self-injury is around twice as common in men than in women aged 40–59 years in England, whereas self-poisoning is more common in women.[123] More lethal methods are consistent with suicide deaths (60% of suicide deaths in men are from hanging, versus 45% in women). The proportion of deaths from hanging in men has been increasing since 2000.[124] In the USA, where the proportion of suicide deaths in men is higher than in women, 61% of suicide deaths in men were from firearms (compared with 35% in women).[125] Alcohol is strongly associated with increased suicide risk, with associations being broadly similar for men and women;[126] however, since alcohol consumption is more common in men, this reflects a far greater increase in absolute suicide burden. Intimate partner relationship distress and disruption are substantial risk factors for male suicidality and suicide. Contact with the criminal justice system is also a risk factor—the absolute burden of suicide in men in prisons and men with comminity sentences is higher than that of women.[127,128]

Communicable diseases

Communicable diseases do not contribute as much to men's poorer health as other causes of death or disability, but some conditions are noteworthy. The COVID-19 pandemic disproportionately affected males.[129] In 2023, there were an estimated 0·38 million COVID-19 deaths in females and 0·47 million deaths in males.[38] COVID-19 exacerbated existing ethnic and racial health inequalities, with large differences in exposure risk and mortality reported globally.[130] Black and other minoritised men in the USA and the UK tended to have a higher rate of mortality from COVID-19 than White men in each country.[131,132] Although this disease burden is expected to decrease, it will probably contribute to the lower life expectancy of male individuals for some time.

Tuberculosis also disproportionately affects men—there are more cases among males (60% of the total), and men with tuberculosis experience poorer health outcomes than women (65% of tuberculosis-related deaths are in males). These differences might be partly driven by lower levels of

engagement with treatment, remaining infectious for longer, and differing patterns of social contact. There are axes of inequity that magnify each other between gender and social disadvantage; as shown in the first paper in this Series, tuberculosis infection risk is greater in those experiencing material deprivation, overcrowding, or social exclusion.[133]

Patterns for some infectious diseases are more complex. Globally, males experience fewer DALYs from HIV (22 million) than females (23 million),[38] but opposing patterns are seen in Latin America and the Caribbean and in central and eastern Europe, with this burden concentrated among men who have sex with men (MSM). The emergence of mpox also highlights the greater disease burden among MSM,[134] particularly for infectious diseases. This burden is underpinned by processes of stigmatisation that can lead to reduced health care access, poorer quality of care, and ineffective health promotion initiatives.[1,135]

Social and structural determinants of health

Public policies hold huge potential to improve or harm men's health, particularly for the most vulnerable. The experience of the transition from communist to market-based societies following the collapse of the USSR illustrates this. In Russia, political upheaval led to major disruption to employment and rapid changes to men's roles within society, resulting in reduced life expectancy, driven by a large increase in alcohol-related mortality.[136–138] However, government policies played an important role in determining the extent of these changes, with marked variations in health trends across post-Communist countries. Mass privatisation programmes have been linked to higher mortality rates in these countries, and they are also associated with increased unemployment rates.[139] The protective role of belonging to a social organisation was also suggested, with mortality rates not rising when such social connections were common.[137,139]

The adverse health effects of economic recessions more generally are consistently gendered, affecting men's health disproportionately, with rises in rates of common mental disorders, substance-related disorders, and suicide-related mortality.[140] Despite the increasing participation of women in the labour market, the disproportionate effect among men seems to have remained consistent over time (eg, in the 2008 Great Recession) and across the world (although most of the available evidence arise from HICs), potentially reflecting the centrality of employment to masculine identities (panel 4).[141] The effects of unemployment on mental health differ across different groups of men. Although retirement is generally helpful for health, there is a trade-off between reductions in work-related stress and physical demands, and losses of purpose, social networks, and mobility.[142] Consequently, retirement can increase inequalities in health, reflecting financial security, social support (including relationships), and previous health.[19] Rising ages for pension payment in many countries might widen inequalities, with healthy high-earning men continuing to work (and reaping associated health benefits) and low-wage (often manual) workers or those in poor health retiring through disability, registering for unemployment, or having to work with little job security (with detrimental health effects).[143]

Panel 4: Differential effects of unemployment on mental health

We analysed representative longitudinal data from the UK Household Longitudinal Study (UKHLS) to estimate the causal effects of unemployment on poor mental health across intersectional groups. The UKHLS administers surveys to residents of approximately 40 000 households who are interviewed annually, collecting self-reported information on employment status, health, and detailed sociodemographic variables. The analysis focused on working-age people (25–64 years), covering 2009–19, thereby avoiding the potential disruption arising from the COVID-19 pandemic. We followed previously used methods, applying marginal structural models to address time-varying confounding informed by a directed acyclic graph, to estimate the causal effect of becoming unemployed among working-age participants (appendix p 16).[194,195] Poor mental health was assessed using the General Health Questionnaire-12 scale, with the presence of probable anxiety or depression defined by caseness (a score of ≥4 of 12). Doubly robust logistic regression models with inverse probability of treatment weighting estimated the causal effects of unemployment on mental health (expressed as odds ratios and absolute risk differences). We estimated stratified estimates across intersectional groups of interest (gender combined with age, education, and marital status).

We found larger effect sizes of unemployment among men than women, echoing the broader literature, which finds that employment has greater health benefits for men than women (table 2). The effect sizes were larger among partnered men than single men, but there was no effect modification by education or age. This finding potentially reflects the greater social responsibilities perceived by partnered men.

	Odds ratio (95% CI)	Percentage change (95% CI)
All women	2·09 (1·83–2·39)	11·5% (9·1–13·9)
All men	3·17 (2·77–3·62)	17·0% (14·5–19·4)
Stratified results within men		
High education	3·20 (2·54–4·04)	17·3% (13·1–21·5)
Medium education	3·21 (2·60–3·97)	16·7% (13·0–20·5)
Low education	3·19 (2·39–4·26)	16·0% (11·1–20·8)
Younger working age	3·28 (2·61–4·11)	17·6% (13·6–21·6)
Older working age	3·22 (2·71–3·82)	16·8% (13·7–20·0)
Single	2·19 (1·77–2·72)	11·3% (7·7–14·9)
Partnered	3·59 (3·06–4·22)	18·8% (15·8–21·7)

Table 2: **Causal effects of unemployment on poor mental health across intersectional groups**

Chronic stressors

Chronic stressors, such as those from financial strain (including employment, debt, and housing insecurity), relationship challenges, and conflict with societal norms of masculinity intersect with social and structural determinants of health. For example, extremes of employment strain, from overwork and burnout to unemployment, are associated with chronic stress that shape men's power and agency for health behaviours.[4]

With regards to overwork, cohort studies from Finland and South Korea show lower self-reported health, less vitality, and lower general health in men with longer working hours, possibly through an interaction with less sleep.[144,145] Financial insecurity exacerbates many diseases through an effect on health behaviour or the causes of that disease. Longitudinal retrospective cohorts report that financial security (and upward financial mobility) reduces the risk cardiovascular events over 20 years by around 16%, whereas insecurity leads to a 15% increase in risk of a future event; these risks are greater in men than women.[146] Similarly, systematic reviews report that poor social relationships (leading to loneliness and isolation) increase the risk coronary heart disease by 29% and stroke by 32%, regardless of sex.[147] Multiple studies detail that chronic stress also arises through compliance or conflict with societal norms of masculinity.[148–151]

Biological vulnerability

Male biology affects physiology and risk of disease, and changes with age. Testosterone is beneficial to muscle mass production, bone density, red cell production, libido, and mood, which are in turn protective of osteoporosis, diabetes, and depression.[152] However, higher testosterone concentrations are associated with risk taking and poor health behaviours, hypertension, and aggression.[153] Testosterone suppresses part of the immune system, leading to more severe infections (eg, COVID-19 and flu), impaired vaccine response, and slower wound healing.[154] Impaired immunity might explain why men have fewer autoimmune disorders (such as rheumatoid arthritis, relapsing-remitting multiple sclerosis, and systemic lupus erythematosus) than women.[155] With ageing, testosterone concentrations decrease, which affects energy metabolism, fat distribution, bone density, and mood. Anatomically, men have higher visceral fat (which can be inflammatory), more atherogenic lipid profiles, and earlier onset of vascular stiffness than women.[156–158] These differences lead to earlier onset and higher rates of cardiovascular disease in men than women. The XY genotype in men leads to X-linked conditions (eg, haemophilia, Duchenne's muscular dystrophy, and colour blindness) and susceptibility to loss of unique DNA from the Y chromosome. Loss of the Y chromosome is the most common post-zygotic mutation in men and increases with ageing, smoking, pollution, and environmental factors.[159] Loss of the Y chromosome results in pleiotropic, cell-type-specific effects, such as immune-modulation when affecting leukocytes, disturbance of platelet–erythrocyte production in bone marrow (potentially leading to more thromboembolic events), and levels of sex hormone-binding globulin. Disease associations (and higher risks in men) with potential mechanistic consequences of loss of the Y chromosome have been observed for Alzheimer's disease (through microglia cells), azoospermia, cardiovascular diseases (monocytes and macrophages infiltrating cardiac muscle), and immunotherapy responses for advanced cancers through changes in the tumour microenvironment.[82]

Limitations of the evidence

It is worth reflecting on the evidence we have used to inform this review. Due to our reliance on available data, we present predominantly a binary view of gender and have often been reliant on sex-disaggregated data. This approach underplays the complexity of gendered experiences in the real world, and the current data are not sufficient to fully inform an intersectional framework, which would offer a more nuanced picture of the inequalities and inequities in and across women's and men's health.[160] We also focus on measures that affect mortality and life expectancy (which are typically greater in men), rather than morbidity (which is typically higher in women). Although mortality-based measures are more reliably gathered, that potentially reflects the structural prioritisation of men's experiences within many societies—an issue that the analyses presented within this review potentially reinforce. We also acknowledge that there are many valuable ways of defining and measuring health,[161] some of which might relate more to vitality than life expectancy and could favour men.[162] Choices about measurement might lead to different assessments of men's health and different goals for the future. We acknowledge we have not been able to conduct comprehensive searches of the existing evidence base, having searched only two databases (PubMed and Google Scholar), supplemented by citation searching, given the breadth of the material covered within this paper. We might therefore have missed important literature from LMICs, although we did try to purposively seek case studies from these parts of the world to supplement the evidence base. Furthermore, we were unable to explore how the effects of exposures (such as obesity and physical activity) differ between men and women within our analysis.

There are multiple important data gaps that must be acknowledged. For example, when contextualising intersecting health inequalities (eg, sociodemographic characteristics that interact with gender), many datasets, particularly those collected through surveys, are often underpowered for intersectional analyses, and the most comprehensive data are from HICs. Therefore, the generalisability of findings are potentially limited to those settings, and we might be overlooking considerable health inequalities between and across men in LMICs. In accompanying articles,[1,45] we discuss these gaps and identify topics on which more robust data collection is key if we wish to understand men's health, sex and gender health differences, and how sex and gender intersect with other social characteristics.

Conclusion

Despite limitations in global health data, we summarise what is currently known about the epidemiology of men's

health globally, and provide case studies to illustrate specific patterns in-depth. Multiple risk factors and causes contribute to males' shorter life expectancies and greater DALYs compared with female individuals; however, this is only part of the picture. There are huge variations within men, with those experiencing health-harming social, economic, commercial, and political drivers of health bearing the greatest challenges. Solutions to address men's health and the wide-ranging inequalities will come from understanding how different types of masculinity are experienced within specific contexts and how they intersect with other social and structural determinants of health, exploring sex differences and gender diversities, and implementing evidence-based interventions that prevent and delay the main causes of death and ill-health. The goal is to forge a global commitment and explicit strategy to improving men's health. The third paper in this Series builds on this paper to provide recommendations for how this goal can be achieved.[45]

Contributors

JWFC contributed to conceptualisation, literature search, methodology, figures, analysis, writing the original draft, writing (review and editing), and supervision. RMT contributed to literature search, methodology, figures, analysis, writing the original draft, and resources. DMG contributed to conceptualisation, analysis, and writing. WM contributed to analysis, and writing (review and editing). JG contributed to analysis, figures, and writing (review and editing). FM and SFR contributed to analysis and writing (review and editing). SF contributed to analysis, writing the original draft, and writing (review and editing). BRE, MLB, WN, JLO, DP, and SJH contributed to writing (review and editing). LSF contributed to analysis and writing (review and editing). RT contributed to conceptualisation, analysis, and writing (review and editing). ST contributed to conceptualisation, analysis, and writing (review and editing). SVK contributed to conceptualisation, literature search, methodology, figures, analysis, writing the original draft, and supervision.

Declaration of interests

JWFC has received a grant from Roche (payment to the institution); consulting fees or honoraria from Astellas, AstraZeneca, Bristol Myers Squibb, CG Oncology, Roche, Ferring, Janssen, Johnson and Johnson, Medscape, Pfizer, and Merck; support for attending meetings from Janssen; has participated on the External Advisory Boards for the PROMOTE trial (University of Oxford), Bespoke trial (University College London Hospitals, London), and CISTO trial (Bladder Cancer Advocacy Network, USA); has played a leadership or fiduciary role with Fight Bladder Cancer UK and Weston Park Cancer Charity; and is Director of the Sheffield National Institute for Health and Care Research Clinical Research Facility. RMT received a Wellcome Trust Research Award for Health Professionals (218105/Z/19/Z), National Institute for Health and Care Research (NIHR) Development Award (co-principal investigator; NIHR154243), NIHR Researcher-Led Award (co-investigator; NIHR168008), and a Public Health Scotland award (Safer Drugs Consumption Facility Evaluation—Baseline Data Collection). DMG declares National Institute on Minority Health and Health Disparities funding for Fathers and Children Exercising Together (FACEiT) & Black Health Block & Quit and Screen Project - Supplement to University of Arkansas for Medical Sciences P50, US Department of Defense funding for Impact of Online Prostate Cancer Information on Health Disparities, Movember Foundation funding for Rooted & Rising Collective: Movember Foundation Accelerator Program for Young Black Men; payment for lecture for Men's Health World Congress, National Maternal Health Innovation Symposium, University of Minnesota's 8th Annual Research Ethics Day Conference, Community Engagement Grand Rounds (University of Texas Southwestern Medical Center), 13th Annual Health Equity & Social Justice Conference, Annual Public Health Conference Promoting Health Equity, Speaker Series University of Arkansas for Medical Sciences (Center for Research, Health and Social Justice), Promoting Father Engagement to Enhance Baby's Brain Health Development (School of Public Health, University of Texas), Equity ECHO Series—The Ethics of Doing Research with Communities (University of New Mexico Health Science Center), Partners for Advancing Health Equity (P4HE) webinar (Tulane School of Public Health and Tropical Medicine), Curtis Center Health Equity Seminar at University of Michigan, Black Health & Wellness Speaker Series at University of Pittsburgh, Health Equity: From Lens to Science series at University of California, Workshop at Rutgers University, Precision Prevention, Early Detection, and Interception of Cancer Special Conference at American Association for Cancer Research; member of Global Men's Health Advisory Committee (Movember Foundation) and Men's Health Network, Chair of Global Action on Men's Health. SFR, BRE, RT, and ST were supported by funding from the UK Research and Innovation (UKRI) Global Challenges Research Fund Accountability for Informal Urban Equity Hub (a UKRI Collective Fund award with award reference ES/S00811X/1). WM, SFR, RT, and ST were supported with funding from Gender Equity and Antimicrobial Resistance (GEAR UP), funded by the Department of Health and Social Care's Fleming Fund using UK aid–MottMacDonald (grant number FF152 558). ST is the part-time UKRI Foreign, Commonwealth & Development Office (FCDO) Senior Research Fellow in Gender (2024–27, payment to the institution), and the views expressed in this publication are those of the authors and not necessarily those of UKRI–FCDO or any other funder. ST has received payment and travel expenses from The Wellcome Trust. RT is supported by funding from the Canadian International Development Research Centre and UK FCDO for Urban Transformative Research for Adaptation to Climate Change in Informal Settlements (grant number 110642-001). SF is an expert member of the UK Ministry of Justice's Independent Panel for Deaths in Custody. SJH has received grants to Global 50/50 from Gates Foundation and Co-Impact; consulting fees from Elsevier Research Cultures Board and Swedish Government Research Funding Board; payment or honoraria from Swiss National Science Foundation (paid to Global 50/50); has participated on an advisory board with WHO as chair of Data Safety and Monitoring Board trial; and is a UK Government appointed Commissioner and Chair of the Awards Policy Committee for the Commonwealth Scholarship Commission. SVK was supported by funding from the European Research Council (949582), the Medical Research Council (MC_UU_00022/2), and the Scottish Government Chief Scientist Office (SPHSU17); has received reimbursement from the Medical Research Council to attend grant panel meetings; and is an unpaid member of Obesity Action Scotland. All other authors declare no competing interests.

Acknowledgments

JWFC is funded by an NIHR Research Professorship. SF is supported by the NIHR Oxford Health Biomedical Research Centre. JLO is supported by a Tier 1 Canada Research Chair in Men's Health Promotion. RT, BRE, SFR, and ST were supported by funding from the UK Research and Innovation (UKRI) Global Challenges Research Fund Accountability for Informal Urban Equity Hub: a UKRI Collective Fund award with award reference ES/S00811X/1. SVK acknowledges funding from the European Research Council (949582), the Medical Research Council (MC_UU_00022/2) and the Scottish Government Chief Scientist Office (SPHSU17). These funding sources played no role in any aspect of study design, data collection, analysis or interpretation. The funders played no roles in data collection, data analysis, interpretation, in writing the manuscript, or in the author's decision to submit.

Editorial note: The Lancet Group takes a neutral position with respect to territorial claims in published maps and institutional affiliations.

References

1 Tolhurst R, Egid BR, Mavhu W, et al. Men's health: an intersectional and multilevel framework for understanding syndemic patterns of health. *Lancet* 2026; **408:** 1866–90.

2 Hawkes S, Sy EA, Barker G, et al. Achieving gender justice for global health equity: the *Lancet* Commission on gender and global health. *Lancet* 2025; **405:** 1373–438.

3 Náfrádi L, Nakamoto K, Schulz PJ. Is patient empowerment the key to promote adherence? A systematic review of the relationship between self-efficacy, health locus of control and medication adherence. *PLoS One* 2017; **12:** e0186458.

4 Hammarström A, Lundman B, Ahlgren C, Wiklund M. Health and masculinities shaped by agency within structures among young unemployed men in a northern Swedish context. *PLoS One* 2015; **10:** e0124785.

5 Acevedo P, Mora-Urda AI, Montero P. Social inequalities in health: duration of unemployment unevenly effects on the health of men and women. *Eur J Public Health* 2020; **30:** 305–10.

6 Favril L, Rich JD, Hard J, Fazel S. Mental and physical health morbidity among people in prisons: an umbrella review. *Lancet Public Health* 2024; **9:** e250–60.

7 O'Connor DB, Thayer JF, Vedhara K. Stress and health: a review of psychobiological processes. *Annu Rev Psychol* 2021; **72:** 663–88.

8 Wang Y, Hunt K, Nazareth I, Freemantle N, Petersen I. Do men consult less than women? An analysis of routinely collected UK general practice data. *BMJ Open* 2013; **3:** e003320.

9 Song F, Bachmann M, Howe A. Factors associated with the consultation of GPs among adults aged ≥16 years: an analysis of data from the Health Survey for England 2019. *BJGP Open* 2023; **7:** BJGPO.2022.0177.

10 Reczek C. Sexual- and gender-minority families: a 2010 to 2020 decade in review. *J Marriage Fam* 2020; **82:** 300–25.

11 Sudha S, Suchindran C, Mutran EJ, Rajan SI, Sarma PS. Marital status, family ties, and self-rated health among elders in South India. *J Cross Cult Gerontol* 2006; **21:** 103–20.

12 Kaplan RM, Kronick RG. Marital status and longevity in the United States population. *J Epidemiol Community Health* 2006; **60:** 760–65.

13 Monin JK, Clark MS. Why do men benefit more from marriage than do women? Thinking more broadly about interpersonal processes that occur within and outside of marriage. *Sex Roles* 2011; **65:** 320–26.

14 Po JY, Subramanian SV. Mortality burden and socioeconomic status in India. *PLoS One* 2011; **6:** e16844.

15 Kumari M, Mohanty SK. Caste, religion and regional differentials in life expectancy at birth in India: cross-sectional estimates from recent National Family Health Survey. *BMJ Open* 2020; **10:** e035392.

16 Subramanian SV, Nandy S, Irving M, Gordon D, Lambert H, Davey Smith G. The mortality divide in India: the differential contributions of gender, caste, and standard of living across the life course. *Am J Public Health* 2006; **96:** 818–25.

17 Radhamanohar M. Health and the Indian caste system. *Lancet* 2015; **385:** 416.

18 Mallath MK, Taylor DG, Badwe RA, et al. The growing burden of cancer in India: epidemiology and social context. *Lancet Oncol* 2014; **15:** e205–12.

19 Chandola T, Ferrie J, Sacker A, Marmot M. Social inequalities in self reported health in early old age: follow-up of prospective cohort study. *BMJ* 2007; **334:** 990.

20 IHME-CHAIN Collaborators. Effects of education on adult mortality: a global systematic review and meta-analysis. *Lancet Public Health* 2024; **9:** e155–65.

21 Welmond MJ, Gregory L. Educational underachievement among boys and men. 2021. https://documents1.worldbank.org/curated/en/111041644611110155/pdf/Educational-Underachievement-Among-Boys-and-Men.pdf (accessed Jan 21, 2026).

22 Broström L, Jansson B. Leaving boys behind? The gender gap in education among children and young people from foreign backgrounds 2010–2020: a Nordic review. 2022. https://pub.norden.org/nord2022-003/ (accessed March 17, 2025).

23 World Population Review. Education rankings by country 2025. 2025. https://worldpopulationreview.com/country-rankings/education-rankings-by-country (accessed Nov 11, 2026).

24 Gostin LO, Monahan JT, Kaldor J, et al. The legal determinants of health: harnessing the power of law for global health and sustainable development. *Lancet* 2019; **393:** 1857–910.

25 Institute for Crime Justice Policy Research. Prison populations continue to rise in many parts of the world, with 11·5 million held in prisons worldwide. 2024. https://www.icpr.org.uk/news/2024/prison-populations-continue-rise-many-parts-world-115-million-held-prisons-worldwide#:~:text=Prison%20populations%20continue%20to%20rise,Institute%20for%20Criminal%20Policy%20Research (accessed Dec 2, 2025).

26 Fazel S, Baillargeon J. The health of prisoners. *Lancet* 2011; **377:** 956–65.

27 Bashir AY, Moloney N, Elzain ME, et al. From nowhere to nowhere. Homelessness and incarceration: a systematic review and meta-analysis. *Int J Prison Health* 2021; **17:** 452–61.

28 Bales WD, Piquero AR. Racial/ethnic differentials in sentencing to incarceration. *Justice Q* 2012; **29:** 742–73.

29 Favril L, Shaw J, Fazel S. Prevalence and risk factors for suicide attempts in prison. *Clin Psychol Rev* 2022; **97:** 102190.

30 Borschmann R, Kinner SA. Rates and causes of death after release from incarceration among 1471 526 people in eight high-income and middle-income countries: an individual participant data meta-analysis. *Lancet* 2024; **403:** 1779–88.

31 Beltrán-Sánchez H, Finch CE, Crimmins EM. Twentieth century surge of excess adult male mortality. *Proc Natl Acad Sci USA* 2015; **112:** 8993–98.

32 Case A, Deaton A. Mortality and morbidity in the 21st century. *Brookings Pap Econ Act* 2017; **2017:** 397–476.

33 Rochelle TL, Yeung DK, Bond MH, Li LMW. Predictors of the gender gap in life expectancy across 54 nations. *Psychol Health Med* 2015; **20:** 129–38.

34 Roth GA, Mensah GA, Johnson CO, et al. Global burden of cardiovascular diseases and risk factors, 1990–2019: update from the GBD 2019 study. *J Am Coll Cardiol* 2020; **76:** 2982–3021.

35 Oksuzyan A, Juel K, Vaupel JW, Christensen K. Men: good health and high mortality. Sex differences in health and aging. *Aging Clin Exp Res* 2008; **20:** 91–102.

36 GBD 2021 Demographics Collaborators. Global age-sex-specific mortality, life expectancy, and population estimates in 204 countries and territories and 811 subnational locations, 1950–2021, and the impact of the COVID-19 pandemic: a comprehensive demographic analysis for the Global Burden of Disease Study 2021. *Lancet* 2024; **403:** 1989–2056.

37 Gorman BK, Read JG. Gender disparities in adult health: an examination of three measures of morbidity. *J Health Soc Behav* 2006; **47:** 95–110.

38 Institute for Health Metrics and Evaluation. GBD 2023 Results. Seattle, WA: University of Washington, 2024.

39 Murray CJ, Lopez AD. Mortality by cause for eight regions of the world: Global Burden of Disease Study. *Lancet* 1997; **349:** 1269–76.

40 Cislaghi B, Weber AM, Gupta GR, Darmstadt GL. Gender equality and global health: intersecting political challenges. *J Glob Health* 2020; **10:** 010701.

41 Murray CJL. The global burden of disease study at 30 years. *Nat Med* 2022; **28:** 2019–26.

42 Patwardhan V, Gil GF, Arrieta A, et al. Differences across the lifespan between females and males in the top 20 causes of disease burden globally: a systematic analysis of the Global Burden of Disease Study 2021. *Lancet Public Health* 2024; **9:** e282–94.

43 Bilsker D, Fogarty AS, Wakefield MA. Critical issues in men's mental health. *Can J Psychiatry* 2018; **63:** 590–96.

44 Fazel S, Runeson B. Suicide. *N Engl J Med* 2020; **382:** 266–74.

45 Hawkes S, Griffith DM, Catto JWF, et al. Charting a course to men's health and wellbeing: applying a lens of power and politics to improve men's health outcomes. *Lancet (London, England)* 2026: **408:** 1899–911.

46 Wellings K, Collumbien M, Slaymaker E, et al. Sexual behaviour in context: a global perspective. *Lancet* 2006; **368:** 1706–28.

47 Millett GA, Jeffries WL 4th, Peterson JL, et al. Common roots: a contextual review of HIV epidemics in black men who have sex with men across the African diaspora. *Lancet* 2012; **380:** 411–23.

48 Thomas ML, Zuma K, Loykissoonlal D, et al. Substantial but spatially heterogeneous progress in male circumcision for HIV prevention in South Africa. *Commun Med (Lond)* 2024; **4:** 1.

49 Plotkin M, Castor D, Mziray H, et al. "Man, what took you so long?" Social and individual factors affecting adult attendance at voluntary medical male circumcision services in Tanzania. *Glob Health Sci Pract* 2013; **1:** 108–16.

50 Fitzmaurice C, Abate D, Abbasi N, et al. Global, regional, and national cancer incidence, mortality, years of life lost, years lived with disability, and disability-adjusted life-years for 29 cancer groups, 1990 to 2017: a systematic analysis for the global burden of disease study. *JAMA Oncol* 2019; **5:** 1749–68.

51 Mansouri D, McMillan DC, Grant Y, Crighton EM, Horgan PG. The impact of age, sex and socioeconomic deprivation on outcomes in a colorectal cancer screening programme. *PLoS One* 2013; **8:** e66063.

52 Sedani AE, Gomez SL, Lawrence WR, Moore JX, Brandt HM, Rogers CR. Social risks and nonadherence to recommended cancer screening among US adults. *JAMA Netw Open* 2025; **8:** e2449556.

53 Co M, Lee A, Kwong A. Delayed presentation, diagnosis, and psychosocial aspects of male breast cancer. *Cancer Med* 2020; **9:** 3305–09.

54 Jamaluddine Z, Abukmail H, Aly S, Campbell OMR, Checchi F. Traumatic injury mortality in the Gaza Strip from Oct 7, 2023, to June 30, 2024: a capture-recapture analysis. *Lancet* 2025; **405:** 469–77.

55 Regitz-Zagrosek V, Kararigas G. Mechanistic pathways of sex differences in cardiovascular disease. *Physiol Rev* 2017; **97:** 1–37.

56 Regitz-Zagrosek V, Gebhard C. Gender medicine: effects of sex and gender on cardiovascular disease manifestation and outcomes. *Nat Rev Cardiol* 2023; **20:** 236–47.

57 Kaur H, Werstuck GH. The effect of testosterone on cardiovascular disease and cardiovascular risk factors in men: a review of clinical and preclinical data. *CJC Open* 2021; **3:** 1238–48.

58 Gilmore AB, Fabbri A, Baum F, et al. Defining and conceptualising the commercial determinants of health. *Lancet* 2023; **401:** 1194–213.

59 Saini A. Superior: The return of race science. Fourth Estate, 2019.

60 Monteiro CA, Louzada ML, Steele-Martinez E, et al. Ultra-processed foods and human health: the main thesis and the evidence. *Lancet* 2025; **406:** 2667–84.

61 Peters SAE, Muntner P, Woodward M. Sex differences in the prevalence of, and trends in, cardiovascular risk factors, treatment, and control in the United States, 2001 to 2016. *Circulation* 2019; **139:** 1025–35.

62 Charrier L, van Dorsselaer S, Canale N, et al. A focus on adolescent substance use in Europe, central Asia and Canada. Health Behaviour in School-aged Children international report from the 2021/2022 survey, volume 3. World Health Organization, 2024.

63 Islami F, Stoklosa M, Drope J, Jemal A. Global and regional patterns of tobacco smoking and tobacco control policies. *Eur Urol Focus* 2015; **1:** 3–16.

64 Passey M, Bonevski B. The importance of tobacco research focusing on marginalized groups. *Addiction* 2014; **109:** 1049–51.

65 Spaulding AC, Eldridge GD, Chico CE, et al. Smoking in correctional settings worldwide: prevalence, bans, and interventions. *Epidemiol Rev* 2018; **40:** 82–95.

66 Hanafin J, Sunday S, Clancy L. Inequalities in smoking and e-cigarette use in young adults with mental ill-health, 20 years after Ireland's smoking ban. *Tob Use Insights* 2024; **17:** 1179173X241283744.

67 Patel AP, Wang M, Kartoun U, Ng K, Khera AV. Quantifying and understanding the higher risk of atherosclerotic cardiovascular disease among south Asian individuals: results from the UK Biobank Prospective Cohort Study. *Circulation* 2021; **144:** 410–22.

68 Aggarwal R, Chiu N, Wadhera RK, et al. Racial/ethnic disparities in hypertension prevalence, awareness, treatment, and control in the United States, 2013 to 2018. *Hypertension* 2021; **78:** 1719–26.

69 Howard VJ, Madsen TE, Kleindorfer DO, et al. Sex and race differences in the association of incident ischemic stroke with risk factors. *JAMA Neurol* 2019; **76:** 179–86.

70 Bray F, Laversanne M, Sung H, et al. Global cancer statistics 2022: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin* 2024; **74:** 229–63.

71 James ND, Tannock I, N'Dow J, et al. The *Lancet* Commission on prostate cancer: planning for the surge in cases. *Lancet* 2024; **403:** 1683–722.

72 Coelho KR. Challenges of the oral cancer burden in India. *J Cancer Epidemiol* 2012; **2012:** 701932.

73 Bhan N, Karan A, Srivastava S, Selvaraj S, Subramanian SV, Millett C. Have socioeconomic inequalities in tobacco use in India increased over time? Trends from the national sample surveys (2000–2012). *Nicotine Tob Res* 2016; **18:** 1711–18.

74 Rajpal S, Kumar A, Ronanki S, Sathesh N, Kim R, Subramanian SV. Changes in prevalence of alcohol and tobacco consumption across districts of India, 2016 and 2021. *BMC Public Health* 2025; **25:** 1962.

75 Dsouza V, Kembhavi PM, Rao S P, P K, Hebbar PB. How does Indian news media report smokeless tobacco control? A content analysis of the gutka ban enforcement. *PLOS Glob Public Health* 2023; **3:** e0001724.

76 Kumar S, Gawde N, Pednekar MS. Social determinants and the prevalence of Paan Masala use among adults in India: results from Global Adult Tobacco Survey, 2016–17. *Asian Pac J Cancer Prev* 2023; **24:** 3773–81.

77 Conway DI, Petticrew M, Marlborough H, Berthiller J, Hashibe M, Macpherson LM. Socioeconomic inequalities and oral cancer risk: a systematic review and meta-analysis of case-control studies. *Int J Cancer* 2008; **122:** 2811–19.

78 Sankaranarayanan R, Ramadas K, Gauvreau CL. Socioeconomic factors and cancer prevention in India: diverse interventions are needed. International Agency for Research on Cancer, 2020.

79 Ibrahim Khalil A, Franceschi S, de Martel C, Bray F, Clifford GM. Burden of Kaposi sarcoma according to HIV status: a systematic review and global analysis. *Int J Cancer* 2022; **150:** 1948–57.

80 Mak LY, Liu K, Chirapongsathorn S, et al. Liver diseases and hepatocellular carcinoma in the Asia-Pacific region: burden, trends, challenges and future directions. *Nat Rev Gastroenterol Hepatol* 2024; **21:** 834–51.

81 Jackson SS, Marks MA, Katki HA, et al. Sex disparities in the incidence of 21 cancer types: quantification of the contribution of risk factors. *Cancer* 2022; **128:** 3531–40.

82 Abdel-Hafiz HA, Schafer JM, Chen X, et al. Y chromosome loss in cancer drives growth by evasion of adaptive immunity. *Nature* 2023; **619:** 624–31.

83 Movember. The Real Face of Men's Health 2025 United States Report. 2025. https://us.movember.com/movember-institute/the-real-face-of-mens-health-report (accessed Jan 13, 2026).

84 Siegel RL, Giaquinto AN, Jemal A. Cancer statistics, 2024. *CA Cancer J Clin* 2024; **74:** 12–49.

85 Jubber I, Ong S, Bukavina L, et al. Epidemiology of bladder cancer in 2023: a systematic review of risk factors. *Eur Urol* 2023; **84:** 176–90.

86 Kalager M, Bretthauer M. Improving cancer screening programs. *Science* 2020; **367:** 143–44.

87 Macleod U, Mitchell ED, Burgess C, Macdonald S, Ramirez AJ. Risk factors for delayed presentation and referral of symptomatic cancer: evidence for common cancers. *Br J Cancer* 2009; **101** (suppl 2): S92–101.

88 Smith LK, Pope C, Botha JL. Patients' help-seeking experiences and delay in cancer presentation: a qualitative synthesis. *Lancet* 2005; **366:** 825–31.

89 Adams SJ, Stone E, Baldwin DR, Vliegenthart R, Lee P, Fintelmann FJ. Lung cancer screening. *Lancet* 2023; **401:** 390–408.

90 Halpern MT, Liu B, Lowy DR, Gupta S, Croswell JM, Doria-Rose VP. The annual cost of cancer screening in the United States. *Ann Intern Med* 2024; **177:** 1170–78.

91 Le Marchand L, Wilkens LR, Kolonel LN. Ethnic differences in the lung cancer risk associated with smoking. *Cancer Epidemiol Biomarkers Prev* 1992; **1:** 103–07.

92 Yamane CYEW, Baumhofer-Merritt NK. Multilevel Racism, Historical Trauma, Resilience, and Native Hawaiian Health. In: Racism: Science Tools for the Public Health Professional, 2nd edn. American Public Health Association Press, 2024: 65–82.

93 Nixon AJ, Hudson D. Racism and the health of Black Americans: how racism has shaped the health of Black people and what to do about it. In: Ford CL, Griffith DM, Bruce MA et al, eds. Racism: science tools for the public health professional, 2nd edn. American Public Health Association, 2024: 103–20.

94 Mendez D, Le TTT. Consequences of a match made in hell: the harm caused by menthol smoking to the African American population over 1980–2018. *Tob Control* 2021; tobaccocontrol-2021-056748.

95 Nash R, Ward KC, Jemal A, Sandberg DE, Tangpricha V, Goodman M. Frequency and distribution of primary site among gender minority cancer patients: an analysis of U.S. national surveillance data. *Cancer Epidemiol* 2018; **54:** 1–6.

96 Aldridge RW, Story A, Hwang SW, et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. *Lancet* 2018; **391:** 241–50.

97 Leone AG, Trapani D, Schabath MB, et al. Cancer in transgender and gender-diverse persons: a review. *JAMA Oncol* 2023; **9:** 556–63.

98 Frost DM, Meyer IH. Minority stress theory: application, critique, and continued relevance. *Curr Opin Psychol* 2023; **51:** 101579.

99 Wylie K, Knudson G, Khan SI, Bonierbale M, Watanyusakul S, Baral S. Serving transgender people: clinical care considerations and service delivery models in transgender health. *Lancet* 2016; **388:** 401–11.

100 Kiran T, Davie S, Singh D, et al. Cancer screening rates among transgender adults: cross-sectional analysis of primary care data. *Can Fam Physician* 2019; **65:** e30–37.

101 Tabaac AR, Sutter ME, Wall CSJ, Baker KE. Gender identity disparities in cancer screening behaviors. *Am J Prev Med* 2018; **54:** 385–93.

102 Armes J, Visser R, Lüchtenborg M, et al. Cancer in prison: barriers and enablers to diagnosis and treatment. *EClinicalMedicine* 2024; **72:** 102540.

103 Edge C, Stockley MR, Swabey ML, et al. Secondary care clinicians and staff have a key role in delivering equivalence of care for prisoners: a qualitative study of prisoners' experiences. *EClinicalMedicine* 2020; **24:** 100416.

104 Asgary R. Cancer screening in the homeless population. *Lancet Oncol* 2018; **19:** e344–50.

105 Holowatyj AN, Heath EI, Pappas LM, et al. The epidemiology of cancer among homeless adults in metropolitan Detroit. *JNCI Cancer Spectr* 2019; **3:** pkz006.

106 Ng N, Weinehall L, Ohman A. 'If I don't smoke, I'm not a real man'—Indonesian teenage boys' views about smoking. *Health Educ Res* 2007; **22:** 794–804.

107 Griffith DM, Thorpe RJ Jr. Men's physical health and health behaviors. American Psychological Association, 2016.

108 Hinote BP, Webber GR. Drinking toward manhood: masculinity and alcohol in the former USSR. *Men Masculinities* 2012; **15:** 292–310.

109 Yu R, Nevado-Holgado AJ, Molero Y, et al. Mental disorders and intimate partner violence perpetrated by men towards women: a Swedish population-based longitudinal study. *PLoS Med* 2019; **16:** e1002995.

110 Babor TF, Casswell S, Graham K, et al. Alcohol: no ordinary commodity—a summary of the third edition. *Addiction* 2022; **117**(12): 3024–36.

111 Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. *Lancet* 2002; **360:** 1083–88.

112 Blondeel K, de Vasconcelos S, García-Moreno C, Stephenson R, Temmerman M, Toskin I. Violence motivated by perception of sexual orientation and gender identity: a systematic review. *Bull World Health Organ* 2018; **96:** 29–41L.

113 Derzon JH. The correspondence of family features with problem, aggressive, criminal, and violent behavior: a meta-analysis. *J Exp Criminol* 2010; **6:** 263–92.

114 Barbosa KGN, Walker BB, Schuurman N, Cavalcanti SDLB, Ferreira e Ferreira E, Ferreira RC. Epidemiological and spatial characteristics of interpersonal physical violence in a Brazilian city: a comparative study of violent injury hotspots in familial versus non-familial settings, 2012–2014. *PLoS One* 2019; **14:** e0208304.

115 Murray J, Degli Esposti M, Loret de Mola C, et al. Life-course influences of poverty on violence and homicide: 30-year Brazilian birth cohort study. *Int J Epidemiol* 2024; **53:** dyae103.

116 Sariaslan A, Mikkonen J, Aaltonen M, Hiilamo H, Martikainen P, Fazel S. No causal associations between childhood family income and subsequent psychiatric disorders, substance misuse and violent crime arrests: a nationwide Finnish study of >650 000 individuals and their siblings. *Int J Epidemiol* 2021; **50:** 1628–38.

117 Ko J, Lee HF, Leung CK. War and warming: the effects of climate change on military conflicts in developing countries (1995–2020). *Innovation and Green Development* 2024; **3:** 100175.

118 Guha-Sapir D, Schlüter B, Rodriguez-Llanes JM, Lillywhite L, Hicks MH. Patterns of civilian and child deaths due to war-related violence in Syria: a comparative analysis from the Violation Documentation Center dataset, 2011–16. *Lancet Glob Health* 2018; **6:** e103–10.

119 Bendavid E, Boerma T, Akseer N, et al. The effects of armed conflict on the health of women and children. *Lancet* 2021; **397:** 522–32.

120 Richardson C, Robb KA, O'Connor RC. A systematic review of suicidal behaviour in men: a narrative synthesis of risk factors. *Soc Sci Med* 2021; **276:** 113831.

121 Favril L, Yu R, Geddes JR, Fazel S. Individual-level risk factors for suicide mortality in the general population: an umbrella review. *Lancet Public Health* 2023; **8:** e868–77.

122 Sinyor M, Silverman M, Pirkis J, Hawton K. The effect of economic downturn, financial hardship, unemployment, and relevant government responses on suicide. *Lancet Public Health* 2024; **9:** e802–06.

123 Clements C, Hawton K, Geulayov G, et al. Self-harm in midlife: analysis using data from the Multicentre Study of Self-harm in England. *Br J Psychiatry* 2019; **215:** 600–07.

124. Office for National Statistics. Suicides in England and Wales: 2019 registrations. 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2019registrations (accessed June 12, 2026).

125 National Institute for Mental Health. Suicide. 2025. https://www.nimh.nih.gov/health/statistics/suicide#part_2558 (accessed June 12, 2026).

126 Lange S, Kim KV, Lasserre AM, et al. Sex-specific association of alcohol use disorder with suicide mortality: a systematic review and meta-analysis. *JAMA network open* 2024; **7:** e241941–e.

127 Mundt AP, Cifuentes-Gramajo PA, Baranyi G, Fazel S. Worldwide incidence of suicides in prison: a systematic review with meta-regression analyses. *Lancet Psychiatry* 2024; **11:** 536–44.

128 Yukhnenko D, Blackwood N, Lichtenstein P, Fazel S. Association of substance use and other psychiatric disorders with all-cause and external-cause mortality in individuals given community sentences in Sweden: a national cohort study. *Lancet Reg Health Eur* 2023; **33:** 100703.

129 Griffith DM, Sharma G, Holliday CS, et al. Men and COVID-19: a biopsychosocial approach to understanding sex differences in mortality and recommendations for practice and policy interventions. *Prev Chronic Dis* 2020; **17:** E63.

130 Irizar P, Pan D, Kapadia D, et al. Ethnic inequalities in COVID-19 infection, hospitalisation, intensive care admission, and death: a global systematic review and meta-analysis of over 200 million study participants. *EClinicalMedicine* 2023; **57:** 101877.

131 Griffith DM, Holliday CS, Enyia OK, Ellison JM, Jaeger EC. Using syndemics and intersectionality to explain the disproportionate COVID-19 mortality among Black men. *Public Health Rep* 2021; **136:** 523–31.

132 McIntyre N. Black men in England three times more likely to die of COVID-19 than white men. 2020. https://www.theguardian.com/society/2020/jun/19/black-men-england-wales-three-times-more-likely-die-covid-19-coronavirus (accessed March 17, 2026).

133 Narasimhan P, Wood J, Macintyre CR, Mathai D. Risk factors for tuberculosis. *Pulm Med* 2013; **2013:** 828939.

134 Ugwu CLJ, Bragazzi NL, Wu J, et al. Risk factors associated with human Mpox infection: a systematic review and meta-analysis. *BMJ Glob Health* 2025; **10:** e016937.

135 Altman D, Aggleton P, Williams M, et al. Men who have sex with men: stigma and discrimination. *Lancet* 2012; **380:** 439–45.

136 Leon DA, Saburova L, Tomkins S, et al. Hazardous alcohol drinking and premature mortality in Russia: a population based case-control study. *Lancet* 2007; **369:** 2001–09.

137 Zaridze D, Lewington S, Boroda A, et al. Alcohol and mortality in Russia: prospective observational study of 151 000 adults. *Lancet* 2014; **383:** 1465–73.

138 Saburova L, Keenan K, Bobrova N, Leon DA, Elbourne D. Alcohol and fatal life trajectories in Russia: understanding narrative accounts of premature male death in the family. *BMC Public Health* 2011; **11:** 481.

139 Stuckler D, King L, McKee M. Mass privatisation and the post-communist mortality crisis: a cross-national analysis. *Lancet* 2009; **373:** 399–407.

140 Frasquilho D, Matos MG, Salonna F, et al. Mental health outcomes in times of economic recession: a systematic literature review. *BMC Public Health* 2016; **16:** 115.

141 Cislaghi B, Bhatia A, Hallgren EST, Horanieh N, Weber AM, Darmstadt GL. Gender norms and gender equality in full-time employment and health: a 97-country analysis of the world values survey. *Front Psychol* 2022; **13:** 689815.

142 van der Heide I, van Rijn RM, Robroek SJ, Burdorf A, Proper KI. Is retirement good for your health? A systematic review of longitudinal studies. *BMC Public Health* 2013; **13:** 1180.

143 Staubli S, Zweimüller J. Does raising the early retirement age increase employment of older workers? *J Public Econ* 2013; **108:** 108.

144 Woo D, Lee Y, Park S. Associations among working hours, sleep duration, self-rated health, and health-related quality of life in Korean men. *Health Qual Life Outcomes* 2020; **18:** 287.

145 von Bonsdorff MB, Strandberg A, von Bonsdorff M, Törmäkangas T, Pitkälä KH, Strandberg TE. Working hours and sleep duration in midlife as determinants of health-related quality of life among older businessmen. *Age Ageing* 2017; **46:** 108–12.

146 Machado S, Sumarsono A, Vaduganathan M. Midlife wealth mobility and long-term cardiovascular health. *JAMA Cardiol* 2021; **6:** 1152–60.

147 Valtorta NK, Kanaan M, Gilbody S, Ronzi S, Hanratty B. Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. *Heart* 2016; **102:** 1009–16.

148 Kaya A, Iwamoto DK, Brady J, Clinton L, Grivel M. The role of masculine norms and gender role conflict on prospective well-being among men. *Psychol Men Masc* 2019; **20:** 142–47.

149 Shakya HB, Domingue B, Nagata JM, Cislaghi B, Weber A, Darmstadt GL. Adolescent gender norms and adult health outcomes in the USA: a prospective cohort study. *Lancet Child Adolesc Health* 2019; **3:** 529–38.

150 Sileo KM, Kershaw TS. Dimensions of masculine norms, depression, and mental health service utilization: results from a prospective cohort study among emerging adult men in the United States. *Am J Mens Health* 2020; **14:** 1557988320906980.

151 Fleming PJ, Lee JGL, Dworkin SL. "Real men don't": constructions of masculinity and inadvertent harm in public health interventions. *Am J Public Health* 2014; **104:** 1029–35.

152 Hauger RL, Saelzler UG, Pagadala MS, Panizzon MS. The role of testosterone, the androgen receptor, and hypothalamic-pituitary-gonadal axis in depression in ageing men. *Rev Endocr Metab Disord* 2022; **23:** 1259–73.

153 Booth A, Johnson DR, Granger DA. Testosterone and men's health. *J Behav Med* 1999; **22:** 1–19.

154 Gubbels Bupp MR, Jorgensen TN. Androgen-induced immunosuppression. *Front Immunol* 2018; **9:** 794.

155 Kronzer VL, Bridges SL Jr, Davis JM 3rd. Why women have more autoimmune diseases than men: an evolutionary perspective. *Evol Appl* 2020; **14:** 629–33.

156 Nauli AM, Matin S. Why do men accumulate abdominal visceral fat? *Front Physiol* 2019; **10:** 1486.

157 Sakkers TR, Mokry M, Civelek M, et al. Sex differences in the genetic and molecular mechanisms of coronary artery disease. *Atherosclerosis* 2023; **384:** 117279.

158 Kim H, Kim SE, Sung MK. Sex and gender differences in obesity: biological, sociocultural, and clinical perspectives. *World J Mens Health* 2025; **43:** 758–72.

159 Bruhn-Olszewska B, Markljung E, Rychlicka-Buniowska E, Sarkisyan D, Filipowicz N, Dumanski JP. The effects of loss of Y chromosome on male health. *Nat Rev Genet* 2025; **26:** 320–35.

160 Guan A, Thomas M, Vittinghoff E, Bowleg L, Mangurian C, Wesson P. An investigation of quantitative methods for assessing intersectionality in health research: a systematic review. *SSM Popul Health* 2021; **16:** 100977.

161 Huber M, Knottnerus JA, Green L, et al. How should we define health? *BMJ* 2011; **343:** d4163.

162 Tardy AL, Marguet S, Costantino H, et al. Profile and quality of life of the adult population in good health according to the level of vitality: European NHWS cross sectional analysis. *BMC Public Health* 2023; **23:** 1061.

163 Eisenberg MD, Westermeyer B, Meiselbach MK. Online sports betting is a public policy issue and a public health issue. *JAMA Health Forum* 2026; **7:** e256926.

164 Mancini VO, Brett JD, Heirene RM, Fisher K, Nevill TP, Mitrou F. Predicting problem gambling in young men: the impact of sports gambling frequency and internalizing symptoms. *J Gambl Stud* 2025; **41:** 1119–44.

165 Langham E, Thorne H, Browne M, Donaldson P, Rose J, Rockloff M. Understanding gambling related harm: a proposed definition, conceptual framework, and taxonomy of harms. *BMC Public Health* 2016; **16:** 80.

166 Wardle H, Degenhardt L, Marionneau V, et al. The *Lancet Public Health* Commission on gambling. *Lancet Public Health* 2024; **9:** e950–94.

167 American Gaming Association. Commercial gaming revenue tracker. 2026. https://www.americangaming.org/resources/commercial-gaming-revenue-tracker/ (accessed Feb 3, 2026).

168 Tran LT, Wardle H, Colledge-Frisby S, et al. The prevalence of gambling and problematic gambling: a systematic review and meta-analysis. *Lancet Public Health* 2024; **9:** e594–613.

169 Oliffe JL, Kelly MT, Gao N, Velzeboer R, Sharp P, Li EPH. The commercial determinants of men's health promotion: a case study of gambling, nonnies, and athleisurewear. *Am J Mens Health* 2024; **18:** 15579883241277047.

170 Purba AK, Thomson RM, Henery PM, Pearce A, Henderson M, Katikireddi SV. Social media use and health risk behaviours in young people: systematic review and meta-analysis. *BMJ* 2023; **383:** e073552.

171 McGrane E, Pryce R, Field M, Gu S, Moore EC, Goyder E. What is the impact of sports-related gambling advertising on gambling behaviour? A systematic review. *Addiction* 2025; **120:** 589–607.

172 Gartner C, Bickl A, Härtl S, Loy JK, Häffner L. Differences in problem and pathological gambling: a narrative review considering sex and gender. *J Behav Addict* 2022; **11:** 267–89.

173 Lamont M, Hing N. Sports betting motivations among young men: an adaptive theory analysis. *Leis Sci* 2020; **42:** 185–204.

174 Etuk R, Xu T, Abarbanel B, Potenza MN, Kraus SW. Sports betting around the world: a systematic review. *J Behav Addict* 2022; **11:** 689–715.

175 Goss J, Mangrum D. Sports betting across borders: spatial spillovers, credit distress, and fiscal externalities. 2026. https://www.newyorkfed.org/medialibrary/media/research/staff_reports/sr1184.pdf (accessed June 23, 2026).

176 Hollenbeck B, Larsen P, Prosperpio D. The financial consequences of legalized sports gambling. UCLA Anderson School of Management, 2025.

177 Reuters. Illinois sportsbook operators hit with per-bet tax of 25–50 cents. 2025. https://www.reuters.com/sports/illinois-sportsbook-operators-hit-with-per-bet-tax-25-50-cents--flm-2025-06-02/#:~:text=By%20Reuters,than%2020%20percent%20from%202023 (accessed Feb 3, 2026).

178 Butler N, Quigg Z, Bates R, Sayle M, Ewart H. Gambling with your health: associations between gambling problem severity and health risk behaviours, health and wellbeing. *J Gambl Stud* 2020; **36:** 527–38.

179 Karlsson A, Håkansson A. Gambling disorder, increased mortality, suicidality, and associated comorbidity: a longitudinal nationwide register study. *J Behav Addict* 2018; **7:** 1091–99.

180 Geulayov G, Casey D, Bale L, et al. Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study. *Lancet Psychiatry* 2019; **6:** 1021–30.

181 Olfson M, Wall M, Wang S, Crystal S, Gerhard T, Blanco C. Suicide following deliberate self-harm. *Am J Psychiatry* 2017; **174:** 765–74.

182 Favril L, Yu R, Uyar A, Sharpe M, Fazel S. Risk factors for suicide in adults: systematic review and meta-analysis of psychological autopsy studies. *Evid Based Ment Health* 2022; **25:** 148–55.

183 Wyper GMA, Mackay DF, Fraser C, et al. Evaluating the impact of alcohol minimum unit pricing on deaths and hospitalisations in Scotland: a controlled interrupted time series study. *Lancet* 2023; **401:** 1361–70.

184 Wagenaar AC, Tobler AL, Komro KA. Effects of alcohol tax and price policies on morbidity and mortality: a systematic review. *Am J Public Health* 2010; **100:** 2270–78.

185 Kristensen JH, Pallesen S, Bauer J, Leino T, Griffiths MD, Erevik EK. Suicidality among individuals with gambling problems: a meta-analytic literature review. *Psychol Bull* 2024; **150:** 82–106.

186 Kristensen JH, Baravelli CM, Leino T, Pallesen S, Griffiths MD, Erevik EK. Association between gambling disorder and suicide mortality: a comparative cohort study using Norwegian health registry data. *Lancet Reg Health Eur* 2024; **48:** 101127.

187 Seyedsalehi A, Fazel S. Suicide risk assessment tools and prediction models: new evidence, methodological innovations, outdated criticisms. *BMJ Ment Health* 2024; **27:** e300990.

188 Fazel S, Vazquez-Montes MDLA, Molero Y, et al. Risk of death by suicide following self-harm presentations to healthcare: development and validation of a multivariable clinical prediction rule (OxSATS). *BMJ Ment Health* 2023; **26:** e300673.

189 Walsh CG, Johnson KB, Ripperger M, et al. Prospective validation of an electronic health record-based, real-time suicide risk model. *JAMA Netw Open* 2021; **4:** e211428.

190 Patel A, MacMahon S, Chalmers J, et al. Effects of a fixed combination of perindopril and indapamide on macrovascular and microvascular outcomes in patients with type 2 diabetes mellitus (the ADVANCE trial): a randomised controlled trial. *Lancet* 2007; **370:** 829–40.

191 Lip GY, Nieuwlaat R, Pisters R, Lane DA, Crijns HJ. Refining clinical risk stratification for predicting stroke and thromboembolism in atrial fibrillation using a novel risk factor-based approach: the euro heart survey on atrial fibrillation. *Chest* 2010; **137:** 263–72.

192 D'Agostino RB Sr, Vasan RS, Pencina MJ, et al. General cardiovascular risk profile for use in primary care: the Framingham Heart Study. *Circulation* 2008; **117:** 743–53.

193 Hart J, Lignou S, Fazel S. Health justice, resource allocation and age in suicide risk assessment. *Nat Ment Health* 2026; **4:** 707–14.

194 Thomson RM, Kopasker D, Leyland A, Pearce A, Katikireddi SV. Effects of poverty on mental health in the UK working-age population: causal analyses of the UK Household Longitudinal Study. *Int J Epidemiol* 2023; **52:** 512–22.

195 UK Data Service. Understanding society: longitudinal teaching dataset, waves 1–9, 2009–2018. 2020. https://datacatalogue.ukdataservice.ac.uk/studies/study/8715#details (accessed June 23, 2026).

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Men's Health 3

Charting a course to men's health and wellbeing: applying a lens of power and politics to improve men's health outcomes

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Despite long-standing evidence of poor health and life expectancy outcomes among men, particularly among men who are socially or structurally marginalised, men's health has generally received little and uneven attention in health policy and practice. Its gendered and intersectional aspects have been especially overlooked. This third paper in the *Lancet* Men's Health Series examines why men's health has received so little policy attention and proposes strategies to raise men's health on national and global agendas. We applied a gender lens to the 3-i theory-based framework and analysed how ideas, interests, and institutions shape the prioritisation of men's health within national and global policy agendas. We review the modest development of men's health policies and assess how power and politics, including the roles of a range of stakeholders from global and national health spaces, commercial actors, and civil society organisations, have shaped the construction of the problem as well as policy attention and framing, resource allocation, and interventions. The scarcity of attention paid to men's health on global and national agendas reflects how power operates through ideas and institutions which contribute to the conflation of gender with women, institutional inertia, and contested constructions of individual versus structural drivers of ill health. We highlight how this has created a space in which commercial actors, including the manosphere, can shape narratives and influence men's health in ways that align with commercial or ideological interests. We conclude by proposing politically informed strategies that recognise how power, institutional arrangements, and competing interests shape men's health policy within prevailing gender and structural orders. We identify entry points for advancing men's health equity and wellbeing that draw on empirical evidence and technical guidance, are grounded in political realities, and are consistent with a commitment to gender justice for all people.

Introduction

Men's health presents a striking policy paradox: despite centuries of male dominance in medicine and sociopolitical life, men's own gender-specific health needs remain among the most conspicuous blind spots in national and global health policies. Evidence, both historical[1] and contemporary, documents men's health disadvantages across multiple indicators, including life expectancy, widespread exposure to risk leading to preventable morbidity and mortality, and low rates of engagement with health services.[2,3] These disadvantages have arisen despite the domination of medical systems by male technocrats and experts, and despite centuries of bias and misogyny in medical research and clinical practice, that took the male body as their normative default.[4,5] The consequences affect everyone's health. Women's health needs have been systematically sidelined by a research framework calibrated to the male body, while men's gender-specific patterns of risk, help-seeking, and care provision have remained unrecognised in health policy. Throughout this paper we use the terms men and male in line with the panel on gender, sex, and diversity of intersecting male identities in the first paper in the Series.[2] In most societies, some men have accrued economic, legal, educational, and sociocultural power and privilege at the expense of greater equality of opportunity for all. Yet a comprehensive vision of men's health and wellbeing remains noticeably absent from global and most national health agendas and policies, and the structure of health systems and health services has been criticised for not being sufficiently attentive to gender and other intersecting needs of men and boys.[6,7] The result of this inattention to gender, intersectionality, and men's health is that many men, in numerous contexts, continue to have their lives cut short and their illness burdens under-recognised and under-addressed in national and global policy.

This policy neglect of men's health is not equivalent to, nor does it displace concern with, the ongoing failure of health systems to deliver comprehensive services attuned to the needs of women or of people with other gender identities.[8] A growing body of work recognises and is seeking to redress the inattention paid to women's health,[9] and tackle the entrenched, self-reinforcing patterns (also known as path dependency) that have resulted in policies and programmes being addressed predominantly through a patriarchal lens of reproductive health.[10] We argue that men's gender-specific patterns of risk-seeking and care-seeking have also been overlooked within policy, in part because men have been collapsed into a single category, erasing markers of disadvantage,[11] and policy-makers have not perceived men as requiring specific attention. Making men's specific health needs visible is necessary for, and not in competition with, a wider agenda of gender justice and health equity for all people.

Lancet 2026; 408: 1899–911

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This is the third in a **Series** of three papers about men's health

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Key messages

- Men—particularly those who live in socially and structurally marginalised environments—experience substantial premature mortality and avoidable disease burden, yet men's health remains largely absent from national and global health priorities. This situation reflects political choices about problem-framing and priority-setting rather than an absence of need.
- Globally, the first national men's health policy was not adopted until 2008, and only a small number of countries have followed the adoption since. In some countries where national policies and strategies have emerged, progress has been supported by civil society mobilisation and advanced through wider advocacy coalitions. Policy content, however, has been politically contested—particularly over whether responsibility lies with individual men or with the structural, environmental, and commercial determinants shaping risk exposure and access to their care.
- Policy attention to men's health is shaped by ideas, institutions, and interests, including the widespread conflation of gender with women, and path-dependent policy architectures contributing to institutional inertia within health systems and constraining the legitimacy of men's health as a governable policy issue.
- In the absence of sustained public health leadership and accountability, other powerful interests—including commercial actors and unregulated digital spaces such as the manosphere—have increasingly shaped and conflated narratives about men, masculinity, and grievance. Countervailing measures, including strengthened regulation of private-sector actors and support for civil society and public health stakeholders to promote gender justice and health equity, and contest harmful framings, are therefore crucial to sustaining rights-based, evidence-informed approaches to men's health.
- Progress on men's health is more likely to happen when it is framed as contributing to shared public goods (eg, safety, economic security, family wellbeing, and social cohesion) rather than as a siloed claim on public funds, and when it recognises the heterogeneity among men. Sustaining this progress requires embedding men's health within existing policy architectures (eg, universal health care, primary care, and non-communicable disease strategies), underpinned by clear institutional responsibilities and accountability mechanisms, and supported by cross-sector advocacy coalitions linking communities, civil society, researchers, and policy stakeholders across all stages of governance.

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The absence of men's health and wellbeing from policy and practice has not occurred by chance. Health policies and system priorities are driven by a range of structural factors, including prevailing economic regimes, demographic goals, and the ongoing effects of racism, colonialism, and imperialism, rather than by empirical evidence on health outcomes alone.[11] A widespread conflation of gender as synonymous with women and women's reproductive health,[8,12] and the pervasive neoliberal and commercially driven narrative that poor health outcomes are driven by individual choices rather than political, commercial, and economic contexts[13] have together contributed to men and boys being overlooked in setting priorities for health systems.[2]

Policy frameworks and resource allocation have largely not accounted for or addressed how gendered social norms, intersectional inequities, structural determinants, and the absence of health services and programmes interact to produce avoidable harms for most people, including men and boys.[8] Addressing this policy and practice gap is even more urgent in the current era of escalating anti-gender and anti-rights or anti-justice backlashes, rising authoritarianism, declining trust in institutions, increasing levels of state-led violence and conflict, widening economic inequalities,[14] and the growth of the so-called manosphere—a global interconnected network of online communities promoting anti-feminist, misogynistic, sexist, male-supremacist, and victimhood ideologies.[15]

In this third paper of the *Lancet* Series on men's health, we build on the epidemiological data (paper 2) and the conceptual model of men's health (paper 1), which draws on social determinants of health, intersectionality theory and syndemic theory, to focus on the question: what can be done? We first examine how and why men's health has languished on policy agendas at both national and global levels, with a view to identifying barriers and opportunities for action. Next, we explore positive case studies in which action has been taken, and policies for men's health have been developed. We then use theories and frameworks of power, agenda-setting, and policy formulation to review the interests, ideas, and institutions that influence men's health and keep the issue on or off policy agendas. In the final section of the paper, we offer evidence-informed recommendations to promote positive agendas for improving men's health, drawing on the literature on men's health equity,[16] wider understandings of health equity as a pillar of social justice,[17] and the framework of gender justice put forward by the *Lancet* Commission on gender and global health.[8]

Developing global and national policies to address men's health: historical overview

Health policies matter because they formalise priorities, allocate responsibility, and signal political commitment, but policies alone cannot transform the social or structural and gendered determinants of men's health. Policy attention at the global level matters because for decades organisations operating in the global ecosystem have shaped priorities,[18] norms, and values, and in some cases provided financial development assistance for health. The systems and structures of global institutions, such as those concerning trade and international relations, have been described as an important site for the social construction of masculinities[19] and a powerful influence on regional and national gender dynamics. Although we recognise that these global institutions alone do not shape men's health, understanding how global health[20] and development[21] stakeholders have addressed, or not, gender relations in general, health equity, and men's health, can offer insights into influences on national-level priority-setting.

The question of how stakeholders in the global health sector address gender and gender relations was extensively reviewed in the 2025 *Lancet* Commission on gender and global health.[8] This report, alongside the

work of other authors such as Cornwall and Rivas[22] as well as Payne,[23] highlights how the sector has frequently equated the concept of gender with women. The same conflation was noted in the *Lancet* Series on gender equality, norms, and health,[24] while a review of 25 years of gender mainstreaming concluded that men and boys remain largely missing from such efforts.[25] Further, these analyses show that when gender is included in the policies of global health stakeholders, mainstreaming has often been a tick-box exercise that does not recognise either the relational and power-related aspects of gender or consider the specific health needs of all people, including men and boys. For men in particular, the predominance has been to treat some masculinities as the explanatory notes for poor health outcomes, without considering a more diverse range of structural determinants or producing accompanying gender-responsive policy to address the problems so richly described.

The post-World War 2 development of multilateralism should have promoted and enabled rights-based approaches to health and universal health coverage for all people. However, until the 1990s, men and boys were largely absent as a focus of organisations active in global health, global health policy, or global development efforts.[26] Where gender did feature in global health and population policy in this period, attention was directed mainly towards women and their reproductive health, reflecting prevailing demographic priorities, with little consideration of the health needs of men and boys, including as a justice-based and rights-based issue. The International Conference on Population and Development in Cairo in 1994 marked something of a shift in this framework as men were explicitly (albeit instrumentally) included within more relational and rights-based approaches to health and development, with commitments to "encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles".[27] In the late 1990s and early 2000s, agencies including UNESCO[28] and UNDP[29] highlighted how dominant masculine norms—especially those linked to "toughness"—increased men's exposure to harm, including violence, and contributed to rates of premature mortality. Critics noted, however, that despite growing policy discourse, including around the concept of gender mainstreaming,[30] there was little evidence of male-inclusive initiatives in practice,[19] and little discussion of more positive masculinities, and concerns were raised about portraying men—particularly in low-income and middle-income countries—as culpable for inadequate development outcomes.[31]

Meaningful engagement with men's health gained greater traction with the adoption of more gender-mainstreamed approaches within the HIV response, although the focus on men remained minimal.[32] In the early 2000s, UNAIDS reframed men as allies—for example, in the 2000 World AIDS Day campaign, "Men Make a Difference".[33] Despite these advances, attention to men's health across the global health ecosystem has remained insufficient[34] except in a few disease-specific areas, such as tuberculosis prevention and care.[35] WHO does not have a population-wide focus on men's health, and only their European Regional Office has published a men's health strategy,[36] while the Pan American Health Organisation has delivered an analytical report on men, masculinities, and health.[37] Beyond these dedicated outputs, WHO has periodically acknowledged the importance of gender and men's health within broader reports. For example, its 2019 World Health Statistics report called for "health planning to take account of the different needs of men and women" and recognised that men's poorer health outcomes can be "amplified by gender roles",[38] and its 2019 primary health care report paid some attention to men's health risks and low patterns of care-seeking because of rigid gender norms.[39] These acknowledgments have not, however, translated into policies, strategic initiatives, or sustained institutional commitments. The dearth of formal policy responses from global health stakeholders has, to a degree, been addressed by civil society efforts to produce reports to raise awareness of men's health—for example reports from Global Action on Men's Health,[40] Movember,[41] and Equimundo: Center for Masculinities and Social Justice.[42]

At the national level, post-colonial governments often prioritised nation-building, demographic objectives, and economic prosperity over disease burdens alone and men's health was rarely addressed. Pronatalism or antinatalism were promoted depending on the national context, and maternal and child health and family planning became central to many public health systems. The Tanzanian Government, for example, "understood that the well-being of mothers and children was fundamental for the prosperity of the newly founded state",[43] whereas India saw "'overpopulation' and contraceptive technologies, [as] key aspects of nation-building in postcolonial India".[44] Men's health—particularly leading causes of death such as heart disease and lung cancer—received scant attention, although occupational health programmes were an exception. These programmes were often established during colonial times, particularly in the lucrative extractive industries (eg, mining of copper, uranium, and other heavy metals),[45] where occupational and workplace health services addressed some of the health needs of the working population in formal employment, most of whom were men. However, these services were rarely framed in ways that named or highlighted men's health, especially for men living and working in marginalising environments.

Men's health fared little better in high-income countries. From the 1970s onwards, civil society groups of women's health and feminist health campaigners achieved some success in advancing women's health on policy agendas, sometimes aided by the rise of feminist

policy entrepreneurs to positions of decision-making power.[46,47] To align with these efforts, men's civil society engagement focused largely on critiquing dominant and harmful masculinities (eg, by mobilising men against violence against women),[19] rather than on promoting positive masculinities or men's health needs. Coordinated civil society support for men's health only became more mainstream in the 1990s–2000s with the founding of groups and movements such as the Men's Health Forum in Ireland, the Men's Health Network in the USA, the Confederation of Men's Organisations in Australia, which became the Australian Men's Health Forum, and the global MenEngage Alliance.

It was not until the 1990s that a few countries, namely Australia and Ireland, began to formally recognise men's health as a policy priority, and the first national men's health policies were not adopted until the 2000s. A systematic synthesis of men's health policies identified three countries (Australia, Brazil, and Ireland) as having comprehensive (beyond single-issue) men's health policies.[48] We analysed the development of men's health policies in these three countries as published evidence exists that describes policy and priority-setting processes (panel 1). Beyond these three countries, a handful of other countries have also adopted national men's health policies and strategies, including Malaysia,[60] Iran,[61] and South Africa. South Africa published an integrated men's health strategy in 2020, using medical male circumcision clinics as the entry point for a wider provision of services.[62] However, we found very few publications describing policy processes, evaluation, or monitoring specifically for comprehensive men's health policies in these countries.

England published its first men's health strategy in November, 2025, developed following years of campaigning by civil society groups including the Men's Health Forum, Movember, and Global Action on Men's Health. An All-Party Parliamentary Group report[63] highlights the need for action and draws attention to men experiencing poorer health outcomes than women, including life expectancy, while also explicitly

Panel 1: **How men's health reached national policy agendas: insights from three countries**

Ireland

In 2008, Ireland was the first country to adopt a dedicated national men's health policy, now implemented through the Men's Health Action Plan 2024–28.[49] The policy followed recognition in the national health strategy (2001) that men had distinct health challenges requiring targeted policy attention. Its development was informed by a 3-year government-funded research programme presented at the first national conference on men's health in 2004.[50] An interdepartmental, multisectoral steering group guided policy development, supported by extensive national consultations. These consultations emphasised the need to move beyond binary or essentialist understandings, challenge the neoliberal model of individualised responsibility for health, address upstream determinants of health, and address the health needs of diverse groups of men, including men who are unemployed, farmers, men from minoritised ethnic groups, Travellers, and men who are gay, bisexual, or transgender.[51]

Brazil

Brazil introduced its National Policy of Comprehensive Healthcare to Men (PNAISH) in 2009,[52] following a 2008 commitment to address men's health-care needs within national health policy. The policy was shaped by civil society organisations (eg, Instituto Papai and Instituto Promundo, which became Equimundo), academic advocates for equity-oriented approaches to gender and masculinities, and the Brazilian Urology Association, which played a role in elevating prostate health on the policy agenda.[52,53] Pharmaceutical companies and urologists positioned sexual health as a "portal to men's health" through targeted media campaigns.[52] A multisectoral expert group—bringing together government, non-governmental organisations, academia, medical associations, and national health councils—supported policy development via public consultations.[52] However, tensions emerged between proponents of biomedical and social-determinants perspectives, and criticisms highlighted the medicalisation of the male body, excessive focus on prostate health, and insufficient engagement with gender.[54]

Australia

Australia's National Male Health Policy, introduced in 2010, followed 15 years of debate. An initial 1996 draft[55] prioritised education and research, but progress stalled amid weak network cohesion and little political mobilisation.[56] Momentum increased in the early 2000s following reports highlighting the needs of Aboriginal and Torres Strait Islander men,[57] leading to their inclusion in national policies and agendas. By the mid-2000s, advocacy by medical associations, state governments, and civil-society groups, and increased media attention helped elevate men's health as a policy issue. Policy debates centred on the roles of individual lifestyle versus population-level and structural determinants, the extent of any focus on equity, the balance between biomedical approaches and social perspectives, and the integration of a gender relations perspective.[56] Development was led by a government-appointed National Men's and Women's Health Policy Jurisdictional Working Group, and a Senate Select Committee on Men's Health was established.[58] Policy content has not remained static: whereas the 2010 strategy included explicit attention to social determinants, intersectionality, and strengths-based perspectives,[59] the subsequent 2019 policy shifted towards a stronger behavioural focus on individual health literacy and health service use. Australia has seen both resourcing and interest in health and masculinities, including the November 2025 establishment of a Parliamentary Friends of Healthy Masculinities group.

For more on **Parliamentary Friends of Healthy Masculinities group** see https://www.aph.gov.au/about_parliament/parliamentary_friendship

highlighting groups of men (such as those living in coastal areas, men from minoritised ethnic groups, and boys with special educational needs) as particularly disadvantaged in their health outcomes.[64] Canada has committed to a federal strategy on the health of men and boys, expected in 2027, which aims to create supportive environments, encourage help-seeking, and challenge harmful stereotypes.[65]

A small number of countries, such as Guyana, have dedicated men's health units, while others, including Iran, New Zealand, Norway, and Trinidad and Tobago, have single-issue initiatives for men, such as prostate or bowel cancer screening, cardiovascular health, mental health and suicide prevention, and The Bahamas, Jamaica, and Philippines have sexual or reproductive health programmes aimed at men's health.

Lessons learnt from the development of men's health policies

Reviewing both the successful development of national policies and the wider literature on the struggles to get policy attention paid to gender and health, or to men's health, reveals several lessons for moving forward strategically. However, much of the available evidence is from a few countries (mainly high-income or upper-middle income), illustrating the need for more analysis of this kind in various country settings.

We adopt the 3-i framework,[66,67] which is drawn from comparative political economy and widely used in health policy analysis to explore agenda-setting. The framework uses a lens of power analysis across three interacting forces—ideas, institutions, and interests—to explore whether and how priority-setting and policy-making for men's health have been addressed, including the interaction of problem framing, institutional anchoring, and the role of ideological and commercial interests.

Ideas

The realm of ideas—the beliefs, values, frames, and narratives that shape how a problem, its causes, and its solutions are understood—contributes to the success or failure of gaining policy attention for men's health. Policy makers generally require at least two types of evidence to act: a clear problem,[68] such as men's high rates of premature mortality; and a "causal story" with a solution, meaning that something can be done to address the problem.[69]

Men's health has faced challenges on both counts. The absence of an agreed global definition of men's health was addressed by Bardehle and colleagues through a wide stakeholder consultation and modified Delphi process.[70] Most definitions pay little attention to the heterogeneity among men—including those in poverty, men from minoritised or marginalised racial or ethnic groups, Indigenous men, transgender men, and other structurally marginalised men—and so they do not show who is being overlooked in policy frameworks or where interventions are most needed. This limitation is compounded by data: the health of structurally marginalised men is rarely disaggregated from that of the wider population, rendering these men and their needs invisible in policy and evaluation.[2]

Even when sex-disaggregated data are available, policy attention does not necessarily follow. For example, the *Lancet* Commission on gender and global health showed that the burden of tobacco-driven morbidity and mortality, falls mainly on men in every region of the world.[8] Despite this, few policy or programmatic interventions frame tobacco control as a men's health issue.[71] Reports analysing the attention to and characterisation of male individuals in mental health,[72] sexual and reproductive health,[73] and primary care policies[74] and programmes reveal the same disconnect between evidence of burden and policy and programmatic responses.

Part of the challenge is that worse health alone is rarely treated as sufficient grounds for policy attention; equity and justice frames act to direct attention to groups who are both structurally disadvantaged and in poor health. Men are generally seen as advantaged, so even serious, consistent health harms—such as the high suicide rates of White men in the USA—can be viewed as undeserving of attention,[75] when by any measure of preventable loss of life, they would ordinarily warrant it.

Secondly, contestation around the framing of the underlying causes of risk and illness (panel 1) has meant that competing versions of solutions—addressing individual or biomedical versus structural level interventions, or masculinities versus men's health outcomes—have tended to characterise policy debates. Men's health, including in regional and global bodies, has often been framed and studied as a problem of masculinities. This framing overlooks the full range of drivers and upstream determinants of health[2] and leaves more contentious or politically challenging harms as both under-recognised and under-addressed. Such issues include gambling-related harms and men as survivors of violence, including sexual violence in both conflict and non-conflict settings. The selective visibility of some health issues among men, and the silence around others, is itself a product of problem-framing.

Thirdly, efforts to integrate men's health into existing gender-focused policy and programme activities have often had little support from stakeholders within gender and health communities because of zero-sum game framing,[8] in which concerns are raised about attention diversion and the risk that women's health issues, which took so long to reach global agendas, will be deprioritised. This challenge is particularly acute in situations of resource constraint and political hostility to gender and human rights, such as we are currently experiencing, especially with the rising number of authoritarian regimes around the world.[76]

There is evidence from some localised programmes that have effectively engaged men through gender-sensitive or gender-responsive health promotion interventions, such

as a tuberculosis prevention intervention in Nigeria[77] and weight loss interventions with football fans in Scotland[78] and rugby fans in New Zealand.[79] However, there is an absence of a robust and wide-ranging evidence base on either the effectiveness or cost-effectiveness of interventions to address the leading causes of men's poor health. This absence has contributed to policy content contestation, with debates open to influence by the power of the stakeholders involved. In Brazil, for example, it is reported that the powerful professional association of urology specialists and the pharmaceutical industry promoted narrow biomedical framings of men's health focused on specific diseases and conditions, such as prostate cancer,[52] rather than on structural determinants of health and wellbeing.

In Australia, Iran, and Ireland, successful policy-development processes helped shift narratives towards action on the upstream and intersectional determinants of health. In Australia and Ireland this was partly driven by broad multistakeholder engagement. Public consultations and expert group inputs helped to ensure that national policies addressed the right to health of diverse groups of men marginalised or disadvantaged by their social or structural position, including men who are out of work, men from ethnic or racial minorities, Indigenous men, transgender men, and men in particular occupations. In some settings, widespread consultations with men drove the development of an alternative and more positive frame for engaging men—for example, one that recognises "the strengths of Australian males"[80] and fosters "healthy masculinities"[81] rather than focusing on toxicity. Even when specific policies are developed, reviews find that they rarely receive sufficient fiscal or political support to be fully implemented or evaluated—thus weakening the evidence base around intervention effectiveness and effect.[82]

In the current climate, developing and implementing policies that promote progressive values face powerful opposing forces. The growth of anti-justice, anti-rights, and anti-gender ideas, alongside movements that advance ideas of biological essentialism and neoliberal values of individual responsibility for health, complicates efforts to pursue men's health policies grounded in gender justice and rights-based approaches, and makes addressing the upstream determinants of ill-health more complex. While much of this global pushback occurs within populist and authoritarian political regimes, the manosphere amplifies and disseminates these narratives to a global online audience (panel 2).

Institutions

Institutions refer to the formal and informal rules, laws, bureaucratic norms, governance arrangements, and established patterns of interaction that shape how policy issues are understood and decisions are made, and determine which policy options are considered legitimate or feasible. Several challenges to the adoption of men's health policies are identifiable. Firstly, institutional governance of men's health is frequently absent at national and global levels. Across countries, population-wide institutional homes with responsibility for men's health are uncommon. By contrast, programmes to address some aspects of women's health are often embedded in health ministries, although they are frequently focused on a narrow range of women's health needs, with reproductive and maternal health issues dominating and a lens of gender justice notably absent.[8]

Panel 2: The manosphere and its effect on health

- The term manosphere has been widely used since the 2010s to describe a loose collection of social media influencers, men's rights activists, advocates of the Men Going Their Own Way movement (ie, those who reject relationships with women in favour of male separatism), incels (ie, involuntary celibates, who blame women and feminism for their lack of sexual relationships),[83] red pill followers (ie, men who believe feminism conceals women's true advantage over men), Christian conservatives,[84] and others globally[85] targeting men and boys in an unregulated online space. Commercialisation and monetisation has brought fame, money, and power to so-called manfluencers—a process that has been described as "convert[ing] masculine insecurity into capital".[84]
- The manosphere is one of the most important vehicles influencing men, particularly young men, and is increasingly receiving offline political and public attention. Social media algorithms promote increasingly radical content, including anti-feminism, misogyny, grievance, and neoliberal masculinity.[15] These ideas intersect with nihilism, far-right (and sometimes far-left) political ideologies, and conspiracy beliefs,[84] and are being marketed to young men at a crucial period of social, cultural, and neuro-developmental growth. A 2023 study in the UK reported that 80% of boys aged 16–17 years had consumed content created by Andrew Tate, one of the manosphere's most widely known manfluencers.[15]
- Against a backdrop of rising inequalities, violence, conflict, financial precarity, and job insecurity shaping men's perceptions of their social position and future prospects,[86] the manosphere has contributed to a growing distrust of public institutions and their capacity to address social problems[87] and could also be influencing men's declining trust in women's leadership.[88]
- The effects of the manosphere carry substantial implications for goals of population health equity and gender justice for all people, including by:
  - Fuelling a rise in misogyny in both online and real-life settings, and intersecting strongly with the global anti-gender backlash.[76]
  - Perpetuating ideas of zero-sum framing,[8] with men framed as suffering at the expense of women's advancements.
  - Amplifying an intensely neoliberal view of health as being attained through the promotion of wellness and self-improvement—for example, through the use of supplements, steroids, or so-called biohacking or looksmaxxing.[89] This framing serves to distract from addressing the relationship between men's wellbeing and broader aspects of structural marginalisation.
  - Contributing to the erosion of human rights, including through delegitimising gender-based protections (eg, work on gender-based violence and LGBTQ+ rights) and opposition to sexual and reproductive rights.[90]
  - Promoting norms of hegemonic masculinity,[91] including in relation to physical looks, that could be health-harming—eg, invulnerability, self-reliance, and restricting emotional expression[84]—leading to negative consequences for physical health and mental health for all people.[92]

At the global level, the multilateral health agencies do not have a lead institution with a mandate to monitor or coordinate action to improve men's health, one of the characteristics shown to be important for policy and resource attention in the global health system.[93] WHO engagement with men's health is low, and not yet mainstreamed across the organisation. The UN Population Fund's remit is narrower and is largely centred on sexual and reproductive health, and other health agencies or agencies with a health remit generally apply their gender and health mandates to focus on women and girls. At the highest level of UN mechanisms, the 2025 UN Political Declaration on non-communicable diseases and mental health called for mainstreaming a gender perspective into prevention and control, and to address the health needs of both men and women, and urged particular attention to be paid to the effect of non-communicable diseases on women.[94] This might be unsurprising given that the Sustainable Development Goal concerned with gender equality does not mention men and boys except obliquely in target 5.6, which calls for universal access to sexual and reproductive health and reproductive rights. The result of this absence is poor policy coherence among global organisations, low accountability for men's health outcomes, and a dearth of funding.

The second challenge is that gender mainstreaming and associated policy shifts to benefit all people, have frequently been interpreted and implemented with a target population focus that does not include men.[26] Through a combination of path dependency and institutional inertia[95] the focus of gender mainstreaming is often narrowed to women's reproductive health, not women's overall health or wellbeing. This focus results in little attention being paid to the broader gendered health disadvantages suffered by both men and women[8] and the issue of power inequities as a core focus for addressing gender and health is omitted.[17]

Our analysis of policy-making processes highlights the central role of public consultation and civil society organisations in overcoming some of these institutional challenges (panel 1). However, civil society organisations in Brazil[53] and historically fragmented advocacy networks in Australia[56] appear to have struggled to mobilise sustained, coordinated social movements, although this might now be changing. While some transnational connections have expanded since the 1990s[96] (eg, through Global Action on Men's Health, Movember, the Asia Pacific Coalition on Male Sexual Health, MenEngage, and Equimundo), their effect depends on coordination, stable funding, and routes of access to policy elites and their political will—features that appear variable and, in some settings, scarce.

Interests

The question of interests—ie, who stands to gain or lose from paying attention to men's health—plays an important role in shaping policy responses, including by keeping policies off the agenda. Different types of interest, including material, reputational, and ideological, influence whether powerful stakeholders have an incentive to push for a policy position or block a policy being developed or implemented. There appears to be a shortage of incentives—including political capital, coordinated civil society demand, and strong systems of accountability—for policy makers to pay widespread attention to men's health issues, despite men often occupying leadership roles in these spaces.

Commercial interests play a powerful role in determining attention paid, resources allocated, and narrative framing around harmful masculinities, men's health, and its determinants.[8] Commercial actors include industries that produce health-harming products, as outlined in papers 1 and 2, and the interests (financial, political, or ideological) inherent in the manosphere (panel 2).

The commercial sector has successfully marketed to masculinities, manipulated gender norms, and sought to keep regulation off the policy agenda while yielding vast profits.[97] From the earliest marketing of tobacco use as an expression of rugged, independent, and stoic masculinity[98] to more recent efforts to reinforce the stereotypical view of meat consumption as a masculine consumer trait,[99] masculinities have been shaped by industry, thus contributing to men's health disadvantages. In the case of tobacco, for example, usage rates globally are over four times higher in men than women[100] and in 2020 tobacco smoking accounted for more than one in five deaths in men over 30 years of age in high-prevalence countries and regions (including China and eastern and central Europe),[101] while the burden of smokeless tobacco use in regions such as south Asia (eg, in India[102]) also falls predominantly on men. Men's disproportionate rates of tobacco use helped six tobacco companies make a combined estimated pre-tax profit of US$55 billion in 2018,[103] a year in which WHO's budget was US$2·4 billion.[104]

Yet even in the face of strong and long-standing evidence of how industry uses gender norms as a marketing entry point, and guidance from international treaties such as WHO's Framework Convention on Tobacco Control to incorporate gender into public health responses,[105] the public health community has been slow to attend to the effect of gender and men's health and the range of structural determinants that concentrate tobacco-related mortality among subgroups of men in some of the highest burden health domains.[8]

Discussion

The neglect of men's health as a gendered policy concern sits alongside the absence of comprehensive, rights-based life course policies addressing women's health. One difference is that women's health concerns are frequently incorporated into systems and policies through

the frame of reproductive years[106] and motherhood, with increasing calls to pay attention to post-reproductive years (ie, the menopause).[107,108] The role of gender as a structural determinant of everyone's health has been widely overlooked, to the detriment of gender justice and health equity.

Men's health has been largely absent from global and national health policy agendas despite evidence of high burdens of preventable morbidity and mortality.[3] This omission from agendas reflects, in part, political choices about priority-setting shaped by contested ideas, including about gender and responsibility, constructed frames of who deserves policy attention,[109] asymmetries of power, and weak institutional anchoring, rather than insufficient evidence of need.

The resulting vacuum in policy leadership is not accidental or neutral: it reflects explicit decisions that have created a political and discursive space that is increasingly filled by online influencers, the largely unregulated manosphere and commercial actors, whose constructions of men and masculinity frequently conflict with men's stated aspirations and ideals,[110] population health equity goals, and principles of social justice and gender equality.

It is time for the health community to acknowledge the gendered social and structural determinants of men's health, and to recognise that their persistent neglect reflects the ways in which power operates in health policy: shaping which problems are considered legitimate, which sub-populations are prioritised and why, and which interventions are deemed politically feasible. Informed by our analysis of the processes used to develop comprehensive men's health policies and drawing on the evidence presented in accompanying papers in this Series, we propose a set of recommendations designed to advance policy responses that respect, protect, and fulfil everyone's rights to the highest attainable standard of physical and mental health[111] within a framework of health equity and gender justice (panel 3). These recommendations are contingent on political contexts, institutional arrangements, and prevailing gender orders, and will require adaptation to national and local circumstances. They should therefore be understood as entry points for advancing men's health on policy agendas, rather than as a prescriptive checklist. They are also grounded in the observation that progress on men's health depends on both epidemiological needs alongside how problems are framed, which institutions are mandated to act, and whose interests are advanced or threatened. Addressing men's health is, therefore, both a political as well as a technocratic project. We acknowledge that this will require targeted action and more evidence and rigorous evaluation of policy initiatives to meet the needs of men and boys alongside those of women, girls, and people with other gender identities.

Our analysis highlights that power in men's health policy operates in multiple, reinforcing ways. Discursive power shapes which framings of gender, men, masculinity, and responsibility are considered legitimate; institutional power determines whether mandates, budgets, and accountability mechanisms exist to act on those framings; and structural power embedded in markets, trade, and labour systems influences both exposure to risk and resistance to regulation. Across these domains, the most consequential form of power has often been agenda power: the capacity to render men's health politically sensitive, morally ambiguous, or safely ignored. Men's health has therefore been shaped by agenda, power, and institutionalised silence.

Putting men's health onto public policy agendas requires attention to political contexts alongside rigorous empirical evidence and technical guidance. Advocacy for men's health now faces highly constrained political and social environments, both nationally and globally, and the rise of regressive forces has further narrowed the spaces for pro-gender justice and rights-based principles to be realised. Men's health advocates must develop politically aware strategies that draw on lessons learnt from previous successful policy and programme development but take contemporary challenges into account.

Evidence from successful policy development and from the wider policy and political economy literature highlights several conditions that support and sustain policy attention. First, ideas and framing are crucial. Narratives that emphasise manhood, positive roles of men, and progressive masculinities, including roles in advancing gender equality,[8,112] are more likely to gain public support, including among men themselves, than narratives of masculine toxicity.[113] Overcoming fears inherent in zero-sum narratives that emphasise risks of resource diversion away from women's health programmes is probably key to mobilising support for men's health agendas, particularly in times of perceived and actual resource constraint. Anchoring the health of all men within rights-based frameworks of gender justice and health equity moves to more fair and inclusive policies and programmes that recognise and address the health needs of all people of all gender identities.

Second, a deliberate policy focus on men who are marginalised by structural inequalities (for example, because of poverty, racism, disability, occupation, or Indigenous ethnicity) can broaden collaborations across advocacy coalitions and widen the appeal for policy makers of the message for mobilising within and beyond the health sector.

Third, arguments for addressing men's health have tended to focus on the burden of disease, but evidence points to the wider social and economic impacts of men's unmet needs for effective health-promoting policies, interventions, and care. Women bear a disproportionate burden of caring roles in the domestic sphere and comprise the majority of the underpaid (often unpaid) health workforce in many countries.

Panel 3: Power-informed recommendations to advance men's health within a framework of gender justice

The following recommendations draw on the evidence and analysis presented in this Series and support these papers' calls for reaching a deeper understanding of men's health—for example, through the routine use of sex-disaggregated data, alongside analysis of how gender intersects with age, class, ethnicity, race, caste, disability, and place, and with the wider drivers of men's vulnerability, including unequal systems of power, widening economic inequalities, racism, colonial legacies, and restrictive gender norms.

Reclaim discursive power to open agenda space for men's health

Frame men's health as a legitimate and governable policy issue
Policy agenda-setting research shows that issues gain traction when problems, causes, and solutions are clearly linked and perceived as amenable to government action. Men's health should therefore be explicitly framed as a distinct and legitimate policy concern with identifiable social and structural drivers and feasible policy responses.

Position men's health as contributing to shared public goods
Narratives on men's health should avoid zero-sum framing and emphasise contributions to shared public goods such as economic security, family wellbeing, public safety, gender justice, and social cohesion.

Replace toxic masculinity narratives with frames grounded in addressing the structural, commercial, political, and ideological determinants of health
Understanding and addressing men's health should be framed in terms that foreground how gender interacts with structural, commercial, ideological and political drivers such as labour markets, housing, incarceration, commercial determinants, and digital environments, to produce avoidable health harms.

Use positive and diverse masculinities to broaden political coalitions
Use inclusive, non-stigmatising, and positive representations of men, masculinities, and manhood that are rooted in how men frame and define their ideals and goals to build broader public and political support for men's health policies.

Build institutional power through mandates, accountability, and systems

Assign clear institutional responsibility within existing policy frameworks
Men's health should be assigned a clear institutional home—within the health ministry or an office of intersectoral coordination—with an explicit mandate for policy formulation and delivery.

Embed men's health within gender, equity, and rights accountability mechanisms
Incorporate men's health indicators into existing monitoring systems for gender equality, health equity, and human rights, such as the UN Universal Periodic Review or UHC2030 monitoring platforms. Disaggregate these indicators by sex or gender identity, race or ethnicity, social position, and place, so that inequities among men are visible and governments can be held to account.

Ensure appropriate workforce training on men's health and gender justice
Training for health and humanitarian workers should include men's health content grounded in intersectionality, health equity, and gender justice.

Reform data systems to ensure everyone counts
Advancing men's health requires the collection, analysis, and use of intersectional disaggregated data, so that structurally marginalised men are made visible and their needs addressed.

Confront structural and commercial power shaping men's health

Address commercial determinants as a policy priority
Men's health strategies should confront gendered marketing and corporate practices driving exposure to health-harming commodities (eg, alcohol, tobacco, and firearms) with regulatory initiatives.

Recognise and regulate digital and other harmful environments as determinants of health
Digital infrastructures, including the manosphere, and other environments which are harmful to men's health (eg, online and offline gambling) should be recognised as structural determinants requiring governance and accountability, algorithmic accountability, and investment in positive, evidence-informed alternatives, including approaches for increasing men's real-life social networks and connections.

Mobilise countervailing power for policy attention

Invest in durable, intersectional, and intersectoral advocacy coalitions
Sustained policy change within and beyond the health sector depends on organised, cross-sectoral demands on policy makers. Advancing men's health therefore requires sustained investment in durable advocacy coalitions linking civil society, academia, professional bodies, and social justice movements, including the gender and health movement, and those organisations or social movements representing men experiencing marginalisation and intersecting forms of disadvantage.

The financial effect of men's premature mortality contributes to poverty and economic precarity experienced by families. Analysis of data from road traffic accidents in India and Iran, for example, finds that married men of working age are over-represented in fatality statistics.[114,115] The loss of these men—who are husbands, fathers, and frequently the main sources of family income—gives rise to female-headed households, which in countries such as Azerbaijan have been shown to carry substantial negative effects on family finances, especially among the poorest sections of societies.[116] The men's health agenda could

be advanced more quickly with more robust evidence on the costs and gains to individuals, families and societies as a whole of keeping men healthy. The Movember *Real Face of Men's Health in the United States* reports, and others, have adopted this approach.[117]

Fourth, evidence indicates that increasing attention and resources for men's health depends on coordinated policy action across multiple levels of governance, from local service delivery to national and global policy frameworks. Well resourced and well-connected advocacy coalitions that include civil society, academia, and professional medical associations can generate political demand for reform. While bottom-up demand is necessary, formal accountability mechanisms (eg, the WHO and UN Commission on Information and Accountability for Women's and Children's Health) are essential to track implementation, assess progress, and hold those with power (eg, policy makers, policy implementers, and funders) to account for the protection and realisation of men's health, including through expert oversight and sustained investment in monitoring and evaluation that enables timely responses to changing social, digital, and technological contexts.

Fifth, addressing the interests inherent in the commercial determinants of men's health requires strategic policy responses, that are politically informed and evidence-informed, and that explicitly name and highlight the adverse effects of these products and environments.[118] In the relative absence of inclusive national or global policy frameworks and governance mechanisms that propose action on men's health, commercial actors and digital platforms have been effective in manipulating gender norms and shaping health information and misinformation environments to their advantage. A powerful neoliberal narrative prioritising self-improvement over corporate accountability is widespread. Countering this narrative and the power accrued by these interest groups will require strengthened regulatory and governance measures—and political resolve. Clear obligations must be imposed on commercial actors, including technology companies, to protect public health and prioritise people over profit.

In summary, our analysis suggests that progress on men's health will be made when grounded in technical guidance and empirical evidence and guided by a deeper understanding of the specific political conditions and politically informed strategies for change (panel 3). Men's health might gain greater policy traction when framed as contributing to shared public goods—such as safety, productivity, social cohesion, and wellbeing—rather than as a standalone claim on limited resources. Future research should test the efficacy of these and other narratives to identify ones that overcome rhetorical barriers.

Not all men are equally at risk for poor health. Explicitly anchoring national, regional, and global policies and programmes for men's health within gender and health equity frameworks, applying an intersectional lens, and promoting the right to health including through universal health coverage are essential to preventing marginalisation, facilitating coalition-building, and ensuring accountability. Countervailing coalitions are also needed to challenge commercial, political,[119] and ideological interests that benefit from inaction, fostering division among allies or depoliticisation. Finally, initiatives to advance men's health are more likely to succeed when they combine strategic engagement with policy and governance processes with equally robust investment in community involvement and participation.

Contributors

SH: writing the original draft and co-ordination of all inputs into the text. Conceptualisation: SH, DMG, KB, ST, SVK, WM, BRE, JWFC. Writing: SH, DMG, KB, ST, SVK, RT, SFR, JAS, JLO. All authors contributed to drafts and final review. No authors were precluded from accessing data in the study, and all authors accept responsibility to submit for publication.

Declaration of Interests

SJH declares grants from Gates Foundation and Co-Impact to Global 50/50 for work on gender justice; paid member of Elsevier Research Cultures Board; paid member of review panel for Swedish Government Research Funding Board for gender and health research; lecture for Swiss National Science Foundation (paid to Global 50/50); has participated on an advisory board with WHO as chair of Data Safety and Monitoring Board trial; UK-Government appointed Commissioner and Chair of the Awards Policy Committee of the Commonwealth Scholarships Commission. SVK was supported by funding from the European Research Council (949582), the Medical Research Council (MC_UU_00022/2), and the Scottish Government Chief Scientist Office (SPHSU17); has received reimbursement from the Medical Research Council to attend grant panel meetings; and is an unpaid member of Obesity Action Scotland. KB declares grants to Global 50/50 from Gates Foundation, Co-Impact for work on gender justice; Trustee of World Obesity Federation (unpaid). JWFC has received a grant from Roche (payment to the institution); consulting fees or honoraria from Astellas, AstraZeneca, Bristol Myers Squibb, CG Oncology, Roche, Ferring, Janssen, Johnson and Johnson, Medscape, Pfizer and Merck; support for attending meetings from Janssen; has participated on the External Advisory Boards for the PROMOTE trial (University of Oxford), Bespoke trial (UCLH, London), and CISTO trial (Bladder Cancer Advocacy Network, USA); has played a leadership or fiduciary role with Fight Bladder Cancer UK and Weston Park Cancer Charity; and is Director of the Sheffield NIHR Clinical Research Facility. JAS declares grants from Australian Research Council Mid-Career Industry Fellowship, Movember Foundation for global Indigenous social and emotional wellbeing, Australian Research Council Discovery Project; participation in Scientific Advisory Committee—Ten to Men—Australia's National Longitudinal Study on Men's Health, Scientific Advisory Committee of The Australian Prevention Partnership Centre, Strategic Advisory Board of National Centre for Education and Training in Addiction; Global Executive Board and Vice President Scientific Affairs for International Union for Health Promotion and Education, Deputy Chair, Association for Alcohol and Other Drugs Agencies NT. BR and CU were supported by funding from UK aid Leaving No One Behind; transforming Gendered pathways to Health for TB Research Programme Consortium (The LIGHT Consortium). RMT declares grants from Wellcome Trust Research Award for Health Professionals (218105/Z/19/Z), NIHR Development Award (Co-PI) NIHR154243, NIHR Researcher-Led Award (Co-I) NIHR168008, Public Health Scotland (Safer Drugs Consumption Facility Evaluation—Baseline Data Collection). DMG declares National Institute on Minority Health and Health Disparities funding for Fathers and Children Exercising Together (FACEiT) & Black Health Block & Quit and Screen Project - Supplement to University of Arkansas for Medical Sciences P50, US Department of Defense funding for Impact of Online Prostate Cancer Information on Health Disparities, Movember Foundation funding for Rooted & Rising Collective: Movember Foundation Accelerator Program for Young Black Men; payment for lecture for Men's Health World Congress, National Maternal Health Innovation Symposium,

University of Minnesota's 8th Annual Research Ethics Day Conference, Community Engagement Grand Rounds (University of Texas Southwestern Medical Center), 13th Annual Health Equity & Social Justice Conference, Annual Public Health Conference Promoting Health Equity, Speaker Series University of Arkansas for Medical Sciences (Center for Research, Health and Social Justice), Promoting Father Engagement to Enhance Baby's Brain Health Development (School of Public Health, University of Texas), Equity ECHO Series—The Ethics of Doing Research with Communities (University of New Mexico Health Science Center), Partners for Advancing Health Equity (P4HE) webinar (Tulane School of Public Health and Tropical Medicine), Curtis Center Health Equity Seminar at University of Michigan, Black Health & Wellness Speaker Series at University of Pittsburgh, Health Equity: From Lens to Science series at University of California, Workshop at Rutgers University, Precision Prevention, Early Detection, and Interception of Cancer Special Conference at American Association for Cancer Research; member of Global Men's Health Advisory Committee (Movember Foundation) and Men's Health Network, Chair of Global Action on Men's Health.
SFR, BRE, RT, ST, and LD were supported by funding from the UK Research and Innovation (UKRI) Global Challenges Research Fund Accountability for Informal Urban Equity Hub (a UKRI Collective Fund award with award reference ES/S00811X/1). WM, SFR, RT, LD, and ST were supported with funding from Gender Equity and Antimicrobial Resistance (GEAR UP), funded by the Department of Health and Social Care's Fleming Fund using UK aid–MottMacDonald (grant number FF152 558). ST is a part-time UKRI–FCDO Senior Research Fellow in Gender (2024–27, payment to the institution), and the views expressed in this publication are those of the authors and not necessarily those of UKRI–FCDO or any other funder. ST has received payment and travel expenses from the Wellcome Trust. RT is supported by funding from the Canadian International Development Research Centre and UK FCDO for Urban Transformative Research for Adaptation to Climate Change in Informal Settlements (grant number 110642-001). PB is Chief Executive of Global Action on Men's Health. All other authors declare no competing interests

Acknowledgments

During the preparation of this work, SH used SciSpace to find additional papers that described the political processes of agenda-setting and policy formulation in the development of men's health policies in Australia, Brazil, and Ireland. SciSpace was used as a literature searching tool, not as a writing or drafting tool in any way. After using this tool or service, SH downloaded relevant full-text articles for review, analysis, and synthesis. SH takes full responsibility for the content of the published article.

References

1 Graunt J. Natural and political observations mentioned in a following index, and made upon the bills of mortality, 2nd edn. London: Tho Roycroft, 1662.
2 Tolhurst R, Egid BR, Mavhu W, et al. Men's health: an intersectional and multilevel framework for understanding syndemic patterns of health. *Lancet* 2026; **408:** 1866–80.
3 Catto JWF, Thomson RM, Griffith DM, et al. A global men's health epidemiology within an intersectional framework. *Lancet* 2026; **408:** 1881–98.
4 Healy B. The Yentl syndrome. *N Engl J Med* 1991; **325:** 274–76.
5 Kim AM, Tingen CM, Woodruff TK. Sex bias in trials and treatment must end. *Nature* 2010; **465:** 688–89.
6 Karoski S. Karoski S. Has the health system failed men? The perceptions of the men's movement on men's health in Australia. *Int J Mens Health* 2011; **10:** 45–64.
7 Leon N, Colvin CJ. Gone Missing: the treatment of men in global cancer policy. London: Global Action on Men's Health; published online June 2023. https://gamh.org/wp-content/uploads/2023/06/GAMH-Men-and-Cancer-Policy-Report.June-2023.Final_.HighRes.pdf (accessed Jan 28, 2026).
8 Hawkes S, Sy EA, Barker G, et al. Achieving gender justice for global health equity: the Lancet Commission on gender and global health. *Lancet* 2025; **405:** 1373–438.
9 World Economic Forum. Is women's health finally getting the attention it deserves? May 15, 2026. https://www.weforum.org/stories/2026/05/women-health-research-innovation/ (accessed June 19, 2026).
10 Ginsburg O, Vanderpuye V, Beddoe AM, et al. Women, power, and cancer: a Lancet Commission. *Lancet* 2023; **402:** 2113–66.
11 Griffith DM. Gender health equity: the case for including men's health. *Soc Sci Med* 2024; **351** (suppl 1)**:** 116863.
12 Rashid SF, Desai S, Kumar R. Situating sex, gender, and health in South Asia. In: Sivakami M, Bhushan A, Rashid SF, Khan KS, eds. Handbook on sex, gender and health. Singapore: Springer, 2024: 3–23.
13 Purdie A, Buse K, Hawkes S. Syntax and the "sin tax": the power of narratives for health. *BMJ Opinion*. July 17, 2019. https://blogs.bmj.com/bmj/2019/07/17/syntax-and-the-sin-tax-the-power-of-narratives-for-health/ (accessed Jan 28, 2026).
14 Sivakami M, Bhushan A, Rashid SF, Khan KS, eds. Handbook on sex, gender and health. Singapore: Springer, 2024.
15 Over H, Bunce C, Konu D, Zendle D. Editorial Perspective: what do we need to know about the manosphere and young people's mental health? *Child Adolesc Ment Health* 2025; **30:** 272–74.
16 Griffith DM, Bruce MA, Thorpe RJ Jr. Introduction. In: Griffith DM, Bruce MA, Thorpe RJ Jr, eds. Men's health equity: a handbook. New York: Routledge; 2019: 3–9.
17 Sen A. Why health equity? *Health Econ* 2002; **11:** 659–66.
18 Manton J, Gorsky M. Health planning in 1960s Africa: international health organisations and the post-colonial state. *Med Hist* 2018; **62:** 425–48.
19 Connell RW. Masculinities and globalization. *Men Masculinities* 1998; **1:** 3–23.
20 Clark J, Horton R. A coming of age for gender in global health. *Lancet* 2019; **393:** 2367–69.
21 Tiessen R. Everywhere/nowhere: gender mainstreaming in development agencies. Bloomfield, CT: Kumarian Press, 2007.
22 Cornwall A, Rivas A-M. From 'gender equality' and 'women's empowerment' to global justice: reclaiming a transformative agenda for gender and development. *Third World Q* 2015; **36:** 396–415.
23 Payne S. Gender mainstreaming as a global policy paradigm: barriers to gender justice in health. *J Int Comp Soc Policy* 2014; **30:** 28–40.
24 Heise L, Greene ME, Opper N, et al, and the Gender Equality, Norms, and Health Steering Committee. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet* 2019; **393:** 2440–54.
25 Caywood K, Darmstadt GL. Gender mainstreaming at 25 years: toward an inclusive, collaborative, and structured research agenda. *J Glob Health* 2024; **14:** 04011.
26 Chant S, Gutmann M. Mainstreaming men into gender and development: debates, reflections and experiences. Oxfam, 2000. https://oxfamilibrary.openrepository.com/bitstream/10546/121166/5/wp-mainstreaming-men-genderdevelopment-010100-en.pdf (accessed Nov 19, 2025).
27 United Nations. Programme of action of the International Conference on Population and Development. Cairo, Sept 5–13, 1994. New York: United Nations, 1995.
28 Breines I, Connell R, Eide I, eds. Male roles, masculinities and violence: a culture of peace perspective. Paris: United Nations Educational, Scientific and Cultural Organization (UNESCO); 2000. https://unesdoc.unesco.org/ark:/48223/pf0000120683.locale=en (accessed Jan 28, 2026).
29 Greig A, Kimmel M, Lang J. Men, masculinities and development: broadening our work towards gender equality. Gender in Development Monograph Series. New York: United Nations Development Programme, 2000. https://www.alangreig.net/wp-content/uploads/2017/01/UNDP_Men_and_Masculinities-2.pdf (accessed Nov 19, 2025).
30 Smith JA, White AK, Richardson N, Robertson S, Ward M. The men's health policy contexts in Australia, the UK and Ireland: advancement or abandonment? *Crit Public Health* 2009; **19:** 427–40.
31 Mason CL. Men, HIV/AIDS and culture: an analysis of the World Bank's The other half of gender – men's issues in development. *Int Fem J Polit* 2012; **14:** 247–66.
32 Mane P, Aggleton P. Gender and HIV/AIDS: What Do Men have to Do with it? *Curr Sociol* 2001; **49:** 23–37.
33 UNAIDS. Men make a difference: World AIDS Day 2000. Geneva: Joint United Nations Programme on HIV/AIDS; 2000. https://data.unaids.org/pub/report/2000/20001103_wac_objectives_en.pdf (accessed Jan 26, 2026).

34 Cornell M. Men's health policies: long overdue. *Bull World Health Organ* 2025; **103:** 515–16.

35 World Health Organization [WHO]. Global Tuberculosis Report 2025. Geneva: WHO; 2025. https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/tb-reports/global-tuberculosis-report-2025/featured-topics/tb-and-gender (accessed June 24, 2026).

36 World Health Organization Regional Office for Europe. Strategy on the health and well-being of men in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2018. https://www.who.int/europe/publications/i/item/WHO-EURO-2018-4209-43968-61973 (accessed Jan 28, 2026).

37 Pan American Health Organization. Masculinities and Men's Health in the Caribbean. Washington, DC: PAHO; 2023. https://iris.paho.org/handle/10665.2/58210 (accessed June 19, 2026).

38 World Health Organization. World health statistics 2019: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2019. https://iris.who.int/server/api/core/bitstreams/cf0f0674-1fc2-4c53-9e1a-9086599ab367/content (accessed June 15, 2026).

39 Primary health care on the road to universal health coverage: 2019 global monitoring report. Geneva: World Health Organization; 2019. https://iris.who.int/server/api/core/bitstreams/c9e2c0c0-cfad-4e6c-9982-68d4f9ffe365/content (accessed June 15, 2026).

40 Global Action on Men's Health. Our Reports. https://gamh.org/all-reports/ (accessed Jan 28, 2026).

41 Movember. The real face of men's health, UK report. Movember, UK, 2024. https://uk.movember.com/movember-institute/the-real-face-of-mens-health-report (accessed Jan 28, 2026).

42 Ragonese C, Shand T, Barker G. Masculine norms and men's health: making the connections. Washington, DC: Promundo-US, 2019. https://www.equimundo.org/wp-content/uploads/2018/11/Masculine-Norms-Mens-Health-Report.pdf (accessed Jan 28, 2026).

43 Kimani V. Maternal healthcare and health policy planning in Tanzania, 1961–1970s. *Afr Dev* 2024; **49:** 89–118.

44 Ahluwalia S, Parmar D. From Gandhi to Gandhi: contraceptive technologies and sexual politics in postcolonial India, 1947–1977. In: Solinger R, Nakachi M, eds. Reproductive states: global perspectives on the invention and implementation of population policy. New York: Oxford University Press, 2016.

45 Riva MA, Dekel R, Nemery B, Blanc PD, Naidoo RN. The history of occupational health on the African continent. *J Occup Med Toxicol* 2025; **20:** 14.

46 Gray G. How Australia came to have a national women's health policy. *Int J Health Serv* 1998; **28:** 107–25.

47 Munch S. The women's health movement: making policy, 1970-1995. *Soc Work Health Care* 2006; **43:** 17–32.

48 Hosseini J, Gelehkolaee KS, Hajebrahimi S, et al. A systematic synthesis of national policies and practice initiatives in men's health worldwide. *World Med Health Policy* 2025; **17:** 806–13.

49 Department of Health (Ireland). Men's health action plan 2024–2028. Dublin: Department of Health; 2024. https://www.drugsandalcohol.ie/42274/1/national-men-s-health-action-plan-2024-2028.pdf (accessed Jan 28, 2026).

50 Richardson N. Carroll PC. Getting men's health onto a policy agenda: charting the development of a national men's health policy in Ireland. *J Men's Health* 2009; **6:** 267–27.

51 Richardson N, Carroll P. It's not rocket science: the case from Ireland for a policy focus on men's health. *Int J Mens Soc Community Health* 2018; **1** (suppl 1)**:** e23–35.

52 Lima DC, Schwarz E. The Brazilian national policy of comprehensive healthcare to men. *Int J Mens Soc Community Health* 2018; **1** (suppl 1)**:** e36–49.

53 Gomes R, Leal AF, Knauth D, Nogueira da Silva GS. Meanings attributed to policy directed to Men's Health. *Cien Saude Colet*, **17:** 2589–96.

54 Leal AF, Figueiredo WS, Nogueira da Silva GS. Charting the Brazilian Comprehensive Healthcare Policy for Men (PNAISH), from its formulation through to its implementation in local public health services. *Cien Saude Colet* 2012; **17:** 2607–16.

55 Zinn C. Australia targets men's health. *BMJ* 1996; **312:** 268.

56 Holden CA, Lin V. Network structures and their relevance to the policy cycle: a case study of The National Male Health Policy of Australia. *Soc Sci Med* 2012; **74:** 228–35.

57 Department of Health and Ageing (Australia). National male health policy: building on the strengths of Australian males. Canberra: Commonwealth of Australia; 2010. https://catalogue.nla.gov.au/catalog/3311437 (accessed Nov 11, 2025).

58 Parliament of Australia. Senate Select Committee on Men's Health. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/menshealth/index (accessed Jan 28, 2026).

59 MacDonald J. The Australian male policy: unfinished business. *Int J Mens Soc Community Health* 2018; **1:** e50–56.

60 Ministry of Health Malaysia. National Men's Health Plan of Action, Malaysia 2018–2023. Putrajaya: Ministry of Health Malaysia; 2019. https://hq.moh.gov.my/bpkk/images/3.Penerbitan/2.Orang_Awam/5.Kesihatan_Dewasa/2.PDF/5Mens_Health_Plan_of_Action_Malaysia.pdf (accessed June 11, 2026).

61 Esmailzade H, Mafimoradi S, Elmira Mirbahaeddin S, Rostamigooran N, Farshadfar F. Devising a national men's health policy document: the current challenges to men's health in Iran. *Int J Mens Health* 2016; **15:** 174.

62 National Department of Health. South Africa. The South African national integrated men's health strategy 2020–2025. 2020. https://knowledgehub.health.gov.za/system/files/elibdownloads/2023-04/Men%2526%2523039%253Bs%2520Health%2520Strategy.pdf (accessed June 15, 2026).

63 All-Party Parliamentary Group on Men's Health. The case for a men's health strategy. London: Men's Health Forum, 2018.

64 Department of Health and Social Care (England). Men's health: a strategic vision for England. London: Department of Health and Social Care, 2025.

65 Health Canada. Improving the health of men and boys in Canada. Sept 17, 2026. https://www.canada.ca/en/health-canada/services/healthy-living/improving-health-men-canada.html (accessed Oct 22, 2026).

66 Hall PA. The role of interests, institutions, and ideas in the comparative political economy of the industrialized nations. In: Lichbach MI, Zuckerman AS, eds. Comparative Politics: Rationality, Culture, and Structure. Cambridge: Cambridge University Press, 1997.

67 Hay C. Ideas, interests and institutions in the comparative political economy of great transformations. *Rev Int Polit Econ* 2004; **11:** 204–26.

68 Bletsas A, Beasley C, eds. Bacchi C. Introducing the "What's the problem represented to be?" approach. Engaging with Carol Bacchi: strategic interventions and exchanges. Adelaide: University of Adelaide Press, 2012: 21–24.

69 Stone DA. Causal stories and the formation of policy agendas. *Polit Sci Q* 1989; **104:** 281–300.

70 Bardehle D, Dinges M, White A. What is men's health? a definition. *J Mens Health*, 2017; **13:** e40-e52.

71 World Health Organization. Gender-responsive tobacco control: evidence and options for policies and programmes. Geneva: World Health Organization; 2018. https://iris.who.int/server/api/core/bitstreams/0bd5a9cd-527f-4898-b96e-5ebf1d0bff57/content (accessed Jan 28, 2026).

72 Global Action on Men's Health. Absent-minded: how men's health has been overlooked in global health policy. London: Global Action on Men's Health; 2023. https://gamh.org/absent-minded/ (accessed Jan 28, 2026).

73 Shand T, Evoy C, Baker P, Shattuck D, Cornell M, Griffith DM. Out of focus: limited representation of men's health needs in regional and global sexual and reproductive health policy. *Health Policy Plan* 2025; **41:** 340–5.

74 Global Action on Men's Health. No man's land: how gender biases in health systems risk the lives of men and boys. London: Global Action on Men's Health; 2023. https://gamh.org/no-mans-land/ (accessed Jan 28, 2026).

75 Efird CE, Griffith DM. Structural advantage and white men's health and well-being. *Am J Public Health* 2026; **116:** e1–9.

76 Hawkes S, Connell R, Clark J, et al. Gender and global health: going, going, but not gone. *Lancet* 2025; **405:** 1317–20.

77 Ugwu C, Adekeye O, Ringwald B, et al. Co-creation of a gender-responsive TB intervention in Nigeria: a researcher-led collaborative study. *BMC Health Serv Res* 2025; **25:** 63.

78 Hunt K, Wyke S, Gray CM, et al. A gender-sensitised weight loss and healthy living programme for overweight and obese men delivered by Scottish Premier League football clubs (FFIT): a pragmatic randomised controlled trial. *Lancet* 2014; **383:** 1211–21.

79 Maddison R, Hargreaves EA, Jiang Y, et al. Rugby Fans in Training New Zealand (RUFIT NZ): a randomized controlled trial to assess the effectiveness of a healthy lifestyle program for overweight men delivered through professional rugby clubs. *Int J Behav Nutr Phys Act* 2023; **20:** 37.

80 MacDonald J. A different framework for looking at men's health. *Int J Mens Health* 2016; **15:** 283–95.

81 Flood M, Hewson-Munro S, Keddie A. A critical stocktake of community-based healthy masculinities programs in Victoria, Australia. *J Men's Stud* 2024; **32:** 595–615.

82 Baker P. From the margins to the mainstream: advocating the inclusion of men's health in policy—a scoping study. London: Global Action on Men's Health, 2020. https://gamh.org/wp-content/uploads/2020/06/From-the-Margins-to-The-Mainstream-Report.pdf (accessed Jan 28, 2026).

83 Sparks B, Papandreou C. The manosphere and men's wellbeing: how health care can help young men find alternatives to toxic online spaces. *BMJ* 2023; **383:** 2947.

84 Gerrand V, Ging D, Roose JM, Flood M. Mapping the neo-manosphere(s): new directions for research. *Men Masc* 2025; **28:** 1097184X251350277.

85 Iñigo A. Navigating the manosphere: a scoping review of research on masculinist and misogynist online spaces. *J Men's Stud* 2026; **34:** 166–92.

86 Haslop C, Ringrose J, Cambazoglu I, Milne B. Mainstreaming the manosphere's misogyny through affective homosocial currencies: exploring how teen boys navigate the Andrew Tate effect. *Soc Media Soc* 2024; **10:** 1–11.

87 Barber K. Legal cynicism in men's rights discourses: using corpus linguistics to investigate how distrust in the legal system excuses and perpetuates sexual violence against women. *Appl Corpus Linguistics* 2025; **5:** 100148.

88 Verian. The Reykjavik Index for Leadership 2024–2025. London: Verian; 2024. https://www.reykjavikglobal.com/_files/ugd/8f311d_5069e23611e44b23952fe870e6281a3f.pdf (accessed Jan 18, 2026).

89 Halpin M, Gosse M, Yeo K, Handlovsky I, Maguire F. When help is harm: health, lookism and self-improvement in the manosphere. *Sociol Health Illn* 2025; **47:** e70015.

90 Preston K, Halpin M, Lockyer D. Incels and gender inequality: changing tides in defining the far right. *Soc Probl* 2025; published online Sept 18. https://doi.org/10.1093/socpro/spaf052.

91 Scott-Samuel A, Stanistreet D, Crawshaw P. Hegemonic masculinity, structural violence and health inequalities. *Crit Public Health* 2009; **19:** 287–92.

92 Movember Institute of Men's Health. Young men's health in a digital world. Melbourne: Movember Institute of Men's Health; 2023. https://au.movember.com/movember-institute/masculinities-report (accessed Jan 18, 2026).

93 Shiffman J, Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *Lancet* 2007; **370:** 1370–79.

94 United Nations General Assembly. Draft resolution A/80/L.34: political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being. New York: United Nations; December, 2025. https://docs.un.org/en/A/80/L.34 (accessed Sept 30, 2026).

95 Wilsford D. Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way. *J Public Policy* 1994; **14:** 251–83.

96 Smith JA, Watkins DC, Griffith DM. Fostering transnational research partnerships to advance men's health. *Am J Mens Health* 2020; **14:** 1557988320936893.

97 Gilmore AB, Fabbri A, Baum F, et al. Defining and conceptualising the commercial determinants of health. *Lancet* 2023; **401:** 1194–213.

98 White C, Oliffe JL, Bottorff JL. From the physician to the Marlboro Man: masculinity, health, and cigarette advertising in America, 1946–1964. *Men Masculinities* 2012; **15:** 526–47.

99 Islentyeva A, Zimmermann E. "Tall, dark and tasty": masculinity in food and beverage advertising. *Z Anglistik Am* 2023; **71:** 265–92.

100 World Health Organization. WHO global report on trends in prevalence of tobacco use 2000–2030. Geneva: World Health Organization; 2024. https://www.who.int/publications/i/item/9789240088283 (accessed Dec 13, 2025).

101 McHardy J, Blanco Marquizo A, Bettcher D, Gakidou E. Policy view: worldwide patterns of tobacco use with recommendations for tobacco control. *Lancet Respir Med* 2025; **13:** 756–68.

102 Islam MS, Saif-Ur-Rahman KM, Bulbul MMI, Singh D. Prevalence and factors associated with tobacco use among men in India: findings from a nationally representative data. *Environ Health Prev Med* 2020; **25:** 62.

103 Branston JR. Industry profits continue to drive the tobacco epidemic: a new endgame for tobacco control? *Tob Prev Cessat* 2021; **7:** 45.

104 World Health Organization. Programme budget 2018–2019. Geneva: World Health Organization; 2017. https://iris.who.int/handle/10665/272406 (accessed Jan 18, 2026).

105 World Health Organization. WHO Framework Convention on Tobacco Control. Geneva: World Health Organization; 2003. https://fctc.who.int/resources/publications/i/item/9241591013 (accessed Jan 28, 2026).

106 Bustreo F, de Zoysa I, Araujo de Carvalho I. Policy directions to improve women's health beyond reproduction. *Bull World Health Organ* 2013; **91:** 712–14.

107 Hickey M, LaCroix AZ, Doust J, et al. An empowerment model for managing menopause. *Lancet* 2024; **403:** 947–57.

108 Delanerolle G, Phiri P, Elneil S, et al. Menopause: a global health and wellbeing issue that needs urgent attention. *Lancet Glob Health* 2025; **13:** e196–98.

109 Schneider A, Ingram H. Social construction of target populations: implications for politics and policy. *Am Polit Sci Rev* 1993; **87:** 334–47.

110 Griffith DM, Cornish EK. "What defines a man?": Perspectives of African American men on the components and consequences of manhood. *Psychol Men Masc* 2018; **19:** 78–88.

111 United Nations. International covenant on economic, social and cultural rights. Adopted Dec 16, 1966. *United Nations Treaty Series* 1976; **993:** 3.

112 Marcos-Marcos J, Mateos JT, Gasch-Gallén À, Álvarez-Dardet C. Men's health across the life course: a gender relational (critical) overview. *J Gend Stud* 2021; **30:** 772–85.

113 Roose JM. Militant masculinity, male grievance, and the politics of democratic decline. *J Gend Stud* 2025; published online Oct 24. https://doi.org/10.1080/09589236.2025.2576811.

114 Vardhana TM, Kumaran M, Reddy A, et al. Profile of fatal road traffic accidents at Puducherry: an autopsy-based study. *J Forensic Med* 2018; **12:** 31–36.

115 Montazer MHL, Lashkardoost H, Shamsi F, Askari M, Hamedi E, Hamedi A. Road traffic accidents in Yazd province, Iran: a longitudinal study (2012–2016). *Arch Trauma Res* 2018; **7:** 68.

116 World Bank. Socio-economic costs and human impacts of road accidents in Azerbaijan. Washington, DC: World Bank; 2019. https://openknowledge.worldbank.org/server/api/core/bitstreams/efc7f523-ce55-5fd0-bc53-bcc4379a2ee5/content (accessed Dec 14, 2025).

117 Movember Institute of Men's Health. The real face of men's health: 2025 United States executive summary. Oct 8, 2025. https://movember.com/uploads/files/2025/Movember%20US%20Real%20Face%20of%20Men's%20Health%20report%20-%20Executive%20summary.pdf (accessed Sept 30, 2026).

118 Friel S, Collin J, Daube M, et al. Commercial determinants of health: future directions. *Lancet* 2023; **401:** 1229–40.

119 Smith JA, Potvin L, Ardiles P, et al. Mobilising health promotion action in current geopolitical landscapes. *Glob Health Promot* 2025; **32:** 3–6.

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