6 Health and wellbeing

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6.1 Introduction

This chapter complements Chapter Five on 'Sexual health and rights' to explore recent trends and shifts in social, economic and political factors that influence men's other health attitudes and behaviours including mental health, non-communicable diseases and risk-taking behaviours. Discussions on gender equality and women's empowerment within the context of health and wellbeing have, for many important reasons, traditionally focused on the health-related vulnerabilities of women and girls. However, since gender is relational as well as socially constructed, emerging attention and interest has been given to understand how men's and boys' health and wellbeing – alongside that of women and girls – helps or hinders enabling environments for improving gender equality and supporting the empowerment of women and girls. Gender-transformative health approaches are warranted given the evidence that men's risky and poor health seeking behaviours are tied to gender inequitable attitudes (Pulerwitz *et al*. 2010), and/or create an environment where women and girls become further disadvantaged. The chapter assesses how efforts to promote men's health and wellbeing have integrated gender and its broader impacts on gender equality.

Three reasons for exploring men's broader health in relation to gender equality include: (1) its gendered relational impacts on women, children and others (such as depression and alcohol abuse fuelling some men's violence); (2) the gendered nature of the socioeconomic or structural drivers of such health problems (such as economic crises and stress combined with expectations of masculinity contributing to depression, mental ill health and/or substance abuse); and (3) the importance of identifying policies and programmes that can positively address individual, relational and structural factors that impact gender-equitable access to health care, prevention and treatment. Men tend to be the primary decision-makers within families and often control many health behaviours of their families including contraceptives use, the availability of nutritious food, women's workload, and the allocation of money, transport and time for women to attend health services (Davis, Luchters and Holmes 2012; Roth and Mbizvo 2001; Greene *et al*. 2004; Muralidharan *et al*. 2014), and have been shown to strongly influence the nutritional diets of their children, whether or not they go to school, are immunised, and their age of marriage (Sen 2013; Smith 2011). For men to make informed choices that can benefit themselves and their families, they need to be adequately included in health services and education. This chapter uses a holistic definition of health as a 'state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 1948), and a conception of gender equity as fairness in treatment for women and men according to their respective health needs (WHO 2013). Gaps in the evidence, examples of best practice, strategies, and future priorities for promoting men's health and wellbeing in ways that advance gender equality, are highlighted.

6.2 Changes in the past twenty years in men's health and wellbeing

Over the last two decades, women's health activists have extensively advocated for the ways in which gender inequality and problematic norms of masculinity hinder women's health, and how gender norms are not fixed but fluid and thus malleable. Appreciation of the influence of gender norms on health have more recently evolved to recognise how certain norms of masculinity have emotional, psychological and physical consequences for men's own health,

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often manifested in risky and unhealthy behaviours (Sen, Östlin and George 2007). Indeed, there is now a wealth of global evidence suggesting that dominant constructions of masculinity, such as notions of invulnerability, self-reliance, and the promotion of risk-taking, influence men's poor health and excess mortality, lower life expectancy, and under-utilisation of health care services (Courtenay 2000), thus impacting on their relationships, including with women, and public health more broadly.

As Courtenay (2000: 1385) notes, 'health-related beliefs and behaviours, like other social practices that men and women engage in, are a means for demonstrating femininities and masculinities'. There is evidence to suggest that men's poor use of certain health services is influenced by social constructions of health as a feminine concern (Aoun and Johnson 2002; *Mahalik et al.* 2007; Wilkins 2005), and norms of masculinity that hinder demonstrations of vulnerability and help-seeking, and encourage a sense of immunity and control (Colvin, Robins and Leavens 2010; Oliffe *et al.* 2011; Peacock *et al.* 2009). Men's infrequent use of and/or late presentation to health services has been found to be associated with higher levels of potentially preventable diseases and having reduced treatment options (Fletcher and Higginbotham 2002; Parslow *et al.* 2004). Women's and children's inadequate access to health services can also be influenced by harmful gender norms, including men's greater access to and control of household resources, power and decision-making within the household and in the wider community (Rodin 2013).

Drawing on the 2002 global disability adjusted life years (DALYs) for men and women, Snow (2007) noted the overall greater DALY burden among males worldwide as a result of the ten top causes of disease or disability for men and women. According to a comprehensive study of global health, which analysed yearly deaths from 240 different causes in 188 countries from 1990 to 2013, the global life expectancy for men and women has increased by about six years over the past two decades (Murray 2014). However, despite increases for both men and women, it appears that the difference between men and women in life expectancy is broadening to the detriment of men (Murray 2014). The high rate of morbidity and mortality among men not only has harmful repercussions for men, but also for women, families and communities where men live, and thus society as a whole (Barker *et al.* 2010). Losing a significant proportion of working age men through premature mortality can have serious economic repercussions for families through the loss of the primary income-earner for many households (White 2011). Men's poor health tends to result in a heavy burden on women who are primarily responsible for caregiving, as discussed in Chapter Three on 'Fatherhood, unpaid care and the care economy'. Thus, to build an enabling environment for gender equality, meeting men's and boys' needs within a gender-equitable framework of 'health for all' is increasingly recognised as essential. The consistent question that emerges in gender and health programming is now *when* and *how* to engage men in such programming, rather than *whether* to do so (WHO 2011).

6.3 Relationship between hegemonic norms of masculinity and men's health

There are certain health problems that men face for unique male physiological and biological reasons, such as testicular and prostate cancers. Yet, many of the chronic and non-communicable diseases that are associated with premature and higher rates of mortality in men, such as coronary heart disease, stroke, and some cancers are caused by preventable, yet frequently recurring risk factors (Courtenay 2009; Murray 2014; White 2011). Thus, there is growing consensus about the necessity to address the relationship between norms of masculinity and men's unhealthy and risk-taking behaviours.

Some of the literature has indicated a relationship between adhering to norms of dominant forms of masculinity and poor mental health and general wellbeing among boys and men (Evans *et al.* 2011; Soares *et al.* 2008). In nearly all contexts, boys and men commit suicide at a higher rate than girls and women. It is suggested that this is related to men's general reluctance to access mental health care or their sense of exclusion from it, and dominant

societal expectations that men should not reveal or express emotion or pain (Oliffe *et al.* 2011). A study that analysed data in 2001 and 2002 from 43,000 people who took part in a US National Institutes of Health survey (2011), found that men were more likely to be diagnosed with substance abuse or antisocial disorders, whereas women were more likely to meet diagnostic criteria for depression. The study found that men were more prone to externalising anxiety, which could lead to aggressive, impulsive, and coercive behaviours. Women were more likely to internalise their anxiety, which could heighten their depression and withdrawal.

It has been suggested that gender biases in the diagnosis of depression may underestimate the prevalence of depression among men, and lead to men being diagnosed with addictive behaviours rather than depression, or to health professionals being unresponsive to male patients' emotional distress (Möller-Leimkühler 2002). For the past few decades, certain feminists have questioned assumptions that women are inherently more vulnerable to mental illness than men (White 2011). There is, however, growing interest in better diagnosis and understanding of gendered causes and pathways of depression, including male depression (White 2011).

Across the world, boys and men are likely to consume more alcohol than girls and women, be habitually heavy drinkers, and develop alcohol-related problems (de Visser, Smith and McDonnell 2009), which is partly linked to the strong association between alcohol consumption and manhood that is fostered by the alcohol and advertising industries (Flood *et al.* 2010). According to the Global Burden of Disease Study (WHO 2012), 3.14 million men died as a result of alcohol use compared to 1.72 million women in 2010. Heavy alcohol consumption is associated with many harmful behaviours including intimate partner sexual and physical violence (Verma and Collumbien 2005), unsafe sex and road traffic accidents (Snow 2007). Boys and men are also more likely than women to be smokers and the Global Burden of Disease Study (WHO 2012) noted that 4.25 million men died in 2010 as a result of tobacco use compared to 1.44 million women. In many contexts, smoking for boys and men comprises a transition to manhood and is embedded in social male relations (WHO 2005). Overall, tobacco and alcohol use are two of the major contributory factors to non-communicable diseases for men and women, along with a lack of physical activity and unhealthy diets (WHO 2005). Smoking also contributes to approximately one-third of men's excess in reported tuberculosis (TB) cases (Watkins and Plant 2006). Boys and men are also more likely than girls and women to use illicit drugs and to develop drug-related problems (Greenfield, Manwani and Nargiso 2003). Potential short-term effects of certain drugs include the risk of a fatal overdose and increased rates of accidents and injuries, and long-term risks include psychiatric morbidity, a greater vulnerability to suicide, and difficulty maintaining work (White 2011). Globally, an estimated 70 per cent of all traffic accident deaths occur among adolescent boys and men (Snow 2007). Encouragement of risk-taking among men is said to influence this gender disparity (Barker *et al.* 2010), as well as men's greater access to vehicles than women, and their expected role as drivers (Snow 2007). Alcohol and substance abuse also contribute to road traffic accidents, especially fatal accidents (Snow 2007).

A further range of health disparities between the sexes is related to gendered patterns of work and leisure (Snow 2007). For instance, the greater global risk of drowning among men is attributed to their role as fishermen and boatmen, and the greater number of burnings among women is linked to their responsibility for cooking (Snow 2007). In many contexts, certain men's diets are less healthy and balanced than women's diets (Lyons 2009; White 2011), and/or men report less nutritional awareness (Gough and Conner 2006; Kiefer, Rathmanner and Kunze 2005). It is important to note, however, the dire nutritional disparities between males and females in certain contexts worldwide, especially in Asia, where men and boys are given priority and initial access to a higher quality and amount of food than women and girls (Croll 2010). Yet in many scenarios, men tend to lack control over their diet given

that the onus of purchasing and preparing food typically falls on women (White 2011). Poor dietary habits are also influenced by working hours, in particular for those who work shift hours, and commute long distances (White 2011). According to the Global Burden of Disease Study (WHO 2012), 5.14 million men died in 2010 from dietary risk factors such as low fruit and vegetable intake and eating too much processed meat, compared to 4.18 million women.

Globally, men are more likely to migrate for work, which can make it more difficult for men to access health care (Campbell 1997). In light of the extreme pressures worldwide on men to be economic providers, there are data demonstrating a significant relationship between economic stress among men and vulnerability to depression, mental ill health and/or substance abuse (White 2011). For instance, in South Asia, where TB is often equated with job loss and an inability to be provide financially, studies have found that fear of financial burden and shame discourage men from seeking TB treatment (Muralidharan *et al.* 2014).

Despite significant evidence of the ways in which gendered norms and roles can harm men's and women's health, men's health is rarely deconstructed through the lens of gender and it has been argued that 'patriarchal socialization and hegemonic masculinity are unacknowledged, preventable causes of most health inequalities' (Scott-Samuel, Stanistreete and Crawshaw 2009: 159). Moreover, men's health tends to be simplified as a unified entity, whereby men are understood to be a homogenous group, which fails to appreciate the ways in which factors including socioeconomic status, race and sexuality can impact on men's health (Hearn 2004; Morrell 2001; Peacock *et al.* 2009). This is critical to consider given the evidence that boys' and men's vulnerabilities to poor health and mortality rates intersect with disability, culture, socioeconomic status, migration status, and residence (Barker *et al.* 2010; Evans *et al.* 2011; Peacock and Barker 2012; Wadham 2009). Rates of morbidity and homicide related to alcohol and substance abuse are generally higher among low-income men (Barker *et al.* 2010). Furthermore, age or generational differences affect versions of masculinity and related health behaviours (Evans *et al.* 2011; Oliffe *et al.* 2011). Young men aged 18 to 35 are a particular risk group, with especially high rates of death from suicide and road traffic accidents in much of the world (White 2011). Limited consideration of the impact of such factors on masculinity and health and access neglects the powerful intersecting social and structural forces shaping boys' and men's health and wellbeing.

6.4 Impact of institutions on men's health and wellbeing

In recent years, various institutions have played a role in understanding and addressing the role of gender on determinants of health and wellbeing outcomes. At the Beijing 'Platform for Action' at the 1995 United Nations 4th World Conference on Women, a commitment was made to mainstreaming gender equality to ensure that women's and men's health concerns and experiences are given adequate attention (Derbyshire 2002). Other declarations adopted at the 4th World Conference on Women in 1995 noted the importance of health statistics being collected to allow a thorough analysis of sex differences in exploring health access and outcomes (White 2011).

The men's health sector has witnessed a recent growth in national men's health organisations and international health movements, such as the Movember Campaign to target prostate cancer (see Box 6.1), and the new Global Action on Men's Health (GAMH), which was set up to encourage the World Health Organization (WHO) and international public health agencies to develop research, policies and interventions to promote men's health. GAMH also advocates for governments and non-governmental organisations (NGOs) to implement strategies to address men's poor health, provide guidance on strategies used, and to more heavily emphasise the social and structural determinants of men's health (see http://emhf.org/gamh/). Some organisations, such as RHEG (Network of Men for Gender Equality) and Papai in Brazil, have developed educational materials that highlight the health needs of men and provide recommendations for health providers to specifically include and

cater to men (Barker *et al.* 2010; Medrado *et al.* 2009). Such movements and organisations have put the issue of men's health and wellbeing directly on the global agenda, and influenced national health policies and priorities. However, these efforts are often developed with few or weak links to the men and gender equality agenda, and sometimes take a more biomedical approach that does not position men's health within a patriarchal context, or demonstrate the links between men's and women's health.

Box 6.1 The Movember Foundation

Movember is an annual event that encourages men to grow moustaches during the month of November to raise awareness of men's health issues, such as prostate cancer and depression. By encouraging men to get publicly involved, Movember aims to increase early cancer detection, diagnosis and effective treatments, and ultimately reduce the number of preventable deaths. The Movember Foundation encourages men to go for annual check-ups, to be aware of their family history of cancer and to adopt a healthier lifestyle. Since 2004, the Movember Foundation has hosted events to raise awareness and funds for men's health issues in Australia and New Zealand and, in 2007, events were launched in Ireland, Canada, Czech Republic, Denmark, El Salvador, Spain, the United Kingdom, Israel, South Africa, Taiwan and the United States. For further details, see www.movember.com

As well as dominant constructions of masculinity hindering healthcare-seeking behaviour, there is emerging concern about the fact that primary healthcare provision is often not regarded as being 'male-friendly' or oriented to men's health needs (Wilkins 2005). As was discussed in Chapter Five on 'Sexual health and rights', the lack of information about men's health, and the all too common failure to sufficiently disaggregate data, creates a poor foundation on which to cater health services to address men's health concerns, including those most suited to diverse groups of men. The lack of appreciation of men's health as gendered, or the conflation of gender and health with women's health, has hindered research and responses targeting men's health. Overall, the international community lacks focus on men's health and wellbeing at the global policy level (Hawkes and Buse 2013). Through a review of global health strategies on behalf of institutions, and organisations, Hawkes and Buse (2009) assert that gender is absent from the majority of plans and core objectives, and highlight the tendency to undermine the role of gender on health, or focus it exclusively on the health needs of women. The absence of men's health policies or gender mainstreaming problematically limits the capacity to develop coordinated national and international programmes and policies that can more adequately meet the health needs of men and their families (Hawkes and Buse 2013; Smith *et al.* 2010). In order to achieve the highest standard of health, health policies should recognise that owing to men's and women's biological differences, gendered norms and expectations, they have different health barriers and opportunities that may require targeted approaches.

Overall, there is a lack of gender integration for many health issues facing men. A review of 164 gender-aware health programmes in lower middle income groups found that gender integration was strongest for HIV programmes, and also high for GBV (gender-based violence) and youth SRH (sexual and reproductive health) programmes (Muralidharan *et al.* 2014). For safe motherhood, healthy timing and spacing of pregnancy, and neonatal and child health and nutrition, gender integration was found to be moderate. Gender integration was extremely weak for TB and universal health coverage (UHC). The authors note how differences in the rates of TB infection between women and men should be documented and analysed, and the social contexts of exposure and vulnerability to infection among men and women should be accounted for (Muralidharan *et al.* 2014). The review found no evidence of a government systematically applying a gender lens to the design and implementation of its UHC system to take into account the different health needs of women, men, and sexual and gender minorities (Rodin 2013).

Although international policies and agreements can shape the way health is legislated, recorded and analysed; other institutions, such as corporations and media can shape public consciousness and individuals' expectations around their own health. Images that reinforce hegemonic notions of masculinity have been extensively used by media campaigns to encourage boys and men to partake in risk-taking behaviours including smoking and alcohol use (Fleming, Lee and Dworkin 2014). For instance, the alcohol industry typically uses notions of 'strength' and 'manhood' to promote alcohol use among boys and men (Fleming *et al.* 2014; Peacock and Barker 2012). As discussed in Chapter One, 'Introduction: Framing the evidence and shifting social norms', injunctive gender norms refer to one's social group's ideals of masculinity and femininity, including how the media reinforce gender stereotypes. South Africa has one of the highest reported levels of alcohol consumption in the world and all levels of drinking, particularly binge drinking on weekends, is higher among men than women in all age groups, provinces, and populations (Peacock *et al.* 2008). The South African Minister of Health, Aaron Motsoledi, has attempted to address alcohol abuse through initiatives that include restricting drinking hours, alcohol sales and banning alcohol adverts (Khumalo 2011).

A variety of other global programmes and policies have successfully reduced harmful drinking, including raising alcohol taxes, raising the legal drinking age, decreasing the legal blood alcohol concentration limits for drivers, training of alcohol servers to monitor and control unhealthy alcohol use, and community education about the health consequences of alcohol (Peacock and Barker 2012). Smoking advertisements for boys and men often portray smoking as a manly habit linked to happiness, fitness, wealth, power and sexual success, and/or show men smoking in a risky terrain (Fleming *et* al. 2014). Moreover, a global youth tobacco survey found that 24 per cent of young smokers started by the age ten, which makes it difficult for them to be critical of and resist social and gendered expectations fostered through such advertising (WHO 2003b). The WHO Convention on Tobacco Control (2003b) asserted that different impacts on men and women should be considered when deciding on tobacco pricing, access and bans. They argued that men may be particularly concerned with information about tobacco's actual threat to virility. While pregnant women have been effectively targeted with smoking prevention efforts due to concerns of foetal health (Bottorff *et al.* 2006), the WHO convention also asserted that fathers should be included in such efforts to prevent secondhand smoking. The WHO convention argued that there should be discussion of gender expectations among young people to foster awareness and resistance to smoking advertising targeting gender norms, such as male smokers being portrayed as sexually potent and successful.

6.5 Influence of men's health efforts on women's health and wellbeing

While some gender health literature has highlighted the implications of men's poor health on women, families and the public health systems, this remains limited in scope and scale. As discussed in Chapter One, 'Introduction: Framing the evidence and shifting social norms', certain notions of masculinity and gender inequalities can lead to harmful consequences for women and children, including men's control of decision-making and economic resources, substance abuse and violence. The link between men's use of intimate partner violence and women's poor physical, reproductive and mental health, as well as poor child survival and health, has been extensively documented (Verma and Collumbien 2003). Men's use of intimate partner violence (IPV) is associated with greater rates of depression, anxiety and suicidality among women (Ellsberg *et al.* 2008). Relationship inequity and IPV have additionally been found to increase women's HIV infection risk. One study estimated that 16 per cent of new HIV infections in women could be prevented if women did not experience intimate partner domestic violence (Jewkes *et al.* 2009). As discussed in Chapter Seven on 'Sexual and gender-based violence', boys who are exposed to their father's abusive behaviours against their mother are significantly more likely to be subsequent perpetrators of violence, including sexual violence, which is partly attributed to their socialisation of unequal gender relations.

After doing a review of online databases using key terms to identify health and gender relations literature, Botorff *et al.* (2011: 60) argue that 'although there have been promising developments in accounting for gender influences in health research, the concepts of masculinity and femininity for the most part have been delinked despite the social constructionist premise that gender is relational'. They argue that health behaviours should be understood amidst men's and women's interactions on personal and institutional levels, especially since gender relations between men and women have been documented to influence health outcomes. For example, there is some evidence indicating that married individuals are more likely to engage in healthier behaviours, report better psychological and physical wellbeing, and have lower mortality rates compared to divorced, separated, widowed or single individuals (Annadale and Hunt 2000). Some literature has found that married men generally live longer than single men, and widowed men's life expectancy is significantly shortened following the loss of their partners (Schippers 2007; Strebel *et al.* 2006; Tolhurst *et al.* 2007).

The diets and nutrition of single men living alone have been found to be particularly poor (Gough and Connor 2006). Possible explanations for this include expectations for women to be the carers as evidenced in Chapter Three on 'Fatherhood, unpaid care and the care economy', and the linkages between dominant forms of masculinity and men's disregard for their own health. Although marriage has also been found to be a protective factor for women's health, for example by increasing their financial stability (Strebel *et al.* 2006), married women are also more vulnerable than men to risky factors including IPV (Bottorff *et al.* 2012). A study that interviewed 75 women in Ghana found that marital status was harmful to women's health due to a gender division of labour with heavy responsibilities, lack of access to and control of resources, and physical and verbal abuse from intimate partners (Avotri and Walters 2001). This example is not meant to suggest that marriage should be advocated to protect one's health, or essentialise the relationship between marriage and health, but rather demonstrates the importance of assessing how gender relations and dynamics influences both men and women's health and wellbeing.

Health comparisons disaggregated by sex are increasingly conducted to compare vulnerabilities to poor health practices and diseases between men and women. However, the majority of this literature tends to highlight quantitative differences between the sexes, which can become divisive and fail to appreciate the complexity and diversity of men's health and how it influences the health and wellbeing of women and girls, or the societal and structural factors driving health risks and behaviours for boys, men, girls and women (Hawkes and Buse 2013). There is also a tendency to adopt oppositions between men and women's health, either explicitly or implicitly, upon whose health is more disadvantaged (Wadham 2009). Prioritisations of men's health can be presented as threatening efforts, including funds, to advance women's health (Flood 2007). Such approaches suggest an impression of a finite amount of vulnerability to poor health, can reinforce polarisation between the sexes and neglect the fact that health for all is beneficial to society. Approaches that emphasise differences between the sexes can also make it difficult to foster cross-sex health alliances, including across diverse sexual orientations, or with those whose gender identities are ambivalent or non-normative.

Yet emphasising men's vulnerability to poor health, without sufficient context, may communicate a false sense of symmetry between men's and women's poor health including women's disadvantage, and neglect the implications of patriarchy and what men do to maintain power (Sideris 2004; Wadham 2009). Although different men may be more vulnerable to poor health because of other forms of oppression, for example race, class or sexuality, it is problematic to compare the health status of men and women to primarily emphasise how men are disadvantaged in relation to women. As Peacock (2013: 129) asserted, 'men, even marginalized men or, for that matter, men who oppose patriarchy, continue to derive benefits because of the status bestowed by society on men as dominant

and women as subordinate'. In light of such concerns, it is necessary to prioritise health efforts and approaches that seek to advance gender-equality efforts and ensure that efforts to promote men's health do not threaten the fragile gains made for women's health. This requires encouraging men to adopt accountability for their own health as well as that of others, and acknowledging the power imbalances as a result of patriarchy (Barker *et al.* 2010).

Since the mid-1990s, there has been increasing recognition of the need to actively include men in maternal and child health (MCH). This comes out of the evidence that men tend to be responsible for the allocation of household resources and care-seeking behaviours that directly impact on the health of women and newborns (Davis *et al.* 2012). Moreover, many women experience significant influences and pressures from family members, including male partners, parents, and parents-in-law about infant feeding (Davis *et al.* 2012; Prasanna 2011). Yet many men have not been exposed to breastfeeding messages and have insufficient knowledge to positively influence such decisions. Support from male partners can be a major factor influencing women's decision to immunise children (Babirye et al. 2011; Davis *et al.* 2012). For instance, male involvement programmes in South Asia have increased the number of children being immunised and lowered the prevalence of stunting by improving their nutritional intake. A recent review (Fisher *et al.* 2012) found that higher rates of common perinatal mental disorders were observed among women with an unsupportive or uninvolved partner. Pregnancy can provide an opportunity to connect men to the health system, detect and treat STIs (sexually transmitted infections) and other infections, and provide relevant health messages (Davis *et al.* 2012). Indeed, evidence suggests that many men care deeply about the wellbeing of their families and respond positively to attempts to engage with them at this level (Kamal 2002; Mehta 2002), and to learn about MCH (Natoli *et al.* 2012). Building husbands' awareness of women's health needs during pregnancy may positively influence women's workloads during pregnancy. In India, a pre- and post-intervention programme evaluation assessed the effects of raising men's awareness of healthy behaviours during pregnancy and observed an increase in the number of expectant fathers assisting with household work (from 27.4 per cent to 41.7 per cent, *p*-values not reported) and assisting their wives to access health services (from 46.3 per cent to 57.7 per cent) over 18 months (Sinha 2008). Men have also been found to play a critical role in whether women deliver their child at home or not.

Yet progress towards successfully engaging men in MCH has been slow, especially in most developing country contexts. Davis *et al.* (2012) reviewed 78 studies published between January 2000 and April 2012 that examined the effect of efforts to encourage men to use family planning or improve maternal and newborn health. The evidence suggests that engaging men leads to benefits including use of contraceptives among long-term couples, maternal workload during pregnancy, birth preparedness, postnatal care attendance, couple communication and emotional support for women during pregnancy. The review also noted how poorly designed interventions to promote men's involvement in MCH can lead to less autonomy and decision-making for women. Couples should be encouraged to attend maternal and newborn health services together, yet the authors concluded that such efforts must avoid unintentionally discouraging single or unaccompanied women from accessing health services. The authors argue that involving women in the design of male involvement strategies and pilot testing key messages is critical for minimising the potential harms associated with male involvement. The societal responsibility (including health-related, social and financial responsibility) for contraception and child rearing tends to unduly fall onto women (Campo-Engelstein 2013), which can be reinforced by paternity laws and custody laws. As discussed in Chapter One, 'Introduction: Framing the evidence and shifting social norms', norms and roles around men's involvement in childcare can be challenged through implementing gender-equitable parental and family leave policies.

Davis *et al.* (2012) identified strategies that have proven effective for engaging men in MCH in low-income settings including peer education, community meetings, distribution of education materials, one-on-one counselling sessions, workplace-based initiatives, group education and mass media campaigns. Written or verbal invitations from health workers encouraging men to attend with their pregnant partner, ensuring that clinic facilities and staff are welcoming to men and address men's own health needs, and amending opening times of clinics to enable working men to attend were also effective strategies. Challenges to engaging men in this area include social and cultural barriers, poor physical setup of clinics, lack of staff training and resources to engage men effectively (Davis *et al.* 2012). The authors note how the World Health Organization and other relevant agencies often neglect the need to provide guidance for involving expectant fathers in MCH. The authors highlight the need for more rigorous research into the impact of strategies for engaging men in MCH. There are also major gaps in understanding how male involvement as carers influences the health and wellbeing of their partners and families and their wider communities, or how addressing men's non-communicable diseases affects the health and wellbeing of their families.

Overall, there is limited evidence that assesses the influence of health interventions for men and boys on the health and wellbeing of women and girls. This lack of understanding could reinforce notions that efforts for men's health are not relevant to women's health. The health and social benefits of more equitable relationships between men and women have been extensively documented (Barker *et al.* 2010; Peacock *et al.* 2008; Ricardo *et al.* 2010). For example, when men are respectful towards their partners, share responsibility for disease prevention in relationships, are involved in their children's lives and wellbeing, and do not use violence towards their intimate partners, this benefits the health of men and women (Barker, Ricardo and Nascimento 2007). However, it is limited to primarily obtain perspectives from either men or women in intimate heterosexual relationships to explore the impact of gender relations on health and illness (Bottorff *et al.* 2012). Further research on concepts of ideal masculinities and femininities in health and considerations of what and how gender relations between and among men and women hinder or support health and wellbeing is warranted (Bottorff *et al.* 2012).

6.6 Evidence of effective interventions to promote men's health and wellbeing

In light of the evidence indicating men's vulnerability to certain health issues and related premature mortality, there is an urgent need for more targeted measures that enable boys and men to recognise their risks for poor health and to take increased responsibility for managing their health (White 2011). Gender-sensitive indicators should be used to guide policies, programmes and service delivery, and to monitor the quality of health care for both sexes (Govender and Penn-Kekana 2007; Sen *et al.* 2007; WHO 2003a). To be effective, male involvement activities should seek to address and consider boys' and men's own health needs and concerns as well as the needs of their female partners and children (Davis *et al.* 2012; Muralidharan *et al.* 2014). It is critical to develop skills among health professionals to enable them to understand and apply gender perspectives in their work and best practices to promote men's use of health services (White 2011). Professionals should be encouraged to be aware of and challenge stereotypical notions that discourage men from using health services, such as the notion that men should tolerate their pain or be brave when receiving distressing news about their health (Banks 2004).

Toolkits such as the WHO-Sonke Gender Justice Supplementary Module for health providers on engaging men and boys in achieving gender equality and health equity could be used as the basis for such training (see Box 6.2, below). To address some of the known barriers to men accessing care it has been suggested that healthcare services should open outside normal working hours and hire more male healthcare workers (Holmes 2001; Wilkins 2005). Such efforts should always be introduced and provided in ways that do not undermine existing health services for women, which is why some strategies, such as hosting male-only clinic days, are questionable for their ability to achieve gender equity. Rather, strategies like

providing waiting areas and consultation spaces that men feel comfortable in, or separate spaces for men, are recommended (Muralidharan *et al.* 2014; Raju and Leonard 2000). Outreach services that take some level of primary care to informal venues such as pubs, sports events, workplaces and religious sites have been identified as effective, especially for men who are less likely to use more conventional services (White 2011). For example, some evidence suggests that poorer, ethnic minority men are more likely to participate in health screenings when delivered in a community setting (Loeb 2004). Community delivery of services can undermine barriers between male patients and health professionals, and are also attractive for typically being quick, informal and convenient (Wilkins 2005).

Box 6.2 Gender mainstreaming for health managers: A practical approach

The Department of Gender, Women and Health of the World Health Organization and Sonke Gender Justice Network developed a module to enhance the capacity of WHO staff and national partners including health ministries, development partners and public health stakeholders to implement evidence-informed programmes and policies intended to engage men and boys in achieving gender equality and health equity. Objectives of the manual include: to equip participants to better understand the role of gender in health and public health practice and be familiar with key concepts of gender mainstreaming; to explore how one's own values and stereotypes about men, women, gender and health shape one's lives and work; to promote greater awareness about the need for men to care for their own bodies and health; to examine how gender messages can influence gender relations and health outcomes; to recognise that it can be difficult and dangerous for both men and women to fulfil the gender roles society expects of them; and to provide participants with an understanding of men's health outcomes and how these are shaped by gender norms and practices as well as structural forces such as social exclusion and public sector capacity.

A wealth of literature suggests a positive association between health education programmes and improved health among men, especially those that combine knowledge with skills-building or other health promotion activities (White 2011). A review of 58 health interventions engaging men found that a multi-pronged educational approach including media, workshops for skills-building and critical thinking, and community mobilisation was more likely to change the behaviours of men and boys than single-focus interventions (Barker *et al.* 2010). Norms of masculinity that influence poor health have been effectively challenged through educational programmes using media campaigns and peer education (Colvin *et al.* 2010; Fleming *et al.* 2014; Lynch, Brouard and Visser 2010). Campaigns are more likely to be effective if the messages are tailored to men's values, needs and interests, with relevance to their sociocultural context. Hence, opportunities for men to express their health concerns and barriers to accessing health care are a key component for men's health campaign programmers (Ntshebe, Pitso and Segobye 2012). Campaigns could also appeal to certain notions of culture that would support healthier masculinities, such as personal discipline, responsibility, generosity and caregiving (Morrell 2003; Sideris 2004). Effective educational health efforts should understand and consider how notions of manhood influence men's perceptions of risk of injury and disease (Ratele 2008).

A useful theoretical framework to better understand the influence of norms of masculinity on men's health for health promotion efforts is the health, illness, men and masculinities (HIMM) framework (Evans *et al.* 2011). The authors justify the need for this framework given that the men's health literature tends to oversimplify or neglect how masculinities are related to health and illness, including men's everyday practices. The HIMM framework demonstrates how masculinity and men's health are interconnected, how this changes over time and in relation to particular vulnerabilities among age groups of men, how masculinity and men's health are related to one's social context, and how they intersect with other determinants including socioeconomic status, race, ethnicity, sexuality, ability and employment. Using examples of health risks across men's life course, the framework warrants that social norms of masculinity are the strongest predictors of men's health risk behaviours, and necessitate interventions to be responsive to particular men's health issues or certain groups of men

(Evans *et al.* 2011). Indeed, evidence suggests that men respond better to communication strategies and messages that are tailored to their particular life situation and that adapt to men's different life stages (Davis *et al.* 2012).

It is also imperative to better understand and have concrete strategies to address institutional factors that perpetuate gender norms and behaviours that are harmful to health (Sen *et al.* 2007), such as the alcohol and tobacco industry. In Australia, the government of Victoria implemented a campaign to address cultural factors that contribute to alcohol consumption and risk-taking behaviour, including violence among young men and gender-based violence (Barker *et al.* 2010). The campaign incorporated how gender norms for men and women influence alcohol consumption along with social class and age, and collected data to monitor trends in drinking along these indicators. Programmatic efforts tailored to men's specific motivations and underlying gender norms for alcohol, tobacco and drug use are warranted (Betron *et al.* 2012). Despite the fact that entertainment and marketing regularly equate masculinity with violence and risk-taking, public health advocacy has made limited attempts to undermine such gendered images and media in order to promote health (Snow 2007). More emphasis should be given to the ways in which gender stereotyping harms the health of women and men, and the impact of interventions that offer healthier gender images for men and women should be assessed (Snow 2007). Creating supportive social support for alternative masculinities to be adopted is essential for the greater and sustainable success of programmes that seek to promote health attitude and behaviour change among men (Sideris 2004).

Connell (2006) argued that a main obstacle to promoting behaviour change among men is the belief that some male behaviour cannot be changed, and that men are predisposed to certain behaviours because of genetics, self-interest, socialisation and so forth. Research has shown that promoting a shift in dominant gender norms, as well as more gender-equitable relationships (although it is often a slow and complex process) is particularly effective for health promotion efforts (Barker 2005). Gender transformation approaches attempt to change gender 'biased and discriminatory policies, practices, ideas and beliefs' (Betron *et al.* 2012: 5).

A WHO (Barker *et al.* 2007) review of 57 interventions with men (in the areas of SRH, maternal and child health, gender-based violence, fatherhood and HIV/AIDS) suggested that programmes that are gender-transformative[30] within the education sessions, training with staff, and communication were more likely to change men's attitudes and behaviours than programmes that were gender-sensitive or gender-neutral (Peacock and Barker 2012). Despite successful outcomes, however, this report noted that all reviewed studies were limited to being short-term or pilot programmes (Barker *et al.* 2007). One of the main conclusions of this WHO report was that men must be comprehensively targeted and included in health-related programmes in order to achieve gender equity in health. As Flood (2007: 11) suggests, 'male inclusion [in a gender-transformative way] increases men's responsibility for change and the belief that they too will gain from gender equality'.

There is a need for health policies for men to be integrated into national gender equality and health policies more generally (Sen *et al.* 2007). Brazilian, Irish and Australian governments provide examples of male health-specific national policies, which offer a model for other countries, and an agenda for action to focus attention and improve collaboration (see Box 6.3 below, for details on the Brazilian policy).

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[30] 'Gender-transformative' and 'gender-exploitative approaches stand at opposite ends of a spectrum of programmatic efforts. 'Gender-exploitative' efforts refer to projects that exploit gender inequalities and stereotypes in pursuit of health outcomes. 'Gender-neutral' refers to projects that do not attempt to address gender *per se*. 'Gender-sensitive' refers to projects that accommodate gender differences in pursuit of health and demographic outcomes. 'Gender-transformative' refers to projects that seek to transform gender relations and roles to promote equity as a means to reach health outcomes (Promundo, UNFPA and MenEngage 2010).

Box 6.3 Brazil's Health Ministry

Brazil created a men's health policy in 2009 in dialogue with NGO partners, researchers and various medical associations in responses to data on men's low use of health services and high rates of specific vulnerabilities such as substance use, suicide and prostate cancer. The men's health policy initially focused mostly on promoting vasectomy and prostate cancer prevention. In 2012, the policy expanded its scope to look at key chronic illnesses, how masculinities as commonly constructed contribute to risk-taking behaviour, and analysing missed opportunities to bring men into the health system. One of these missed opportunities is during prenatal visits; national-level data found that 90 per cent of men went to at least one prenatal visit, although no specific programme existed to include men in the prenatal visit. The national health system then created a protocol to encourage men to get a full health exam, including STI testing (HIV and syphilis), prostate exam (if appropriate), blood pressure and so forth, as well as using the space to engage men with information about the birth process. Some participating municipalities in Brazil have started a certification programme to acknowledge clinics and hospitals that are 'father-friendly'. Efforts have also been expanded to look at the specific health needs of young men, men with specific occupational health risks, gay and bisexual men, elderly men and men living with HIV. For further details, see www.saude.gov.br

Routinely monitoring the implementation of policy changes and whether they lead to changing social norms and health outcomes is critical (IGWG 2009). Barker *et al.* (2010) argue that policies engaging men for gender equality should respect and support individual rights, incorporate lessons from evaluated programmes or have a clear hypothesised outcome of a policy based on some evidence, consider how manhood is socially constructed in a particular setting, and account for social exclusion and discrimination. As discussed in Chapter One, 'Introduction: Framing the evidence and shifting social norms', to transform gender norms it is critical to consider how broader societal factors are influenced by policies, and how they interact with individual factors that may respond best to targeted interventions.

6.7 Future priorities for gender health and wellbeing

This chapter has emphasised that a key area of concern is how health policies and programmes can best respond to the ways that social norms, economic and political dynamics condone risk-taking and poor health among men and, in doing so, compromise the health and wellbeing of women and children. Critical to this is ensuring that policies on gender and health at global, regional and national levels include a focus on the specific needs and vulnerabilities of men and women, and gender-relational aspects. It is important to further explore how to develop capacities among health (including public health) professionals to understand and apply gender sensitivity in their care with men and women, as well as to address structural barriers to allow everyone to access health care.

There is little global published evidence on how to improve men's uptake of health services for their own wellbeing and for that of women and children, and more large-scale, systematic evaluations are required to produce greater evidence (Barker *et al.* 2010; Robertson *et al.* 2008). The current stock of knowledge in the area of men's health provides a limited basis for meeting men's needs, and for comprehensively evaluating health interventions that work with men. A more comprehensive account of the social, cultural, historical, economic and political barriers shaping men's health and wellbeing and access of health care is warranted. More also needs to be known about how forms of inequity and structural violence shape men's adoption of health behaviours, perceptions of health and illness, reluctance to seek, delay and/or resist treatment and preventative care, and the availability of healthcare options. Although sex-disaggregated data are increasingly available in the health field, they are not available in all countries (Snow 2007), and it is essential to review sex, gender and vulnerability in all contexts, and how this intersects with other health-influencing factors including race, disability, class, etc.

Much literature supports Courtney's (2000) suggestion that dismissing risks is a crucial means for men to construct their gender. Given that some degree of risk-taking has positive

value, there is a need to assess how risk-taking tendencies could be shifted to avoid harming men and broader society (Snow 2002). Crucially, more evidence is needed that assesses how efforts to improve men's health behaviours and attitudes influence women's health, including men's partners, families and communities, using a gender-relational approach. Sustainability of long-term change with men and whether men's changes in attitude towards gender norms affects their health behaviours and the pathways for this should be more adequately tracked. The lack of government involvement in men's health issues limits opportunities for scaling up and sustaining effective gender-aware and transformative interventions. Muralidharan *et al*. (2014) suggests conducting cost-effectiveness studies to make the case for integrating effective and promising gender-aware strategies in government health programmes. Research that assesses the impact of legal and policy changes on men's health behaviours and attitudes is also warranted. The evidence does encouragingly suggest that poor health consequences resulting from gender inequalities are not static. A broad consensus is currently emerging that changing societal gender norms requires collaboration with and coordination of stakeholders including policymakers, healthcare providers, government, NGOs, and the women's health and rights movement (Barker *et al*. 2010; Wilkins 2005), whereby the common objective of health and wellbeing for all is prioritised.

References

Annadale, E. and Hunt, K. (2000) 'From Gender Inequalities in Health: Research at the Crossroads', in E. Annadale and K. Hunt (eds), *Gender Inequalities and Health*, Philadelphia: Open University Press

Aoun, S. and Johnson, L. (2002) 'Men's Health Promotion by General Practitioners in a Workplace Setting', *The Australian Journal of Rural Health* 10.6: 268–27

Avotri, J.Y. and Walters, V. (2001) '"We Women Worry a Lot about our Husbands": Ghanaian Women Talking About their Health and their Relationships with Men', *Journal of Gender Studies* 10: 197–211

Babirye, J.; Rutebemberwa, E.; Kiguli, J.; Wamani, H.; Nuwaha, F. and Engebretsen, I. (2011) 'More Support for Mothers: A Qualitative Study on Factors Affecting Immunisation Behaviour in Kampala, Uganda', *BMC Public Health* 11: 723

Banks, I. (2004) 'New Models of Providing Men with Health Care', *Journal of Men's Health & Gender* 1.2–3: 155–58

Barker, G. (2005) *Dying to be Men: Youth, Masculinity and Social Exclusion*, London: Routledge

Barker, G.; Greene, M.; Goldstein-Siegel, E.; Nascimento, M.; Segundo, M.; Ricardo, C.; Figueroa, J.G.; Redpath, J.; Morrell, R.; Jewkes, R. *et al*. (2010) *What Men Have to do with it. Policy Policies to Promote Gender Equality*, Washington, DC: International Center for Research on Women

Barker, G., Ricardo, C. and Nascimento, M. (2007) *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence from Program Interventions*, Geneva: WHO

Betron, M.; Barker, G.; Contreras, J. and Peacock, D. (2012) *Men, Masculinities and HIV/AIDS: Strategies for Action*, International Center for Research on Women, Instituto Promundo, Men Engage Alliance, and Sonke Gender Justice Network

Botorff, J.; Oliffe, K.; Robinson, C. and Carey, J. (2011) 'Gender Relations and Health Research: A Review of Current Practices', *International Journal of Equity Health* 10: 60,

www.ncbi.nlm.nih.gov/pmc/articles/PMC3293073/ (accessed 1 June 2015)

Bottorff, J.L.; Oliffe, J.; Kalaw, C.; Carey, J. and Mroz, L. (2006) 'Men's Constructions of Smoking in the Context of Women's Tobacco Reduction during Pregnancy and Postpartum', *Social Science and Medicine* 62: 3096–108

Bottorff, J.L.; Oliffe, J.L.; Kelly, M.T. and Chambers, N. (2012) 'Approaches to Examining Gender Relations in Health Research', in J.L. Oliffe and L. Greaves (eds), *Designing and Conducting Gender, Sex, and Health Research*, Thousand Oaks, CA: Sage

Campbell, C. (1997) 'Migrancy, Masculine Identities and AIDS: The Psychosocial Context of HIV Transmission on the South African Gold Mines', *Social Science & Medicine* 45.2: 273–381

Campo-Engelstein, L. (2013) 'Raging Hormones, Domestic Incompetence, and Contraceptive Indifference: Narratives Contributing to the Perception that Women do not Trust Men to Use Contraception', *Culture, Health & Sexuality* 15.3: 283–95

Colvin, C.; Robins, S. and Leavens, J. (2010) 'Grounding Responsibilisation Talk: Masculinities, Citizenship and HIV in Cape Town, South Africa', *Journal of Development Studies* 46.7: 1179–95

Connell, R. (2006) 'The New Right Triumphant: The Privatization Agenda and Public Education in Australia', in G. Martell (ed.), *Education's Iron Cage*, Toronto: Canadian Centre for Policy Alternatives

Courtenay, W. (2009) 'Behavioural Factors Associated with Disease, Injury, and Death among Men: Evidence and Implications for Prevention', *Journal of Men's Studies* 9.1: 81–129

—— (2000) 'Engendering Health: A Social Constructionist Examination of Men's Health Beliefs and Behaviours', *Psychology of Men and Masculinities* 1.1: 4–15

Crawshaw, P. (2009) 'Critical Perspectives on the Health of Men: Lessons from Medical Sociology', *Critical Public Health* 3/4: 279–85

Croll, E. (2010) 'Amartya Sen's 100 Million Missing Women', *Oxford Development Studies* 29.3: 225–44

Davis, J.; Luchters, S. and Holmes, W. (2012) *Men and Maternal and Newborn Health: Benefits, Harms, Challenges and Potential Strategies for Engaging Men*, Melbourne: Compass: Women's and Children's Health Knowledge Hub

De Visser, R.; Smith, J. and McDonnell, E. (2009) '"That's not Masculine": Masculine Capital and Health-Related Behaviour', *Journal of Health Psychology* 14: 1047–58

Derbyshire, H. (2002) *Gender Manual: A Practical Guide for Development Policy Makers and Practitioners Social Development Division*, London: Department for International Development

Ellsberg, M.; Jansen, H.; Heise, L.; Watts, C. and Garcia-Moreno, C. (2008) 'Intimate Partner Violence and Women's Physical and Mental Health in the WHO Multi-Country Study on Women's Health and Domestic Violence: An Observational Study', *The Lancet*, 371.9619: 1165–72

Evans, J.; Frank, B.; Oliffe, J. and Gregory, D. (2011) 'Health, Illness, Men and Masculinities (HIMM): A Theoretical Framework for Understanding Men and their Health', *Journal of Men's Health* 8.1: 7–15

Fisher, J.; Cabral del Mello, M.; Patel, V.; Rahman, A.; Tran, T.; Holton, S. and Holmes, W. (2012) 'Prevalence and Determinants of Common Perinatal Mental Disorders in Women in Low- and Lower-Middle-income Countries: A Systematic Review', *Bulletin of the World Health Organization* 90.2: 139G–49G

Fleming, P.; Lee, J. and Dworkin, S. (2014) '"Real Men Don't": Constructions of Masculinity and Inadvertent Harm in Public Health Interventions', *American Journal of Public Health* 104.6: 1029–35

Fletcher, R.J. and Higginbotham, N. (2002) 'Men's Perceived Health Needs', *Journal of Health Psychology* 7.3: 233–41

Flood, M. (2007) 'Involving Men in Gender Policy and Practice', *Women for Women International* 5.1: 9–14

Flood, M.; Peacock, D.; Greig, A. and Barker, G. (2010) *Policy Approaches to Involving Men and Boys in Achieving Gender Equality and Health Equity*, Geneva: WHO Press

Gough, B. and Connor, M.T. (2006) 'Barriers to Healthy Eating Among Men: A Qualitative Analysis', *Social Science and Medicine* 62: 387–95

Govender, V. and Penn-Kekana, L. (2007) 'Gender Biases and Discrimination: A Review of Health Care Interpersonal Interactions', *Global Public Health* 1: 90–103

Greene, M.; Mehta, M.; Pulerwitz, J.; Wulf, D.; MBankole, A. and Singh, S. (2004) 'Involving Men in Reproductive Health: Contributions to Development', background paper to the report *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development* Goals, www.unmillenniumproject.org/documents/Greene_et_al-final.pdf (accessed 1 June 2015)

Greenfield, S.F.; Manwani, S.G. and Nargiso, J.E. (2003) 'Epidemiology of Substance Use Disorders in Women', *Obstetrics & Gynecology Clinics of North America* 30: 413–46

Hawkes, S. and Buse, K. (2013) 'Gender and Global Health: Evidence, Policy and Inconvenient Truths', *The Lancet* 381: 1783–87

Hearn, J. (2004) 'From Hegemonic Masculinity to the Hegemony of Men', *Feminist Theory* 5.1: 49–72

Holmes, W. (2001) 'Effective Provision of Antenatal Care', *The Lancet* 358.9285: 928

IGWG (Interagency Gender Working Group) (2009) *Engaging Men for Gender Equality and Improved Reproductive Health*, Washington, DC: IGWG

Jewkes, R.; Sikweyiya, Y.; Morrell, R. and Dunkle, K. (2009) *Understanding Men's Health and Use of Violence: Interface of Rape and HIV in South Africa*, Pretoria, South Africa: Medical Research Council

Kamal, I. (2002) *Field Experiences in Involving Men in Safe Motherhood*, Geneva: WHO

Khumalo, G. (2011) 'South Africa: Health Minister Set to Drive Ban on Alcohol Advertisements', http://allafrica.com/stories/201107201301.html (accessed 30 March 2012)

Kiefer, I.; Rathmanner, T. and Kunze, M. (2005) 'Eating and Dieting Differences in Men and Women', *Journal of Men's Health & Gender* 2.2: 194–201

Loeb, S. (2004) 'Older Men's Health: Motivation, Self-ratings, and Behaviors', *Nursing Research* 53.3: 198–206

Lynch, I.; Brouard, P. and Visser, M. (2010) 'Constructions of Masculinity Among a Group of South African Men Living with HIV/AIDS: Reflections on Resistance and Change', *Culture Health & Sexuality* 12.1: 15–27

Lyons, A.C. (2009) 'Masculinities, Femininities, Behaviour and Health', *Social and Personality Psychology Compass* 3: 394–412

Mahalik, J.R.; Burns, S.M. and Syzdek, M. (2007) 'Masculinity and Perceived Normative Health Behaviours as Predictors of Men's Health Behaviours', *Social Science & Medicine* 64: 2201-09

Marcell, A.V.; Ford, C.A.; Pleck, J.H. and Sonenstein, F.L. (2007) 'Masculine Beliefs, Parental Communication, and Male Adolescents' Health Care Use', *Paediatrics* 119: 966–75

Medrado, B.; Jorge, L.; Mariana, A.; Granja, E. and Vieira, S. (2009) *Princípios, Diretrizes e Recomendações para Uma Atenção Integral aos Homens na Saúde*, Recife, Brazil: Instituto Papai, www.engagingmen.net/files/resources/2010/EME/diretrizes_homens_e_saude.pdf (accessed 26 May 2015)

Mehta, M. (2002) *Communicating with Men to Promote Family Planning: Lessons Learned and Suggestions For Programming*, Geneva: WHO

Moller-Leimkuhler, A.M. (2002) 'Barriers to Help-seeking in Men: A Review of Socio-cultural and Clinical Literature with Particular Reference to Depression', *Journal of Affective Disorders* 71: 1–9

Morrell, R. (2003) 'Politics, Theory and Research: Postcolonial Masculinities and Schooling in South Africa', paper to Congress of the Social Sciences and Humanities, Nova Scotia, Canada, 28 May – 5 June

—— (2001) *Changing Men in Southern Africa: Global Masculinities*, Durban: University of Natal

Muralidharan, A.; Fehringer, J.; Pappa, S.; Rottach, E.; Das, M. and Mandal, M. (2014) *Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries*, Washington DC: Futures Group, Health Policy Project; and Chapel Hill, North Carolina: MEASURE Evaluation

Murray, C. (2014) 'Global, Regional, and National Age–Sex Specific All-Cause and Cause-Specific Mortality for 240 Causes Of Death, 1990–2013: A Systematic Analysis for the Global Burden Of Disease Study 2013', *The Lancet* 6736.14: 61682

Natoli, L.; Holmes, W.; Chanlivong, N.; Chan, G.; and Toole, M. (2012) 'Promoting Safer Sexual Practices among Expectant Fathers in the Lao People's Democratic Republic', *Global Public Health* 7.3: 299–311

Ntshebe, O.; Pitso, J. and Segobye, A. (2012) 'The Use of Culturally Themed HIV Messages and their Implications for Future Behaviour Change Communication Campaigns: The Case of Botswana', *SAHARA J* 3.2: 466–76

Oliffe, J.L.; Kelly, M.T.; Bottorff, J.L.; Johnson, J.L. and Wong, S.T. (2011) '"He's More Typically Female Because He's not Afraid to Cry": Connecting Heterosexual Gender Relations and Men's Depression', *Social Science & Medicine* 73: 775–82

Parslow, R.; Jorm, A.; Christensen, H.; Jacomb, P. and Rodgers, B. (2004) 'Gender Differences in Factors Affecting Use of Health Services: An Analysis of a Community Study of Middle-Aged and Older Australians', *Social Science & Medicine* 59: 2121–29

Peacock, D. (2013) 'South Africa's Sonke Gender Justice Network: Educating Men for Gender Equality', *Agenda* 27.1: 128–40

Peacock, D. and Barker, G. (2012) *Working with Men and Boys to Promote Gender Equality. Expert Group Meeting on the Prevention of Violence Against Women and Girls*, Thailand: UN Women.

Peacock, D.; Redpath, J; Weston, M; Evans, K; Duab, A. and Greig, A. (2008) *Gender, Health and HIV and AIDS in South Africa*, Cape Town: Sonke Gender Justice

Peacock, D.; Stemple, L; Sawires, J; Sharif, D. and Coates, T. (2009) 'Men, HIV/AIDS and Human Rights', *Journal of Acquired Immune Deficiency Syndromes* 51.3: 119–125

Prasanna, S. (2011) *Together, We Can: The Success of the Migende Practice Model for Preventing Parent-To-Child Transmission of HIV in Papua New Guinea*, Bangkok: UNICEF

Promundo, UNFPA and MenEngage (2010) *Engaging Men and Boys in Gender Equality and Health*, New York: UNFPA

Pulerwitz, J.; Michaelis, A.; Verman, A. and Weiss, E. (2010) 'Addressing Gender Dynamics and Engaging Men in HIV Programs: Lessons Learned from Horizons Research', *Public Health Reports* 125.2: 282–92

Raju, S. and Leonard, A. (2000) *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality*, New York: Population Council

Ratele, K. (2008) 'Masculinity and Male Mortality in South Africa', *African Safety Promotion* 6: 19–41

Ricardo, C.; Fonseca, V.; Segundo, M. and Nascimento, M. (2010) *Program H and Program M: Engaging Young Men and Empowering Young Women to Promote Gender Equality and Health*, Washington, DC: Promundo

Robertson, L.; Douglas, F.; Ludbrook, A.; Reid, G. and Van Teijlingen, E. (2008) 'What Works with Men? A Systematic Review of Health Promoting Interventions Targeting Men', *BMC Health Services Research* 8: 141

Rodin, J. (2013) 'Accelerating Action Towards Universal Health Coverage by Applying a Gender Lens', *Bulletin of the World Health Organization* 91: 710–11

Roth, D. and Mbizvo, M. (2001) 'Promoting Safe Motherhood in the Community: The Case for Strategies that Include Men', *African Journal of Reproductive Health* 5.2: 10–21

Schippers, M. (2007) 'Recovering the Feminine Other: Masculinity, Femininity, and Gender Hegemony', *Theoretical Sociology* 36: 85–102

Scott-Samuel, A.; Stanistreet, D. and Crawshaw, P. (2009) 'Hegemonic Masculinities, Structural Violence, and Health Inequalities', *Critical Public Health* 19: 287–92

Sen, G. (2013) *Sexual and Reproductive Health and Rights in the Post-2015 Development Framework*, Bangalore: Centre for Public Policy, Indian Institute of Management

Sen, G.; Östlin, P. and George, A. (2007) 'Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it Exists and How we Can Change It', final report to the WHO Commission on Social Determinants of Health. Women and Gender Equality Network, Geneva: WHO

Sideris, T. (2004) 'Men, Identity and Power: A Case Study of the Re-Invention of "Tradition": Implications for Involving Men in Training and Education about Gender', *Agenda* 18.60: 88–93

Sinha, D (2008) *Empowering Communities to Make Pregnancy Safer: An Intervention in Rural Andhra Pradesh*, New Delhi: Population Council

Smith, J.; White, A.; Richardson, N.; Robertson, S. and Ward, M. (2010) 'The Men's Health Policy Contexts in Australia, the UK and Ireland: Advancement or Abandonment?', *Critical Public Healt*h 3/4: 427–40

Snow, R.C. (2007) *Sex, Gender and Vulnerability*, Michigan, IL: University of Michigan, Population Studies Center, Institute for Social Research

Soares, J.; Macassa, G.; Grossi, G. and Viitasara, E. (2008) 'Psychosocial Correlates of Hopelessness Among Men', *Cogn Behav Ther* 37.1: 50–61

Strebel, A.; Crawford, M.; Shefer, T.; Cloete, A.; Henda, N.; Kaufman, M.; Simbayi, L.; Magome, K. and Kalichman, S. (2006) 'Social Constructions of Gender Roles, Gender-based Violence and HIV/AIDS in Two Communities of the Western Cape, South Africa', *Journal of Social Aspects of HIV/AIDS* 3: 516–28

Tolhurst, R.; Amekudzi, Y.P.; Nyonator, F.K.; Bertel S.S. and Theobald, S. (2007) '"He Will Ask Why the Child Gets Sick So Often": The Gendered Dynamics of Intra-Household Bargaining over Healthcare for Children with Fever in the Volta Region of Ghana', *Social Science & Medicine* 66: 1106–17

US National Institutes of Health (2011) *US National Health Interview Survey 2011*, Toledo, OH: National Center for Health Statistics, Division of Health Interview Statistics

Verma, R. and Collumbien, M. (2005) 'Wife Beating and the Link with Poor Sexual Health and Risk Behaviour Among Men in Urban Slums in India,' *Journal of Comparative Family Studies* 34.1: 61–74

Wadham, B. (2009) 'Men's Health and Men's Rights', www.xyonline.net/content/mens-health-and-mens-rights (accessed 30 December 2014)

Watkins, R.E. and Plant, A.J. (2006) 'Does Smoking Explain Sex Differences in the Global Tuberculosis Epidemic?', *Epidemiology and Infection* 134: 333–39

White, A. (2011) 'The State of Men's Health in Europe', Center for Men's Health, Leeds Metropolitan University, http://ec.europa.eu/health/population_groups/docs/men_health_extended_en.pdf (accessed 03 January 2014)

WHO (World Health Organization) (2013) 'What Do we Mean by Sex and Gender?', Geneva: WHO, Department of Gender, Women and Health, www.who.int/gender/whatisgender/en/ (accessed 22 October 2012)

—— (2012) *Global Burden of Disease Study 2010*, Geneva: WHO

—— (2011) *District Planning Tool for Maternal and Newborn Health Strategy Implementation*, Geneva: WHO

—— (2005) *Preventing Chronic Disease: A Vital Investment*, Geneva: WHO

—— (2003a) *Gender, Health and Aging*, Geneva: WHO

—— (2003b) *Framework on Convention on Tobacco Control*, Geneva: WHO

—— (1948) 'Preamble to the Constitution of the World Health Organization', as adopted by the International Health Conference, New York, 19 June – 22 July 1946, www.who.int/suggestions/faq/en/ (accessed 30November 2005)

Wilkins, D. (2005) '"Getting it Sorted": Identifying and Implementing Practical Solutions to Men's Health', *The Journal of Men's Health & Gender* 2.1: 13–16