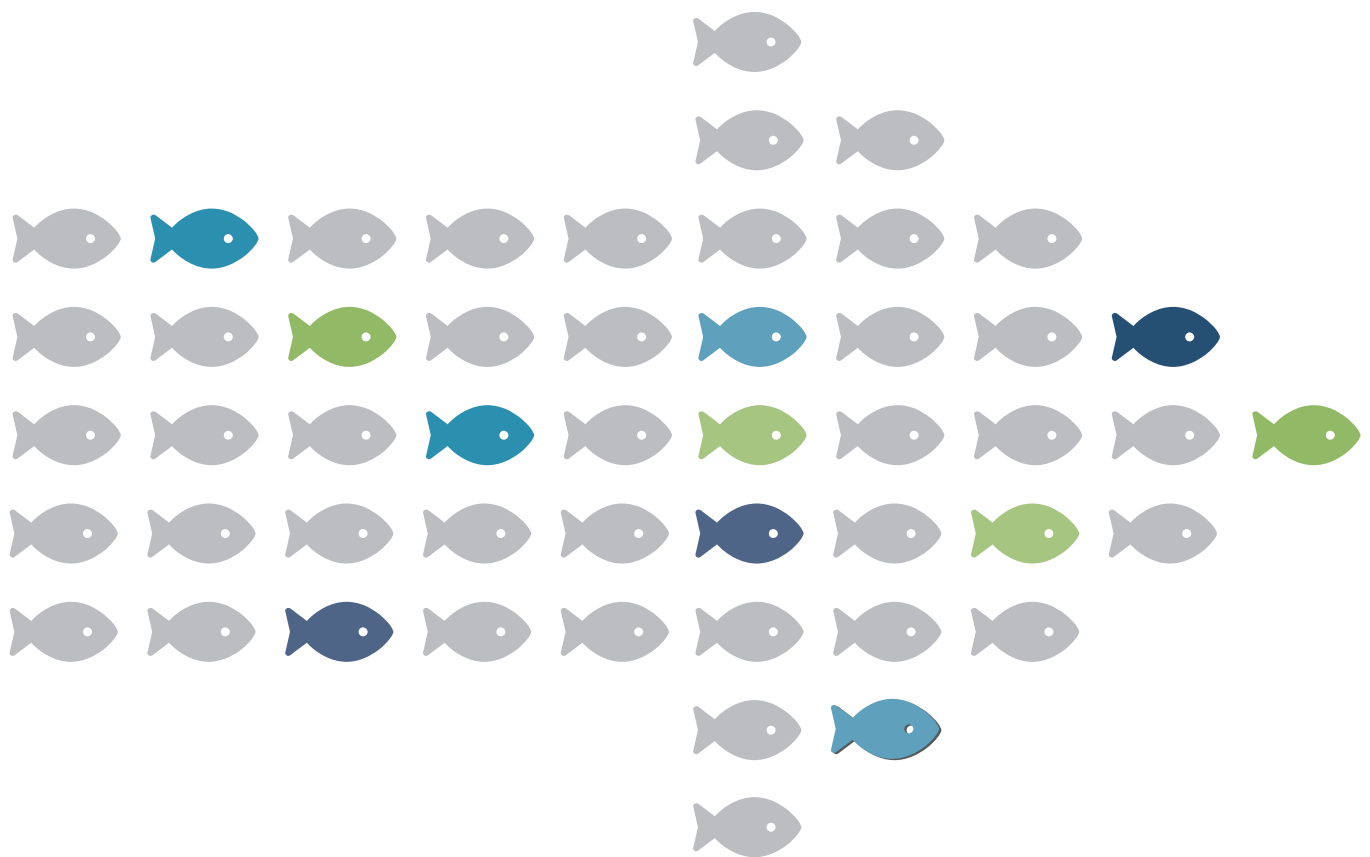




FROM THE MARGINS TO THE MAINSTREAM



Advocating the inclusion
of men's health in policy.
A SCOPING STUDY

GLOBAL ACTION ON MEN'S HEALTH

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

GAMH's mission is to create a world where all men and boys have the opportunity to achieve the best possible health and wellbeing wherever they live and whatever their backgrounds.

Far too many men and boys suffer from health and wellbeing problems that can be prevented. Globally, male life expectancy at birth is just 70 years but poor male health is not recognised or tackled by global health organisations or most national governments.

GAMH wants to see:

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

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

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**GLOBAL ACTION ON
MEN'S HEALTH**

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Needless to say, the contents of this report are solely the responsibility of Global Action on Men’s Health and do not necessarily reflect the views of any of the above organisations or individuals.

METHODOLOGY

A mixed methods research approach was used to prepare this report. The three main research arms were:

- A literature review of English language research, policy reports and other relevant material. Google Scholar was the primary search tool.
- Two online multinational global surveys. The Smart Survey platform was used to conduct:
 - The Men's Health Policy Survey (MHPS) of professionals working in the men's health field. These were primarily from men's health and related public health or advocacy organisations and academic and other research institutions. The survey sample was initially generated from GAMH's mailing list and Google Scholar. Survey recipients were invited to forward the survey to colleagues and it was also promoted via GAMH's Twitter account. The survey was live for a four-week period in January/February 2020 and generated 75 responses from 19 countries. Three quarters (76 per cent) of the responses came from five countries (Australia, Canada, Ireland, UK and USA).
 - The Prostate Cancer Policy Survey (PCPS) of professionals working in the prostate cancer field specifically. These were primarily from patient and professional organisations. The survey sample was initially generated from a Google search of prostate and urology organisations mainly in Europe and North America. Survey recipients were invited to forward the survey to colleagues and it was also promoted via GAMH's Twitter account. The survey was live for a four-week period in January/February 2020 and generated 16 responses from six countries and three international organisations. Just over half (56 per cent) of the responses came from three countries (Spain, UK and USA).
- A series of semi-structured interviews with key informants in a number of countries including men's health and other organisations and advocates, researchers, health policymakers and others. Most of the interviewees had an interest in men's health generally but a sub-set had a particular focus on prostate cancer. A total of 14 interviews were conducted in the period January-March 2020.

ABBREVIATIONS

EC – European Commission

FFIT – Football Fans in Training

GAMH – Global Action on Men's Health

MHPS – Men's Health Policy Survey

NCDs – Non-communicable diseases

PCPS – Prostate Cancer Policy Survey

SDGs – Sustainable Development Goals

UK – United Kingdom

UN – United Nations

UNAIDS – The Joint United Nations Programme on HIV/AIDS

USA – United States of America

WHO – World Health Organisation



Foreword

The COVID-19 pandemic has shone a cruel light on the state of men's health globally. The most recently-available data, which is provisional, shows that in 38 out of 40 countries for which data is available, more men have died than women as a result of the virus.¹ In several countries, about twice as many men as women have died.

This excess mortality burden on men is almost certainly due to a mix of biological, behavioural and structural factors. Men have a weaker immune response to respiratory infections, for example, and they are more likely to drink alcohol at unsafe levels and smoke. They are less likely to wash their hands regularly or seek medical help at the right time.

Crucially, a higher proportion of men have an underlying health condition, such as cardiovascular disease, diabetes or chronic obstructive pulmonary disease, that can significantly increase the risk of serious COVID-19 disease and death. Men who are in low-paid, precarious work or who are from certain ethnic groups are most at risk.

The particular vulnerability of men to COVID-19 is directly linked to the historic neglect of men's health. If men's health had been systematically addressed before the pandemic, especially for men in the most economically and socially disadvantaged groups, the virus would almost certainly have had a less dramatic impact. And there would also have been far fewer cases of the underlying conditions that were already exacting a heavy toll on men's lives – and which will continue to do so once the pandemic has passed.

Many are hoping that something good will come out of the suffering caused by COVID-19. From a men's health perspective, that could be a new understanding of the extent of men's health problems and the need for concerted action to address them at the global, national and local levels.

This action has to start with policy. Drawing on the latest clinical knowledge and the growing body of robust evidence on effective health promotion, new policies can be developed that can stimulate and facilitate the development of new kinds of services, programmes and interventions that improve men's health outcomes, especially for men in the most disadvantaged and at-risk groups.

This report examines the policy response to men's health to date, the barriers to policy development, the currently-available opportunities and, most importantly, the policy priorities and the next steps necessary for their achievement through effective advocacy. The impact of COVID-19 has without doubt made this much more urgent work.

**Peter Daker, Director,
Global Action on Men's Health**



EXECUTIVE SUMMARY

Sex (biology) and gender (behavioural norms) affect everyone's health and the health needs of men and women cannot be fully met unless both factors are taken into account by policymakers and practitioners. Historically, this has generally not been the case.

For men, the consequences of this oversight are clear. Men currently die four years earlier than women, on average at the global level. They are at much greater risk of dying prematurely from any of the four major non-communicable diseases (NCDs). Men are the main users of tobacco and alcohol, being about six times more likely to smoke and consuming over three times as much alcohol.

Over the past 20 years, there has undoubtedly been some progress in developing policies that address men's health at the global, national and local levels. The World Health Organisation (WHO) European Region published a men's health strategy for its 53 member states in 2018. National men's health policies have been introduced in Australia, Brazil, Iran and Ireland. At the local level, the Government of Quebec in Canada has in place a Ministerial Action Plan on Men's Health and Wellbeing. Men's health needs have also been reflected in some specific health policy areas: over 30 countries have now added boys to their national HPV vaccination programmes, for example.

But the overall position remains disheartening: men's health remains generally absent from policies and programmes at all levels. *From the Margins to the Mainstream* takes a forensic look at the role of policy in men's health. As well as identifying the current state of play with men's health policy at the global, national and local levels, it explores the barriers to progress in men's health policy, the opportunities for advocacy work to advance men's health policy and, finally, suggests how policymakers could be more effectively engaged.

This report is based on a literature review, surveys of professionals in the men's health field and interviews with key informants. It includes a case-study on prostate cancer which aims to inform its findings.

It suggests that the key barriers to the inclusion of men's health in policy include:

- Gender is not a priority issue for global health organisations: many have formal strategies about gender but in practice few have prioritised the issue.
- When gender is addressed, it is often assumed to be synonymous

with women. This has led to men's health issues being overlooked, a problem not effectively mitigated by attempts to implement gender mainstreaming or gender equality policies.

- Policymakers have not engaged with men's health issues. This is due to the lack of sex-disaggregated data, the paucity of research into the economic cost of poor men's health, the sheer breadth of the issue, and the indifference of politicians.
- A lack of concern for men's health in global health circles because of their power and privilege in most other areas of public and private life. Discrimination against women is endemic worldwide and many women experience male-perpetrated violence. In the health field, specifically, it is clear that women have generally been overlooked in medical research which has historically regarded men as the prime objects of study.
- Men are perceived to behave irresponsibly. It is commonly believed that men's thoughtless and reckless behaviour results in self-inflicted health problems that could easily be avoided if they took more responsibility for themselves and others.
- Men are seen as a homogenous group. By failing to adopt an 'intersectional approach' (one that looks at the interaction with gender of different dimensions of disadvantage, such as race, sexuality, disability and age), it can seem that all men are equally privileged and powerful and therefore not deserving of attention.
- A lack of a common advocacy agenda among men's health organisations. Men's health organisations now exist in around 10 countries but have diverse foci and lack a clearly-defined set of common advocacy goals.

There are, however, some significant opportunities for policy development, including:

- The existing platform of men's health policies at the international, national and local levels.
- Men's health is a more visible issue, helped by publications like Men's Health magazine, Movember, Men's Health Week and disease-specific awareness-raising campaigns, such as on prostate cancer. There are now a range of academic books and journals with a men's health focus. COVID-19 could also help to focus professional and public attention on men's health because men are much more likely to die following infection by the virus than women.
- Evidence of the very significant cost of male morbidity and mortality. This is as yet limited but it does point to the cost-effectiveness of actions to improve men's health.
- Evidence of the effectiveness of men's health interventions. Robust evidence about how to deliver health services, including health promotion, that meet men's needs effectively is now increasingly available.
- The Sustainable Development Goals (SDGs). It is increasingly

well-understood by the WHO and others that the goal of reducing premature mortality from NCDs would be more quickly achieved if the disproportionate burden of many NCDs on men was reduced.

- The social determinants of health. The role of gender as one of the key determinants is now more widely accepted.
- Men's biological frailty. COVID-19 has focused attention on men's innate vulnerability to a number of serious health problems and, although other factors have a bigger impact on men's health, this could help to dispel the notion that their poor health is simply 'their fault'.
- Human rights-based approaches to health. There is increasing acceptance of the concept that each and every person has an innate right to optimal health.

The primary goals for men's health policy development are identified as:

- State of men's health reports, setting out the evidence at all levels.
- Men's health policies, with effective governance, funding, implementation and monitoring.
- Gender and health policies that include men.
- Men's health included in all appropriate health policies, in areas such as cancer, cardiovascular disease, mental health and diabetes.

A review of prostate cancer policy as a case-study found that this issue, which many believe characterises or is indicative of men's health more broadly, has received significant attention over the past 20-30 years. This reflects its growing incidence, professional controversies (such as about the pros and cons of screening to improve early diagnosis), the work of prostate cancer advocacy organisations and awareness-raising by celebrities.

There have without doubt been significant improvements in care and treatment. But problems remain, including men's lack of knowledge about the condition, gaps in medical practitioner training, delayed diagnoses, inequitable access to the most effective treatments, the low priority given to advanced prostate cancer, the need for more care support for patients and men living with the physical and psychological problems caused by prostate cancer, and the lack of definitive research on prevention.

The insufficient attention given to prostate cancer is attributed to several factors. It has been overlooked because it is a men's health issue and, generally, men's health issues are marginalised. Prostate cancer mainly affects older men who are generally not highly valued. There is a widespread (and false) belief that men are more likely to die with rather than of prostate cancer. The fear, embarrassment and stigma about prostate cancer and its treatments inhibit men with lived experience from publicly advocating change. Advocacy groups have so far not been able to push politicians to take sufficient action. Sharp differences of opinion among clinicians on key issues, not least screening, have also made it

harder for policymakers to formulate strategies.

But there are nevertheless opportunities for policy progress, including a growing clinical consensus about screening, better knowledge about effective care and treatment, the increased profile of men's health generally, and advocacy work by men's health organisations.

The next steps for advocacy on men's health generally should include:

- Collating and presenting the evidence: a report produced by a prestigious research institution and/or a paper in a high-ranking health or medical journal would be ideal.
- Focused demands: these should be developed through an intersectional approach that identifies groups of men who are particularly disadvantaged.
- Policy alignment: men's health policies that are aligned with current health policy priorities are more likely to create traction with policymakers and politicians.
- A focus on gender norms: this is currently emerging as a significant issues in discussions on gender and global health.
- Supporting gender equality: locating men's health within a policy framework that embraces a genuine commitment to gender equality is far more likely to be effective, especially at the global level.
- Building alliances: the case for policy change must engage the widest possible group of stakeholders, including clinicians, public health experts, politicians, civil society organisations and policymakers.
- Monitoring and evaluating progress: developing a system for assessing whether health policy is embracing men's health and, if so, the extent to which this is impacting on outcomes.
- Taking a long-term perspective: significant change is likely to be achieved incrementally and therefore slowly.



INTRODUCTION

Sex and gender affect everyone's health. Some of the impacts are obvious, others less so.

Clearly, only those who are biologically male can be affected by prostate or testicular diseases. It is also possible that the XY sex chromosome affects men's immune systems making them susceptible to a range of respiratory diseases², including COVID-19³. On top of these physiological factors, the gender norms men are expected to follow lead many to take risks with their health, such as drinking too heavily and smoking, and to delay seeking medical help.

Assumptions about men, based on gender norms, can also affect how health and other services are provided. For example, the belief that eating disorders are a 'women's issue' has led to men with these disorders (possibly up to a quarter of the total number in the USA) being overlooked in research, the development of appropriate treatments and service provision.⁴

The global consequences for men's health* include:⁵

- Boys born in 2016 can expect to live about 70 years on average with 62 of those years in good health. By comparison, girls can expect to live for 74 years with 65 years in good health.
- In 2016, a 30-year old man had a 150 per cent greater risk of dying from any of the four major non-communicable diseases (NCDs) before the age of 70 than women.
- Men were more than five times more likely to smoke tobacco in 2016 than women and, on average, they consumed the equivalent of over three times as many litres of pure alcohol as women.

The health needs of men – and those of women - cannot be fully met unless sex and gender are acknowledged and acted on by policymakers and practitioners. Historically, these issues have been neglected but, fortunately, there are now some signs of change. The World Health Organisation (WHO) and other health bodies are at last beginning to recognise that health systems must become more responsive to gender.

There is also a greater understanding that policies that explicitly take account of men's health are an important first step towards the design, implementation and delivery of programmes and services that lead to better health outcomes.^{6,7} The evidence from Australia, Brazil and Ireland about the value of national men's health policies is particularly compelling.⁸

* Throughout this report, the term 'men's health' is used as shorthand for 'the health and wellbeing of men and boys'.

From the Margins to the Mainstream provides a more forensic focus on the role of policy in men's health. In particular, it identifies:

- The current state of men's health policy, primarily at the global level but also at national and local levels.
- The barriers to progress in men's health policy.
- Opportunities for advocacy work to advance men's health policy.
- Ways in which policymakers could be more effectively engaged.

The report will be used for the development of an advocacy campaign by Global Action on Men's Health (GAMH), and hopefully others, to make policymakers and key influencers more aware of the need for action on men's health and to obtain specific policy commitments.

While the report is global in scope, its focus is on those regions and countries for which most information is available (primarily Europe, North America and Australia). The report includes a case-study with a focus on prostate cancer.



MEN'S HEALTH POLICY: AN OVERVIEW

Over the past 20 years, there has undoubtedly been some progress at the local, national and international levels in the development of policies that address men's health. This is the view of both MHPS respondents (see findings below) and this study's key informants. A majority of those working in the men's health field are no longer claiming, as men's health advocates once did⁹, that their issue is conspicuous by its complete or near-complete absence from policy. Some of the key developments are summarised in this chapter.

The Men's Health Policy Survey: Key Findings

- 63 per cent of respondents *Agreed* or *Strongly Agreed* that men's health has a generally higher policy profile in 2020 than in 2000.
- 73 per cent *Agreed* or *Strongly Agreed* that the policy profile of men's health had increased at the national level. 67 per cent believed progress had been made at the global level. 57 per cent detected an increase in profile at the local level.
- 22 per cent *Disagreed* or *Strongly Disagreed* that men's health has a higher profile in 2020.
- 67 per cent considered the way the health and wellbeing of men and boys is currently treated as a policy issue is either *Unsatisfactory* or *Very Unsatisfactory*. The responses were broadly similar for the local (68 per cent), national (68 per cent) and global levels (65 per cent).
- A majority felt that the way men's issues were dealt with in mental health policies at all levels was *Very Unsatisfactory* or *Unsatisfactory*. A minority believed that the way men's issues were dealt with in cancer, cardiovascular disease or diabetes at all levels was *Satisfactory* or *Very Satisfactory*.
- Most respondents considered that policy initiatives are needed: 74 per cent at the local level, 73 per cent at the national, and 68 per cent at the global.
- The three main barriers to the inclusion of men's health in policy at all levels were thought to be:

- A lack of awareness and knowledge by policymakers about men's health issues
- A lack of political will to push men's health issues into policy
- A belief that men are the dominant sex and already benefit from an inequitable share of power and resources.
- The main opportunity for the inclusion of men's health in policy at all levels was thought to be the evidence now available about how to improve men's health outcomes.
- At the national and global levels, the UN's Sustainable Development Goals (SDGs) and their focus on non-communicable diseases and the WHO Europe men's health strategy were also thought to provide good opportunities. At the local levels, Movember and Men's Health Week were identified.
- The four main policy initiatives identified as required at all levels were:
 - A state of men's health report
 - A men's health policy
 - A gender and health policy that includes men
 - Men's health included in all appropriate health policies.

Key Policy Developments in Men's Health 1: GLOBAL

A men's health strategy was agreed by the 53 member states of the **WHO European Region** in 2018.¹⁰ The strategy, which complements a women's health strategy adopted in 2016, recognises that many men's health outcomes are unacceptably poor and linked to gender norms that encourage risky behaviours. The strategy also aims to help the European region achieve the UN's Sustainable Development Goals (SDGs), in particular SDG 3 on good health and wellbeing, SDG 5 on gender equality and SDG 10 on reducing inequalities. The strategy is based on a non-medicalised and social determinants approach (it looks at the 'causes of the causes' of men's health problems), explores issues of intersectionality (looking at race, sexuality and socioeconomic status as well as gender), and calls for a 'systems-wide' rather than an exclusively health service response. No information is as yet available about the impact of the strategy.

There have been other international developments which, while they do not constitute policy, are nevertheless significant because they have the potential to inform future policy development. In 2019, for example, the WHO region for the Americas (**PAHO – the Pan American Health Organisation**) published a major report on masculinities and health.¹¹ One of the recommendations called for the development of public policies and care programmes for the comprehensive prevention of the most important problems affecting men during the life-course. PAHO has also published guidance for its member states on gender and COVID-19 which recommends consideration of 'the ways in which COVID-19 risk factors disproportionately affect men due to co-morbidities and access to health

services that are related to constructions of masculinities.¹²

At the global level, the WHO has begun to publish more data disaggregated by sex, to pay more attention to the impact of gender norms on health, and to call for a gendered policy approach. **The World Health Statistics 2019** report concludes with the suggestion that action should be taken to make health systems responsive to gender:¹³

Health planning needs to allow for the different needs of men and women, regarding exposure to risk factors, barriers to access and use of services and health outcomes. In many circumstances, men experience poorer health outcomes than women do. Although some of these poorer health outcomes may have a biological basis, they may be amplified by gender roles. Gender analysis and health policies should consider women, men and gender-diverse population groups, to ensure equitable health outcomes.

A WHO report on **Universal Health Coverage** (UHC) includes a similar call:¹⁴

In the 2030 Sustainable Development Agenda, UN Member States pledged to ‘leave no one behind.’ For health systems that means that countries should prepare inclusive and gender-responsive national health strategies that consider wider dimensions of inequality, such as wealth, ethnicity, education, geographic location and sociocultural factors and implement them within a human rights framework. Countries must consider the inequities and disparities within and across groups and geographic areas in accessing health care, learn how gender norms and unequal power relations impede access and identify the key barriers to access for women, men, and lesbian, gay, bisexual, transgender and intersex populations.

Key Policy Developments in Men’s Health 2: NATIONAL

National men’s health policies have been introduced in four countries to date: **Australia, Brazil, Iran** and **Ireland**. The Irish policy, which in its first version, ran from 2008-13¹⁵ was independently reviewed in 2015¹⁶ and subsequently re-launched for a further five-year period (2017-2021).¹⁷ The Australian policy followed a similar path: it was first published in 2010 and then revised and reissued in 2019 for the period 2020-2030.¹⁸ Brazil’s policy was published in 2009.¹⁹ There is limited information available about Iran’s men’s health policy but it is believed to have been introduced in the Iranian year starting in March 2019.²⁰

A Men’s Health Act was passed in Costa Rica in 2013.²¹ This proposed the formulation of a National Men’s Health Policy but it is not clear whether this has been published. A national men’s health policy has recently been under development in Austria but its progress has been delayed by a change of government and no publication date has been scheduled.

An analysis of the policies in Australia, Brazil, Iran and Ireland found they had some common threads.²² They seek to promote optimum health and well-being for men, with a particular focus on health equity between

population groups of men. They are integrated with existing policy, adopt a social determinants approach, work from a strengths-based perspective, and support men to take increased responsibility for their own health.

Despite problems with implementation in Australia, Brazil and Ireland, the analysis concluded that national men's health policies have been important in identifying men's health as a priority area, providing a framework for action and acting as a catalyst for an increased range and number of men's health activities.

Key Policy Developments in Men's Health 3: LOCAL

In 2017, the **Government of Quebec** published a Ministerial Action Plan on Men's Health and Wellbeing for the period 2017-2022.²³ It focuses to the development of promotion and prevention strategies and adapting services to improve access and better meet the needs of men. It also aims to improve understanding of men's experiences, attitudes and practices through a research programme.

In the UK, a health improvement programme for men was adopted in 2000 by a local health authority (**Worcestershire**), although this was relatively short-lived.²⁴ More recently, **Leeds City Council** commissioned a comprehensive report into the state of men's health locally²⁵ which has led not to a specific men's health policy but to several significant policy developments. The council has started setting targets for reaching men and tailoring support so that has a greater chance of engaging them; it has also invested in civil society organisations that work with men, for example by running health promotion sessions at rugby and soccer matches as well as men-only swimming sessions and walking soccer.²⁶ A local charity has additionally been funded to develop a suicide prevention project, Manbassadors, which reaches out to isolated men via a network of local businesses.

There are two Australian states with active men's health policies: **New South Wales** and **Western Australia**. The NSW Men's Health Framework, published in 2018, aims to encourage a holistic view of men's health and wellbeing, achieve health equity among and between groups of men, empower men to play an active role in their health (especially preventive health) and promote improved access and engagement in health services and programmes for all men.²⁷ The Western Australian Men's Health and Wellbeing Policy was published in 2019.²⁸ This is organised around three main goals: empowering men to be proactive in managing their health and wellbeing, men having equitable access to services, and monitoring and evaluating men's health and wellbeing needs to inform continual improvements in programmes, services and initiatives. The states of **Victoria**²⁹ and **South Australia** also published men's health policies for 2010-14 and 2008-12 respectively.

The **Tennessee** Men's Health Report Card has been developed over the past 10 years to collate and publish data, consider its implications and highlight policy and programmatic initiatives that can improve men's

health in this US state. The Report Card, which has been published four times to date (in 2010, 2012, 2014 and 2017), is produced by Vanderbilt University in partnership with the Tennessee Department of Health, Meharry Medical College and the Tennessee Men's Health Network. A review of the impact of the Report Card has suggested that it constitutes an important model for other states and a blueprint for a national men's health report.³⁰

Key Policy Developments in Men's Health 4: SPECIFIC POLICIES

Men's health needs have been addressed in several specific health policy areas. In the last five years or so, for example, an increasing number of countries have added boys to their national **human papillomavirus (HPV) vaccination programmes**.³¹ This follows growing scientific evidence that HPV can cause a wide range of cancers – penile in men, vaginal and vulval as well as cervical in women, and anal, head, neck in both sexes – and also genital warts in both men and women. Over 30 countries have now adopted universal (also known as 'gender-neutral') vaccination policies and programmes.

UNAIDS has examined the changes in policy and practice that are needed to improve **men's use of HIV and other health services**. Its report, *Blind Spot*, suggested that, despite their many social and economic advantages, men are less likely than women to seek out health care, to take an HIV test or to initiate and adhere to HIV treatment.³² The report calls for revised health and HIV strategies and policies that address gaps and disparities in access to and use of services, whether for men and boys or women and girls.

The UK government's **suicide prevention** strategy for England recognises that men are disproportionately at risk of suicide, especially young, middle-aged and gay men.³³ The strategy sets out a range of interventions believed to be effective for men – such as engagement at community locations rather than at formal health settings – and some of the resources available to support work with men.

Overall, however, the position remains disheartening. At the global level, men's health remains generally absent from policies and programmes.³⁴ One study has suggested that the global health community has either ignored the evidence on gender and health or 'selectively [chosen] to focus on the health needs of only some of population (usually women and girls)'.³⁵ Another commentary states that:³⁶

Global health promotion advocacy, research, policy and practice efforts addressing the nexus between equity, gender and health have typically focused on women and children's health ... The World Health Organisation has occasionally embraced commentary about men and boys; however, this has usually sat at the periphery of gender equity discussions.

A study by the Global Health 50/50 initiative, based at the University College London Centre for Gender and Global Health, reviewed the policies of a large number of organisations with an interest and influence in global health (OGHs) and found that the health needs of women and girls received more attention than the health needs of men and boys.³⁷

There are no known examples (as far as we are aware) of national (or global) health policies that address gender as an issue for all people. Health programmes at global, national and subnational levels frequently respond to the health needs of women and girls (and may even apply a gender lens in responding to their needs) but in our review of 140 OGHs, we were unable to find a single global health NGO working in at least three countries and focusing only on the health of men and boys.

A review of the policies and programmes of 11 of the world's most influential global health organisations, including WHO, found that they did not address the health needs of men.³⁸ A complementary study of 18 Global Public Private Partnerships for Health (e.g. GAVI, Global Road Safety Partnership and TB Alliance) came to similar conclusions.³⁹

An assessment of the World Bank's gender policies and its financing for gender programmes in the context of global health found that it had given little emphasis to the needs of males.⁴⁰ The UN's Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) overlooked boys.⁴¹

The overwhelming majority of individual countries, or local areas within them, have also not addressed men's health as a specific issue. Growing recognition of the health gap among men and boys has for the most part not been translated into national policy; in most countries, men's health is not recognized by governments as an issue of concern.⁴²

The European Commission (EC) published a major report on the state of men's health in 2011.⁴³ This revealed, for example, that each year over twice as many men of working age (15-64 years) die compared to women. But the EC did not follow up the report with any policy proposals despite its lead author's calls for a strategic response.⁴⁴

An analysis of 35 national health policies in WHO European Region Member states found that the word 'gender' appeared in only about half of the documents (and was not always used accurately), only two policies referred to the need for health services with a gender focus, and the term 'men's health' appeared just once in all of the documents reviewed.⁴⁵ A detailed policy analysis of gender and coronary artery disease in European Union countries found little mention of men's increased risk or prevention strategies for men specifically.⁴⁶ A review of national policies on health, HIV, sexual and reproductive health and mental health in 14 countries in eastern and southern Africa commissioned by UNAIDS and the WHO found that the health of men and boys was well addressed in the health policy of just one country, Swaziland.⁴⁷



BARRIERS TO MEN'S HEALTH POLICY INCLUSION

Before men's health policy can be more effectively advocated, it is necessary to understand the barriers that are currently in the way of its inclusion.

A number of key barriers were identified by the MHPS respondents, key informants and the literature review.

Gender is not a priority issue for global health organisations

Although many global health organisations have adopted formal strategies to integrate gender into their programming, few have prioritised the issue in practice.⁴⁸ Work on gender is insufficiently funded, gender experts are often not employed as dedicated core staff but instead as external consultants (or responsibility for gender is allocated to someone already working full-time on other issues), gender is either not addressed in a meaningful way or the focus is on process rather than outcomes, and programme implementation is poorly monitored.

There are several underlying reasons for this neglect of gender:

Few global health organisations consider gender systematically in their policy-making and programming. They are impeded by their organisational cultures, political environments and characteristics of the issue. Among the barriers are entrenched, patriarchal practices; lack of training of professionals in these organisations to value gender analysis; conservative governments that view gender equality as a Western imposition; fear by government and global health officials that addressing gender will upset existing power relations; a conflation of gender with a concern for women and girls; and the complexity of the concept. Other barriers concern the proponents themselves: the absence of a cohesive community; differences among them on the nature of the problem and solutions, including which health issues to prioritize; and divergence on how to position the issue, particularly

surrounding the use of instrumentalist, economics-oriented arguments.

In this context, it is perhaps not surprising that men's health issues have generally been overlooked.

Policymakers' lack of engagement with men's health issues

Men's health is not yet on the radar of most policymakers. This has been very clear in the global response to HIV/AIDS. 25 per cent of men with HIV are unaware of their status, 45 per cent of men with HIV are not receiving anti-retroviral treatment and 53 per cent do not have a suppressed viral load.⁴⁹ Despite this, men lack entry points to health services, a problem which is compounded by a lack of extended opening hours and facility-based healthcare which hinders access to men who work outside their communities during the day. In most countries, however, men are still largely missing from public health policies and strategies on HIV/AIDS. There is a similar picture for men with tuberculosis.⁵⁰

The policy response to the COVID-19 pandemic has also overlooked men. Even though men are much more likely to become seriously ill and to die, policy has been essentially gender-neutral at global and national levels.⁵¹ Men may have biological traits that make them more vulnerable than women post-infection – a weaker immune response, for example – but this should mean that every effort is made to reduce their risk of infection. Gender-sensitive health messaging on the importance of handwashing and physical distancing could help, for example. It would also be valuable to emphasise the need to seek medical help at the right time.

A lack of available sex-disaggregated data or gender analyses is a significant barrier to policymaking. An analysis of the extent to which sex-related research and reporting occurs in scientific publications looked at about 11.5 million papers.⁵² It found that, in 2016, just 54 per cent of public health studies and only 43 per cent of clinical medicine studies reported on both female and male populations. Biomedical research lagged even further behind with only 30 per cent of papers reporting on sex. Such data is currently available at the global level for just 39 per cent of the SDG indicators.⁵³

Policy- and decision-makers in public health often come from medical or other backgrounds (such as economics) for which there is little if any training or professional development in gender issues.⁵⁴ They tend to focus on clinical or 'quick fix' solutions (eg. food distribution in areas of famine) rather than longer-term and more complex interventions that take account of gender and other social determinants of health.

There has been very little research into the economic cost of poor men's health and the savings that might accrue from actions taken to improve it. Health economics have generally been neglected by researchers and advocates in the men's health field – their case for action has generally been based on ethics and equity – but this has meant that one key policy driver has been overlooked.⁵⁵

The sheer breadth of the issue may also be a barrier to action. Health policy mostly aims to address specific diseases (eg. cancer, diabetes), risk factors (eg. smoking, alcohol use), or services (eg. primary or secondary care). An issue, such as gender or men's health specifically, that cuts across potentially almost every other area of policy can seem like too big a challenge. Also, once an issue becomes the responsibility of many actors across different policy domains, it risks being the responsibility of none.⁵⁶

The lack of interest in men's health shown by politicians in particular also helps to explain why policymakers have not engaged with the issue. The reasons for this have not been properly explored but are likely to be related to a lack of grassroots pressure from individual citizens as well as from health organisations.

Citizens care most about access to healthcare and its cost as well as specific conditions.⁵⁷ Few are likely to identify 'men's health' as a particular issue of concern and one that they would wish to raise with their political representatives. Men generally do not consciously see themselves as being part of social group (men) with a shared identity, experiences, needs and goals in respect of health or other issues. Their experience in this respect is very different from women's and reflects their lack of experience of disadvantage or discrimination as men.

Men's health organisations are, generally, small and have limited political clout. They are mostly if not entirely professionally led and managed and 'user' involvement is limited. The largest men's health organisation, Movember, funds research and runs awareness campaigns but, to date at least, has not undertaken advocacy work. The electoral risks run by politicians by ignoring men's health issues appear to be small.

Finally, it may seem paradoxical that men's health has received relatively little attention even though most senior politicians and the heads of global health organisations are men. One might expect men with power and privilege, perhaps especially populist and misogynistic politicians, to take action to protect men in general from the burden of ill-health. There is no known evidence on this issue but it can be hypothesised that powerful men, who can reasonably expect to live relatively long and healthy lives themselves, do not identify with other men, especially those in the most socially disadvantaged groups who have much poorer health outcomes. It might also be that those men who are the main beneficiaries of male power and privilege are likely to be unwilling to take action that potentially challenges the male gender norms that underpin their dominance and the identities of men in general.

An assumption that gender is synonymous with women

There is a common assumption in the public health field that gender is synonymous with women and girls.⁵⁸ Academic and policy discussions about gender and health are frequently just or mostly about women's issues. This may be because many of those working in this field are primarily interested in gender equality – an issue that inevitably, and rightly, focuses on ending discrimination against women. There are few, if any,

aspects of men's domestic or working lives where men can legitimately claim they face systematic discrimination because they are men. But a continuing focus on women alone means that opportunities to address areas where men fare badly, to transform harmful gender norms and to improve everyone's health and wellbeing are being missed.

The 'gender equals women' paradigm has not been significantly changed by the development of 'gender mainstreaming'. This means assessing the implications for both men and women of any planned action (such as legislation, policies or programmes) so that both sexes benefit equally and that inequalities are not perpetuated.⁵⁹ The gender mainstreaming approach has been criticised for its focus on women rather than men and women, being under-resourced, becoming largely a process-oriented box-ticking exercise, and not addressing gender norms.

At least one country, the UK, has attempted to use legislation to achieve greater equality for both sexes. The gender equality duty introduced by the Equality Act 2006 required all public bodies (including health bodies) to take gender into account when planning and delivering local and national services. In effect, health organisations were expected to work towards the achievement of more equitable use of services and more equal health outcomes between men and women.⁶⁰ The legislation was a bold attempt to bring about a cultural change that would put the recognition of gender at the heart of policymaking and service provision across the public sector.

At the time, many in the UK men's health field believed that the gender equality duty had the potential to transform the way men's health was addressed.⁶¹ It was argued that the health service could no longer ignore men's health or treat it simply as if it is an 'interesting' or even 'ethical' thing to do; it now had to be addressed because there was a clear legal requirement. However, in practice, national policy changes appeared to have little impact locally. Both compliance and enforcement were poor and, where there was activity, its focus tended to be on internal administration and process, not on how to achieve equitable outcomes between men and women.

A lack of concern for men

In almost all areas of public and private life, men are the dominant sex and benefit from an inequitable share of power and resources. Globally, women are paid less than men, are less likely to be in leadership positions, and bear a disproportionate responsibility for unpaid care and domestic work.⁶² It is also well established that, for certain cohorts of the male population, this dominance manifests as violence and abuse towards women. For example, it is estimated that 35 per cent of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner at some point in their lives.⁶³ Sixty five per cent of women in some parts of sub-Saharan Africa, and around 40 per cent of women in South Asia, as well as Andean parts of Latin America have experienced partner violence.⁶⁴

The #MeToo movement has, very successfully and quite rightly, focused

attention on many men's sexually abusive behaviour towards women. At the same time, there has been concern about mass shootings and white nationalist and Islamist terrorism, overwhelmingly perpetrated by men. This has sparked much popular discussion about the notion of 'toxic masculinity' which in many cases has gone well beyond describing specific harmful aspects of masculinity and instead implied that masculinity in every aspect is dangerous and unacceptable.

Furthermore, a disproportionate focus by men's health advocates on sex differences in health outcomes can be construed as implying that women's health problems are of less significance than men's, that men are somehow the 'real victims', that there is a binary choice to be made between men's health and women's health in some sort of zero sum game, or that the goal should be simply to raise men's outcomes to the level of women's.^{65,66} Over-emphasising sex differences obscures the fact that both men and women face a wide range of health problems and that an approach that takes account of sex and gender would be beneficial for everyone. And, of course, a simple focus on sex differences also ignores the health issues of nonbinary individuals.

Women have been overlooked in much medical research which has tended to focus on men as the norm. The failure to study women has had serious health consequences. In the field of cardiovascular disease, for example, it has led to an underestimation of cardiac risk in women; the misinterpretation of symptoms of coronary heart disease in women has led to less referral for cardiac testing and specialty care.⁶⁷ Women are also less likely to be referred for cardiac catheterization during acute coronary syndromes and less likely to receive percutaneous ('by way of the skin') intervention.

In this context, it is perhaps unsurprising that there may be a lack of sympathy in global health circles for men who experience poor health and also a concern that the expansion of efforts to engage men will draw funding and political space away from hard-won efforts to improve women's rights and empowerment.⁶⁸ This barrier is probably most salient in low- and middle-income countries with high morbidity and mortality rates and where gender inequalities are greatest. It also exists at the global policy level because these countries are the focus of much of the work of international public health agencies. It has also made it harder for men's and women's health organisations to work together.

Men are perceived to behave irresponsibly

It is commonly believed that men's thoughtless and reckless behaviour results in self-inflicted health problems that could easily be avoided if they took more responsibility for themselves and others. This view was evident in an article in a popular UK newspaper on men's vulnerability to COVID-19 which effectively blamed them for the health behaviours – 'booze, fags and drugs' – that lead to the underlying conditions that in turn result in poorer outcomes.⁶⁹ The popular discourse about 'man flu' – which implies that many men exaggerate relatively minor symptoms to elicit sympathy – reflects a similarly negative view of men and their health problems.

Men are seen as a homogenous group

When men's health is considered, it is often assumed that they constitute a homogenous group. This assumption is reinforced by the fact that 'men's health' is a very broad and undifferentiated concept and because men's health is almost invariably compared to women's health in very general terms (eg. male life expectancy is, globally, four years lower than women's). But, of course, men are not all the same whether at the local, national or global level.⁷⁰ There are important differences and inequalities within the category of 'men', including those related to income, race, age, sexuality and disability. A failure to adopt an 'intersectional' approach (one that looks at the interaction of different dimensions of disadvantage with gender), can make it seem that all men are equally privileged and powerful and therefore not deserving of attention.

The lack of a common advocacy agenda by men's health organisations

Men's health organisations, or organisations with a wider focus but which also work with men on health issues, have grown and developed around the world over the past 25 years and now exist in some 10 countries. However, they have diverse foci: some emphasise the importance of individual behaviour change by men, for example, while others pay greater attention to changing policy and the way services are delivered.

A number of organisations focus on specific issues (eg. prostate cancer or mental health) or have a medical/clinical focus while others have a greater interest in the social determinants of health. Some prefer to emphasise men's 'strengths' in addressing health issues while others tend to view male gender norms and men's health behaviours as essentially problematic and work explicitly to transform the norms that are seen as implicit in violence against women or which are damaging to women's sexual and reproductive health.

Most men's health organisations aim to be supportive of women's health. However, there are also some 'men's rights' organisations whose activities are damaging and divisive. They tend to have an explicitly anti-feminist agenda and to see health as a field in which men are actively discriminated against.

While there is undoubtedly merit in this diversity of activities (men's rights groups aside), the failure to align on a common agenda has made the efforts less helpful from a policy development and advocacy perspective. It is probable that men's health organisations would have a greater impact on policy at all levels if they shared a more clearly-defined set of common goals and were able to allocate greater resources to advocacy.



OPPORTUNITIES FOR POLICY DEVELOPMENT

The existing men's health policy platform

This report has already described some of the previous and current men's health policy initiatives at the international, national and local levels as well as in specific policy areas such as HPV vaccination and suicide. This body of work is far from sufficient but it is also far from insignificant. It provides a platform on which further policy work can be developed and implemented.

Men's health is a more visible issue

It is not possible to accurately measure the visibility of men's health in public and professional domains. However, there is considerable anecdotal evidence that its profile has increased in both over the past 25 years.

Men's Health magazine publishes 35 editions across 59 countries and reaches 71 million readers worldwide.⁷¹ The magazine's view of men's health may not be well-aligned with that of most professionals and advocates working in the field but its presence almost certainly helps to normalise the term and to disseminate some useful information about action individual men can take to improve their lifestyles.

Also operating internationally, in 20 countries, Movember has over 300,000 active participants ('Mo Bros and Mo Sistas') and has raised AUD 87m for over 1,200 men's health projects.⁷² The Foundation also attracts significant media attention during its annual fundraising campaign each November.

Men's Health Week is another important international event. It began in the USA in 1994 following a Senate Joint Resolution to establish the Week by Senator Bob Dole which was then signed by President Bill Clinton. The Week was linked to Father's Day in the USA (the Week always ends on that Day, the third Sunday in June) and it became an international event in 2002 when it was first marked in the UK. It has since been adopted in Australia, Canada, Denmark, Ireland, New Zealand and elsewhere. The Week provides an opportunity for a wide range of organizations and individuals to draw attention to the poor state of men's health, organize activities that engage men, and advocate changes to health policy and practice.

There are also awareness-raising events in several countries that focus on specific men's health issues. For example, National Prostate Health Month is observed in September in the USA and Australia and in March in the UK. Testicular Cancer Month takes place in April, although it has a relatively low profile. Men's mental health has also received increased attention; in the UK, for example, Prince William, the Queen's grandson, appeared on a BBC television programme in 2019 discussing men's mental health with a group of well-known soccer players.⁷³ In Canada, the HeadsUpGuys website provides free information, practical tips and guidance aimed specifically at men about managing and recovering from depression; launched in 2015, it has received over 600,000 visits to the site and more than 80,000 self-checks have been completed.⁷⁴

Although it perhaps too soon to be certain of its long-term impact, the COVID-19 pandemic has focused public and professional attention on men's health. There has been considerable discussion in both the mainstream⁷⁵ and specialist media⁷⁶ about men's greater risk of developing and dying from serious COVID-19 disease and what might be the reasons for this. Attention has so far focussed on a mix of biological and behavioural factors such as immune response, smoking and lower rates of handwashing and help-seeking.

The increasing visibility of men's health in professional circles is reflected in the range of journal papers now being published on a regular basis. There are several specialist publications – *The International Journal of Men's Social and Community Health*, *The American Journal of Men's Health*, *The Journal of Men's Health* and *Trends in Urology and Men's Health* – and the subject is covered in a range of other more general journals. A search of the Google Scholar database on the subject of 'men's health' shows 1,040 entries for 2000, increasing to 2,760 for 2019. A search using the same term over the same time period on PubMed showed an increase from 25 to 362. These are crude statistics and, although the recent numbers are still relatively small, they are indicative of the rising level of research and publication in the field.

Evidence of the cost-effectiveness of improving men's health

There is a small but expanding evidence base that strongly suggests that poor men's health is expensive. A Canadian analysis showed that because middle-aged Canadian males are more likely to smoke tobacco (26 per cent v. 20 per cent), consume hazardous or harmful levels of alcohol (15 per cent v. 8 per cent), and have excess weight (66 per cent v. 47 per cent) than middle-aged Canadian females, the consequential annual economic burden is 27 per cent higher in males than females.⁷⁷ If the prevalence of these risk factors was reduced modestly in males – a 1 per cent reduction in the difference between men and women each year over a 23-year period – there would be a cumulative cost saving of CAD 51 billion.

A separate analysis suggests that men's premature mortality and morbidity costs the US economy approximately USD 479 billion annually.⁷⁸ It has also been suggested that health disparities between men related

to race in the USA create a significant economic burden, possibly amounting to USD 24 billion for the period 2006-2009.⁷⁹

Promundo's report, *The Cost of the Man Box: A study on the economic impacts of harmful masculine stereotypes in the US, UK, and Mexico*, looked at traffic accidents, suicide, depression, sexual violence, bullying and violence, and binge drinking.⁸⁰ It estimated that a minimum of USD 21 million could be saved annually by the US, UK and Mexican economies if there were no 'Man Box'.

In recent years, health economists have looked in some detail at the cost-effectiveness of including boys in HPV vaccination programmes. There has for some time been broad agreement that in countries where HPV vaccination uptake is low in girls, it is cost-effective to vaccinate boys. But it has more recently been shown that, even in countries where there are high vaccination rate in girls (80+ per cent), it is still cost-effective to vaccinate boys too because it will reduce the treatment costs of penile, anal, head and neck cancers, as well as genital warts, in males.⁸¹

Evidence of the effectiveness of men's health interventions

Citing a lack of knowledge about what to do about men's health is no longer a credible excuse for inaction. Evidence on how to deliver health services that meet men's needs effectively is now increasingly available, including in peer-reviewed journals. Much of this is based on evaluations of interventions with different groups of men as well as on research into men's attitudes, behaviours, needs and preferences. Although the quality of evaluations has been variable, it is nevertheless now clear that programmes that take account of gender differences and male sensibilities are much more likely to work than many 'one size fits all' approaches and that policymakers can be confident that well-designed men's health interventions are likely to improve outcomes.

Football Fans in Training (FFIT) in Scotland provides a good example of a lifestyle programme – in this case, weight management – which uses soccer to target men specifically. Based at professional soccer clubs, it has achieved significant participation and resulted in positive outcomes: men who took part in the programme lost almost 5 kg more weight than men in a comparison group.⁸² They also had lower waist size, lower percentage body fat and blood pressure, reported higher levels of physical activity, better diets and felt better about themselves. The FFIT approach is now being used more widely in Europe, branded as EuroFIT⁸³, and also for hockey fans in Canada.⁸⁴

The Men on the Move programme in Ireland is a free, 12-week community-based 'beginners' physical activity programme for inactive adult men that aims to improve the overall health and well-being of participants. It consists of structured group exercise twice a week, two facilitated experiential workshops, a 24-page health information booklet, a pedometer for independent activity sessions, weekly phone contact, a customised wallet card to record measures taken and a 5km celebration event at the end.

An evaluation showed that the programme was successful in recruiting men with a high level of risk factors such as high blood pressure, overweight/obesity and being sedentary.⁸⁵ The majority of men participating in Men on the Move reported increased levels of physical activity, fitness and energy. But importantly other positive spin-offs of the programme included improved dietary habits, nutritional knowledge, and weight loss. It also contributed to improvements in the quality of life of the men; for example, nearly double the men (68 per cent) reported satisfaction with their energy level at the end of the programme compared to the start (35 per cent).

The American Psychological Association has published the first-ever guidelines to help psychologists work with men and boys.⁸⁶ The guidelines were a response to the perception that men's mental health was problematic and not being adequately addressed. 'Traditional' masculinity – characterised by stoicism, competitiveness, dominance and aggression – was understood to be generally harmful, encouraging men to engage in less healthy behaviours. Part of the practitioner's role can be to encourage men to discard the harmful aspects of traditional masculinity (eg. violence, sexism) and find flexibility in the potentially positive aspects (eg. courage, leadership).

The Sustainable Development Goals (SDGs)

The SDGs have helped to focus attention on gender inequalities and gender norms.⁸⁷ This is because many of the SDG targets concern health issues where there are marked sex and gender differences or where taking account of gender norms would clearly help to improve outcomes. For example, the goal of reducing premature mortality from non-communicable diseases would be more quickly achieved if the disproportionate burden of many NCDs on men was reduced. Realising the goal of improved mental health would be helped by reducing the much higher suicide rate in men. Men also carry a greater burden of health problems linked to substance and alcohol abuse, of road traffic accidents, and poor sexual health; again, these problems are directly linked to specific SDG goals.

The social determinants of health

It is well-established that unhealthy behaviours, such as smoking and excessive drinking, drive ill-health. But in recent years, it has become more widely understood that such behaviours are themselves caused by a range of social factors such as income, education, employment, housing race and age. Gender is also a significant social determinant of health. Michael Marmot, a leading world expert in the social determinants field, has stated:⁸⁸

Men's poorer survival rates ... reflect several factors – greater levels of occupational exposure to physical and chemical hazards, risk behaviours associated with male lifestyles, health behaviour paradigms related to masculinity and the fact that men are less likely to visit a

doctor when they are ill and are less likely to report on the symptoms of disease or illness.

Once gender is perceived as a social determinant, it is easier to reject the idea that unhealthy behaviours are simply the result of the bad or irresponsible decisions of individuals. In the case of men, it means that, while men can still be held accountable for the harms they may do to others, they can be more sympathetically perceived as inhabitants of a social and cultural system that actively encourages conformity with a specific set of gendered norms.

The men's health equity agenda

There has been a notable growth in interest in the issue of men's health equity. This has helped to focus attention on more marginalised and vulnerable groups of men. There is now an emerging evidence-base that can be used by decision-makers to generate new and different health promotion and public health strategies. *Men's Health Equity: A Handbook*⁸⁹ is pre-eminent in this field and will be complemented by a forthcoming special issue of the *International Journal of Men's Social and Community Health* which will include conceptual papers and qualitative, quantitative, and intervention research that aims to illustrate the importance of and how to use an intersectional lens to advance men's health and well-being.⁹⁰ Such an approach, if implemented, would have proved invaluable in the development of policy responses to the COVID-19 pandemic which has had a particularly devastating impact on low-income and black men.⁹¹

Men's biological frailty

One key learning from the COVID-19 pandemic is that male biology can play a key role in determining men's health outcomes. In recent years, the pendulum of responsibility for these outcomes has swung away from biology towards social and cultural factors, including gender norms, but the traumatic experience of COVID-19 suggests that a more balanced, inter-relational view of sex and gender may be required.

In the case of COVID-19, it seems that men's naturally weaker immune response is in part responsible for their greater vulnerability to serious illness and death. This is compounded by gendered factors such as male patterns of smoking and drinking and their greater reluctance to follow the guidelines on handwashing and social distancing or to seek medical help at the right time.

A review of sex differences in life expectancy highlighted several biological factors.⁹² Women have two X chromosomes and men only one. The X chromosome contains thousands of genes, most of which are not female-specific. In contrast, the Y chromosome is small and contains only a few genes important for male development and fertility. A clear benefit of having two X chromosomes is that a mutated gene on the X chromosome inherited from one parent will not affect cells in which the other X chromosome is active. Furthermore, testosterone may have a negative

impact on male lifespan because it acts as an immunosuppressant while oestrogen has a positive effect for women due to its protective effect on vascular physiology. At age 65, biology could account for a life expectancy sex difference of 1-2 years.

Wider public and professional understanding of men's innate vulnerability, perhaps prompted by COVID-19, could help to dispel the notion that their poor health is simply 'their fault'. After all, they cannot sensibly be blamed for their chromosomal or endocrinological make-up. However, it is also possible that a greater awareness of men's frailty could result in greater pessimism about the possibility of improving their health outcomes. This could be avoided by emphasising the need to offset the impact of biology by a greater focus on prevention and early diagnosis. Fatalism can also be challenged by the evidence that men clearly have the potential to lead long and healthy lives. For example, average male life expectancy in Iceland in 2016 was 81 years and healthy life expectancy 72 years compared to respective global averages of 70 and 63 years. These differences between men are not because of biology but rather because of favourable social determinants (income, education, housing, etc), healthier lifestyles and easily-accessible and effective health services.

Human rights-based approaches to health

The 1946 Constitution of the WHO is the first international treaty to conceptualize a human right to health. It declared that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.' Drawing on the WHO Constitution, the nascent United Nations (UN) proclaimed the 1948 Universal Declaration of Human Rights (UDHR) as a 'a common standard of achievement for all peoples and all nations' and included in it a set of interrelated rights to medical care and several underlying determinants of health such as food, clothing and housing.⁹³ Since the 1940s, health-related human rights have become firmly established under international law and have more recently become more influential in health systems governance.

The WHO states that a core principle of human rights is that they are 'universal and inalienable [and] apply equally, to all people, everywhere, without distinction' and are exercised 'without discrimination of any kind based on race, colour, sex ... sexual orientation and gender identity.'⁹⁴ Self-evidently, the human right to health applies to men as much as it does to every other group of people and creates a powerful ethical argument for action.

Prostate cancer: a case-study

- Prostate cancer has received significant attention over the past 20-30 years, reflecting its growing incidence, professional controversies, the work of prostate cancer advocacy organisations and awareness-raising by celebrities.
- There have been significant improvements in care and treatment.
- But many men lack knowledge about the condition and there are gaps in medical practitioner training, delayed diagnoses and inequitable access to the most effective treatments.
- Low priority is given to advanced prostate cancer and there is a need for more care support for patients and men living with the physical and psychological problems caused by prostate cancer.
- Prostate cancer has been overlooked because it is a men's health issue and, generally, men's health issues are marginalised. It also mainly affects older men who are generally not highly valued.
- There is a widespread (and false) belief that men are more likely to die with rather than of prostate cancer.
- The fear, embarrassment and stigma about prostate cancer and its treatments inhibit men with lived experience from publicly advocating change.
- Advocacy groups have so far not been able to push politicians to take sufficient action.
- Sharp differences of opinion among clinicians on key issues, not least screening, have also made it harder for policymakers to formulate strategies.
- But there now opportunities for policy progress, including a growing clinical consensus about screening, better knowledge about effective care and treatment, the increased profile of men's health generally, and advocacy work by men's health organisations.

See the Appendix for more information about the prostate cancer case-study.



POLICY GOALS

The primary goals for men's health policy development seem clear. A state of men's health report, a men's health policy, a gender and health policy and health policies that include men's health would represent major progress.

State of men's health reports

A very large amount of global and national data about men's health is now available. The Global Burden of Disease Study alone has made a very substantial contribution. The WHO is also publishing an increasing volume of sex-disaggregated data. However, this has not as yet been collated, analysed and interpreted in a way that clearly and decisively makes the case for a greater focus on men's health and which is helpful to policy development at the global, national and local levels.

There are some good precedents, however, that show how this could be achieved. In 2011, the European Commission published a report on the state of men's health across the European Union member states.⁹⁵ This did not include any policy recommendations but this was eventually remedied by the WHO European Region's report on men's health which was published in 2018. Covering 53 countries, this pulled together a large amount of data and linked directly to the men's health strategy. At the local level, the report into the state of men's health in the UK city of Leeds provides a good model for other cities and regions to follow.⁹⁶

Men's health policies

Men's health policies have been published at the international (European), national (Australia, Brazil, Iran, Ireland) and local (Quebec) levels. There is good evidence that they advance the cause of men's health in several ways, for example by changing service delivery, encouraging community action, accelerating research and improving professional training. The actions generated by these policies have directly resulted in improved health outcomes for men.

It is important that men's health policies adopt a holistic, systems-wide approach to men's health. They need to go beyond the so-called 'medical model' and consider all the social determinants that impact on men, such as education, income and employment. By doing so, policies can

avoid over-emphasising the potential of individual behaviour change. This has a role but runs the risk of 'victim-blaming' and is any case inadequate to the task of achieving population-wide health improvements.

Needless to say, the publication of a policy is, on its own, not a guarantee of success. Many problems have been identified with the existing set of policies, including poor governance, weak implementation and monitoring strategies, lack of prioritisation and inadequate funding support. These issues must be considered and addressed as part of the policy development process if optimal impact is to be achieved.

Gender and health policies that include men

Gender and health policies also have a potentially important role providing they adequately reflect the needs of both men and women. The advantage of policies that cover both sexes is that they offer an approach which is inclusive, integrated and comprehensive and which can more effectively address issues where there are inter-relationships between men and women, such as in sexual and reproductive health.

One of the most comprehensive gender and health policies was published in Ireland in 2012.⁹⁷ *Equal but Different* recommended actions that better enable the health service to deliver its services for women, men and transgender persons and ensure more equal health outcomes for all. The aim was to help to improve the quality of the services provided in relation to the prevention, diagnosis and treatment of illness by improving the utilisation of services and service user satisfaction.

The impact of this policy appears to have been limited, however, suggesting that, as with specific men's health policies, a sustained commitment to implementation is essential.

Men's health included in all appropriate health policies

Because there is a danger that men's health or gender and health policies will take time to achieve or will end up being marginal to the main thrust of health policy, it is important that men's health is fully integrated into other relevant health policies (eg. on cancer, cardiovascular disease, diabetes). Currently, such integration is much more notable by its absence than its presence.

The value of this approach is perhaps most evident for policy on issues, such as suicide, where men's greater burden is very clear. But it is also highly relevant to issues where sex differences are less marked, such as overweight and obesity. Men and women generally have different attitudes to their bodies, food and exercise, for example. There is good evidence that many men prefer same-sex weight management groups and programmes with a physical activity focus.⁹⁸ Programmes delivered at sports stadiums with the branding of top-flight professional clubs have also proved effective.⁹⁹

Bowel cancer screening provides another example of how a policy approach that takes account of gender differences could be helpful. Men are at greater risk of developing bowel cancer than women but are less likely to participate in screening programmes.¹⁰⁰ However, there is evidence that encouraging men to discuss bowel screening with their GP or partner on receipt of an invitation may improve uptake. An Australian study showed sending men a notification letter prior to screening resulted in a 12 per cent increase in uptake compared to those who were not contacted in advance.

There is also a good case for including men's health issues in broader policy, such as employment, education, housing, transport and family life, following the so-called 'Health in All Policies' approach. The health and wellbeing of many men could be improved by better regulation of working hours and entitlement to significant parental leave, for example.



NEXT STEPS

Policies that take proper account of men's health constitute a critically important step towards the design, implementation and delivery of services that lead to better health outcomes.^{101, 102} They are needed at the local, national and global levels.

But many governments and health systems will in practice take little action unless they are encouraged to do so by medical, health and civil society organisations. There now exists the best-ever opportunity for these organisations to make a very strong case for male-targeted policies and subsequent interventions that can improve the health of men, women and children, reduce healthcare and wider costs, and help the achievement of public health targets. This applies to men's health in general as well as to specific issues such as prostate cancer.

Stating what policy measures are needed is of course far easier than actually achieving them. But it is possible to map an approach that is most likely to prove successful.

Collate and present the evidence

The case for policy changes will, clearly, be stronger if it is based on robust evidence which demonstrates not only men's morbidity and mortality outcomes but also the impact of poor men's health on women and girls. The evidence should also cover the ethical and equity issues as well as the cost-effectiveness of interventions targeting men. Ideally, such evidence would be prepared and presented by a reputable and independent research organisation and published in a report and/or in a peer-reviewed high-ranking health or medical journal.

Focused demands

When advocating policy on men's health, it is tempting to seek progress on a very wide range of issues. The result can be a large number of recommendations and action points. One of the criticisms of Ireland's first national men's health policy was that it not only contained an unrealistic number of action points (118 - more than could ever be achieved in its five-year lifespan) but also failed to prioritise them.¹⁰³ The impact could be greater if the focus was sharper.

One way of identifying areas of policy focus could be to adopt the concept of ‘proportionate universalism’; in other words, action should be taken in proportion to the needs of population sub-groups. This sub-groups could be best identified using an intersectional approach to identify where there is particular disadvantage. Such an approach could also help to challenge the assumption that all men are privileged and powerful and therefore underserving of support.

One significant group of men with greater health needs is those with lower incomes. In England in 2016-18, for example, the life expectancy at birth for males living in the most deprived areas was 79 years, compared with 86 years in the least deprived areas.¹⁰⁴ Other groups facing particular health disadvantages include gay, bisexual and transgender men, men in prison or who are homeless, men from some ethnic minorities and men with disabilities.

The mean age of death of homeless men in England and Wales was 45 years in 2018 compared to 76 years for men in general.¹⁰⁵ In Australia, the average life expectancy of an Aboriginal and Torres Strait Islander boy born in 2015-17 was nine years lower than that of a non-Indigenous boy.¹⁰⁶

Policy alignment

Aligning men’s health policies with current health policy priorities, as happened in Ireland with the second national men’s health policy, could help to create traction. Currently, a global health priority is tackling non-communicable diseases as part of achieving the Sustainable Development Goals and the WHO has already highlighted the burden of NCDs on men. COVID-19 has also focused attention on this issue as men’s greater incidence of underlying NCDs is thought to be one part of the explanation for their disproportionately high death rates. It is probable that an advocacy focus on NCDs, and other SDG issues, at the global level is more likely to be effective.

A focus on gender norms

Much of the current discussion about gender and global health focuses on the role of gender norms in determining health outcomes. Men’s health advocates have advocated the importance of taking account of male norms for many years, for example in the development of services located at male-friendly venues like soccer stadia or workplaces. It should not therefore be problematic to emphasise the issue of norms when discussing men’s health in order to participate in wider health policy debates.

This is not the same as seeking the deconstruction or transformation of all male gender norms, however, or as suggesting that masculinity is somehow inherently ‘toxic’. Some male gender norms are clearly damaging to both men and women. But others, such as self-reliance, resilience, physical strength, daring and courage, should perhaps be more accurately referred to more accurately as authentic ‘human’ norms as they represent strengths which should be valued and encouraged in men (as well as in women).¹⁰⁷

A focus on gender norms also does not mean that men's health advocates should cease to recommend other areas of policy that can improve men's health such as tobacco control, sugar taxes or alcohol minimum pricing, improved traffic management, school education programmes, and easier access to primary care services.

Supporting gender equality

At the global level especially, locating men's health within a policy framework that embraces a genuine commitment to gender equality is far more likely to be effective. This is about more than demonstrating that better men's health is good for women's health (which is undeniably the case) and it is also about more than addressing those issues (such as gender-based violence or unsafe sexual health practices) where men directly harm women. It is about supporting actions that help to achieve the goal of dismantling male power and privilege.

Building alliances

The case for policy change has to be built incrementally and engage the widest possible group of stakeholders, including clinicians, public health experts, politicians, civil society organisations and policymakers. Progress may be faster if it proves possible to galvanise media and public support. The sustained support of a major national newspaper was seen as an essential ingredient in the success of the HPV vaccination campaign in the UK. A senior policymaker within government who is willing to act as a champion for men's health can also have a catalytic effect, as was the case in Ireland.

The long-term commitment of a diverse core group of advocates can help to maintain momentum and the support of a wider range of external stakeholders can be mobilised through a programme of conversations, consultations and conferences.¹⁰⁸ The successful campaign run by HPV Action in the UK to secure gender-neutral HPV vaccination demonstrated the value of a wide base of support, with engagement from over 50 organisations from a variety of backgrounds. This approach is now being replicated by the European Cancer Organisation through its HPV Action Network. One of its core goals is gender-neutral vaccination throughout the WHO European region.

There are already a wide range of relevant alliances and networks that men's health organisations can join. At the global level, the NCD Alliance is an example of a formal organisation that men's health organisations can participate in and through which they can seek to raise their particular concerns. There are also organisations with an interest in gender and health, such as Global Health 50/50, and others with a primary focus on women's health with which collaboration on the promotion of a gendered approach to policymaking could be possible. The Gender and COVID-19 Working Group mainly comprises academics and advocates with an interest in women's health but has shown itself to be open to organisations and individuals with a men's health focus, including GAMH.

It is also important to build support for policy change across political parties if progress is to be maintained following a change of government. A policy that is supported by just one political party is much less likely to have longevity in these circumstances. This is evidenced by the virtual cessation of progress on the development of a men's health policy in Austria following a general election and a change in government.

Monitoring and evaluation

Men's health projects and programmes have, historically, not been well-evaluated. This is changing, however, and it is essential that any advocacy campaign which seeks to include men's health in policy at the global, national or local levels is also properly assessed. It is vital that evidence is gathered about works in terms of achieving policy change and what does not. The impact of policy changes on men's health outcomes should also be investigated, although this is not straightforward when it comes to macro-level data such as life expectancy. However, it should be possible to monitor the impact of policy on the development of specific projects and programmes and, in turn, to evaluate their impact on specific and measurable health and wellbeing indicators in the target groups.

The value of evaluation was demonstrated by the independent review of Ireland's first men's health policy which assessed its strengths and weaknesses and made recommendation for future progress which were broadly adopted in the second policy statement.

A long-term perspective

If greater progress on policy is to be made then Ireland's experience with its national men's health policy could be instructive. This showed that significant policy change is achievable but unlikely to happen quickly, suggesting that advocates must be both tenacious and patient. It took about seven years to complete the development process which included a research project, a national conference and an extensive consultation phase.¹⁰⁹ It also took five years for an advocacy campaign in the UK to achieve the inclusion of boys in the national HPV vaccination programme.¹¹⁰

But while it might take time to change policy, the need for action remains urgent. COVID-19 has very starkly exposed the poor state of many men's health and the multiple fronts on which action is needed. Very many unnecessary male deaths and much suffering could be avoided if advocates could more effectively make the case for the changes to policy and practice that must be introduced at the earliest opportunity.



APPENDIX

Prostate cancer: a case-study

Men are more likely than women to develop any kind of cancer.¹¹¹ Globally, the incidence rate for all cancers in 2018 was about 20 per cent higher in men. The mortality rate was 50 per cent higher in men. Lung cancer is the most commonly diagnosed cancer and the leading cause of cancer death in men, followed by prostate and colorectal cancer for incidence, and liver and stomach cancer for mortality.

As the global population ages, the total number of cancer cases is expected to increase from 18 million new cases in 2018 to 29 million in 2040.¹¹² For men specifically, the increase could be from five million to 16 million. The number of estimated number of male deaths a year is expected to increase from about five million to nine million.

Prostate cancer incidence rates have risen significantly in recent years. There was a 40 per cent increase in cases between 2006 and 2016 alone. In 2016 globally, there were 1.4 million new cases of prostate cancer and 381,000 deaths.¹¹³ In 2016, prostate cancer was the cancer with the highest incidence for men in 92 countries, and the leading cause of cancer deaths for men in 48 countries. In 2018, prostate cancer was the fourth most common cancer diagnosed in both sexes and the second most common in men alone.¹¹⁴ Globally, the odds of developing prostate cancer was 1 in 16, ranging from 1 in 56 for low-middle income countries to 1 in 7 in high-income countries. These differences could in large part be explained by the availability of PSA testing but also the higher proportion of older men in the high-income countries.

Men of African descent have the highest incidence of prostate cancer worldwide and more likely to develop disease earlier in life when compared to other racial and ethnic groups. They also have the highest mortality rates. It is likely that black men possess some specific genes that are more susceptible to mutations in prostate cancer and that these mutations are associated with a more aggressive type of cancer.¹¹⁵ Their higher mortality may also be linked to structural disadvantage and discrimination; in the USA, for example, black men are less likely to have the health insurance cover required for the most effective treatments.¹¹⁶

In many ways and for many people, prostate cancer has become identified as the health issue that seems to most characterise men's health. It is, clearly, male-specific, widespread and, at least historically, relatively neglected. Prostate cancer therefore provides an interesting and useful case-study on a specific area of men's health policy.

There have, without doubt, been major advances in the field of prostate cancer. There have been improvements in diagnosis, treatment and care as well as in understanding of men's personal experiences and needs. It has been suggested that research funding for prostate cancer is actually at higher levels than its burden suggests it should be.¹¹⁷ Nevertheless, prostate cancer advocates have identified some significant continuing gaps:

Men remain under-informed about prostate cancer, including their level of risk, the symptoms, diagnosis, and treatment options. A study of prostate cancer understanding in the USA carried out by the Prostate Cancer Foundation in 2018 revealed a significant lack of understanding about early-stage prostate cancer and its symptoms with 32 per cent of men incorrectly believing that there are noticeable symptoms.¹¹⁸ Overall, just 42 per cent of men have discussed prostate cancer screening with their doctor. Although the proportion rises to 67 per cent of all men aged 54 and older, only 35 per cent of black, 30 per cent of Hispanic and 16 per cent of Asian men say they have discussed screening with their doctor. A European study found that just 26 per cent of men aged over 50 could correctly identify the prostate's main function and only 17 per cent understood that the symptoms relating to an enlarged prostate are not a normal sign of ageing.¹¹⁹

Medical practitioners, particularly in primary care, require more information and training. A survey of UK GPs conducted by the Orchid male cancer charity in 2019 looked at their awareness of risk factors.¹²⁰ It found that only five per cent of GPs identified ethnicity as a primary risk factor, less than half recognised that family history and age are risk factors, and 15 per cent mistakenly thought infections such as HPV were a primary risk factor for prostate cancer.

Men are not diagnosed early enough. In England in the period 2012-17, almost half (47 per cent) of prostate cancers for which the diagnostic stage is known were not diagnosed until they were advanced (stages 3 and 4).¹²¹ There is evidence that men with prostate cancer wait longer, following a referral from a primary care doctor, to see a specialist than those suspected of most other cancers.¹²² Apart from the possibility of missing treatment time for aggressive disease, this can also exacerbate psychological distress.

Access to the most effective types of treatment is not equally available to all men. There are clear variations in treatments and outcomes between countries and within them.¹²³ Inequalities exist in relation to access to specialist prostate cancer treatment centres but also concerning ageism (with some treatments being denied to men solely on the basis of age rather than their suitability for treatment), race (with black men often experiencing delayed or less effective clinical care), income (not least in the USA where cost can be a major barrier for many), and access to social and psychological support.

Lower priority is given to advanced prostate cancer issues. While there have been many innovations in this area, there are still many aspects of clinical management that lack high-level evidence to inform practice.¹²⁴

Men with prostate cancer require more support. A recent study of men on active surveillance for prostate cancer found that the information provided to men is inadequate and inconsistent and that men may also be experiencing unmet psychological, emotional, social and other needs.¹²⁵ Similar findings have been reported for men with locally advanced and metastatic prostate cancers.¹²⁶ A survey of almost 3,000 prostate cancer patients from 24 countries by Europa Uomo, the European Prostate Cancer Coalition, found that quality of life issues are under-recognised. Prostate cancer and its treatment affects men

physically and emotionally.¹²⁷ There is often a significant impact on their everyday life, work, social life and sexuality as well as on partners and family members. As the number of prostate cancer survivors increases, Europa Uomo believes that patients, doctors and the broader public should be better informed about the needs of cancer survivors in order to improve their quality of life.

Possible prevention measures have not been fully investigated.

Several preventable risk factors for prostate cancer have been suggested, including smoking, a high-fat diet, obesity, and exercise.¹²⁸ It has also been suggested that lycopene (a chemical found in cooked tomatoes) could be protective. Further research is needed before definitive advice on prevention can be given to men; the European Association of Urology has suggested that the link between obesity and prostate cancer should be a particular focus of further investigation.¹²⁹

Why has prostate cancer issue received insufficient attention?

It is a men's health problem. Prostate cancer issues have been overlooked in the same way as many other men's health issues and for similar reasons. Significantly, Prostate Cancer UK launched an advertising campaign in 2019 which used the strapline 'Men: They're Worth Saving', suggesting that many people are not yet convinced of that fact.¹³⁰

Prostate cancer is mainly a disease of older men. Ironically, the discipline of gerontology derives its roots from the Greek, 'geron-ontos' meaning 'old man'¹³¹ but older men have in fact been relatively overlooked by health and social care services as well as by social researchers. This is partly because there are fewer older men than older women (men are much more likely to die prematurely), although the numbers of older men have increased significantly over the past 20-30 years. There are negative attitudes about older people generally and the stereotypical depiction of older men is that they display 'diminished masculinity' (being sedentary, asexual, just passing time) or are 'Grumpy Old Men', who are 'stuck in the past', difficult to engage with, opinionated, and irascible.¹³²

A belief that men die WITH rather than OF prostate cancer. It is incorrectly assumed by many policymakers that prostate cancer is primarily a disease of very old men who die from other conditions first.

There is fear, embarrassment and a stigma about prostate cancer. Many older men are reluctant to seek medical help for a range of health problems and perhaps particularly for possible symptoms of prostate cancer or to discuss their risk of developing the disease.¹³³ They may be frightened of the condition, a positive diagnosis and the subsequent treatments. Men may also feel embarrassment about the medical examinations and disclosing symptoms related to their sexuality. Stigma can have a significant effect on the quality of men's lives following a diagnosis.¹³⁴ The impact of the disease on men's sexual functioning and their continence can be experienced as particularly shameful. These feelings are a barrier to many men taking on an advocacy role.

Insufficient advocacy. There are prostate-focused civil society organisations in many countries and regions, some relatively large and well-funded, as well as major generic cancer organisations. There are also a range of professional organisations, primarily in the field of urology, that have an interest in policy on prostate health. However, notwithstanding the efforts made by these bodies, there remains a lack of political will to push prostate cancer issues into policy and insufficient awareness and knowledge by policymakers about the disease.

Clinicians have been divided. There have been disagreements, sometimes fiercely expressed, between clinicians on the issue of screening.¹³⁵ Some have argued that all men reaching the age of about 50 should be offered a PSA test, perhaps as part of a national screening programme, in order to detect early-stage symptomless prostate cancers in order to reduce mortality. Others have taken the view that such screening, because it detects tumours that may, if left alone, have been clinically insignificant, results in over-treatment and unnecessarily reduced quality of life for the men affected. There have also been debates and conflicting findings about the pros and cons of different clinical management options for low-to-intermediate risk localised prostate cancer with some doctors recommending surgery, some recommending radiation therapy, and others opting for active surveillance. Often the medical advice a man receives depends on the specialism of his physician. The different views about screening and treatment are confusing for patients and may well have also made it harder to engage policymakers who, understandably, generally prefer to base decisions on clear and unequivocal clinical guidance.

The Prostate Cancer Policy Survey: Key findings

- Respondents stated that the following barriers to the development of prostate cancer policy in the country or area they served were either *Significant* or *Very Significant*:
 - A belief that men generally die WITH prostate cancer rather than OF prostate cancer (81 per cent)
 - Lack of political will to push prostate cancer issues into policy (75 per cent)
 - System inertia (69 per cent)
 - A lack of concern for men's health generally (63 per cent)
 - Lack of knowledge by policymakers about how to address prostate cancer (63 per cent)
 - Financial/resource constraints (including for research) (63 per cent)
 - Lack of awareness by policymakers about prostate cancer (50 per cent)
 - Pessimism about the possibility of improving prostate cancer outcomes (50 per cent)

- A lack of consensus by scientists and clinicians about diagnosis and treatments
- Respondents identified the following possible opportunities for the development of prostate cancer policy as either Significant or Very Significant:
 - The evidence now available about how to improve prostate cancer outcomes (88 per cent)
 - Men's increasing interest in their own health (75 per cent)
 - Movember (each November) (56 per cent)
 - A greater focus on men's health by the WHO and other international bodies (56 per cent)
 - Advocacy work by men's health organisations (56 per cent)
 - Men's Health Week (each June) (50 per cent)

Opportunities for progress in prostate cancer policy

There are now a number of opportunities for developing prostate cancer policy.

The growing burden of prostate cancer. Prostate cancer is common, increasing prevalent and has a significant impact on men, their families and health systems. There are clear ethical and economic imperatives for the disease to be prevented (if possible), diagnosed early, and treated effectively with the least possible impact on men's quality of life.

Growing consensus about screening. Although many clinical issues still need to be fully resolved, there is now much stronger evidence supporting the screening of well-informed asymptomatic men in middle-age. The risks of over-diagnosis and over-treatment can be minimised by analysing PSA results in the context of other clinical characteristics (eg. age, family history, digital rectal examination and prostate volume), using MRI scanning before a biopsy, and the greater use of active surveillance for men with low-risk cancers.¹³⁶

Better knowledge of effective care and treatment. There is now a very significant understanding of how to deliver optimal care and treatment to prostate cancer patients and good evidence that these are best provided by specialist multi-disciplinary prostate cancer clinics.¹³⁷

The increased profile of men's health generally and advocacy work by men's health organisations. Movember, Prostate Cancer Awareness Month, Men's Health Week and other campaigns have helped to raise the public profile of men's health generally and prostate cancer specifically. A number of high-profile men – including Senator Bob Dole, golfer Arnold Palmer, Generals Colin Powell and Norman Schwarzkopf and the actor and writer Stephen Fry – have been willing to talk publicly about their experience of prostate cancer and to help improve awareness of the condition. Professional and patient groups such as Europa Uomo, Prostate

Cancer UK, the European Association of Urology (EAU) and the Prostate Conditions Education Council in the USA have also made a contribution to awareness raising and policy development. Movember has made a major contribution to research into diagnosis and treatment and better care for men with the disease. The EAU is among those making the case for prostate cancer issues to be reflected in the European Commission's Beating Cancer Plan, due to be finalised in late 2020. The greater interest in men's health issues by the WHO and other major health organisations, as well as a greater interest in health and wellbeing among men themselves, is also significant.



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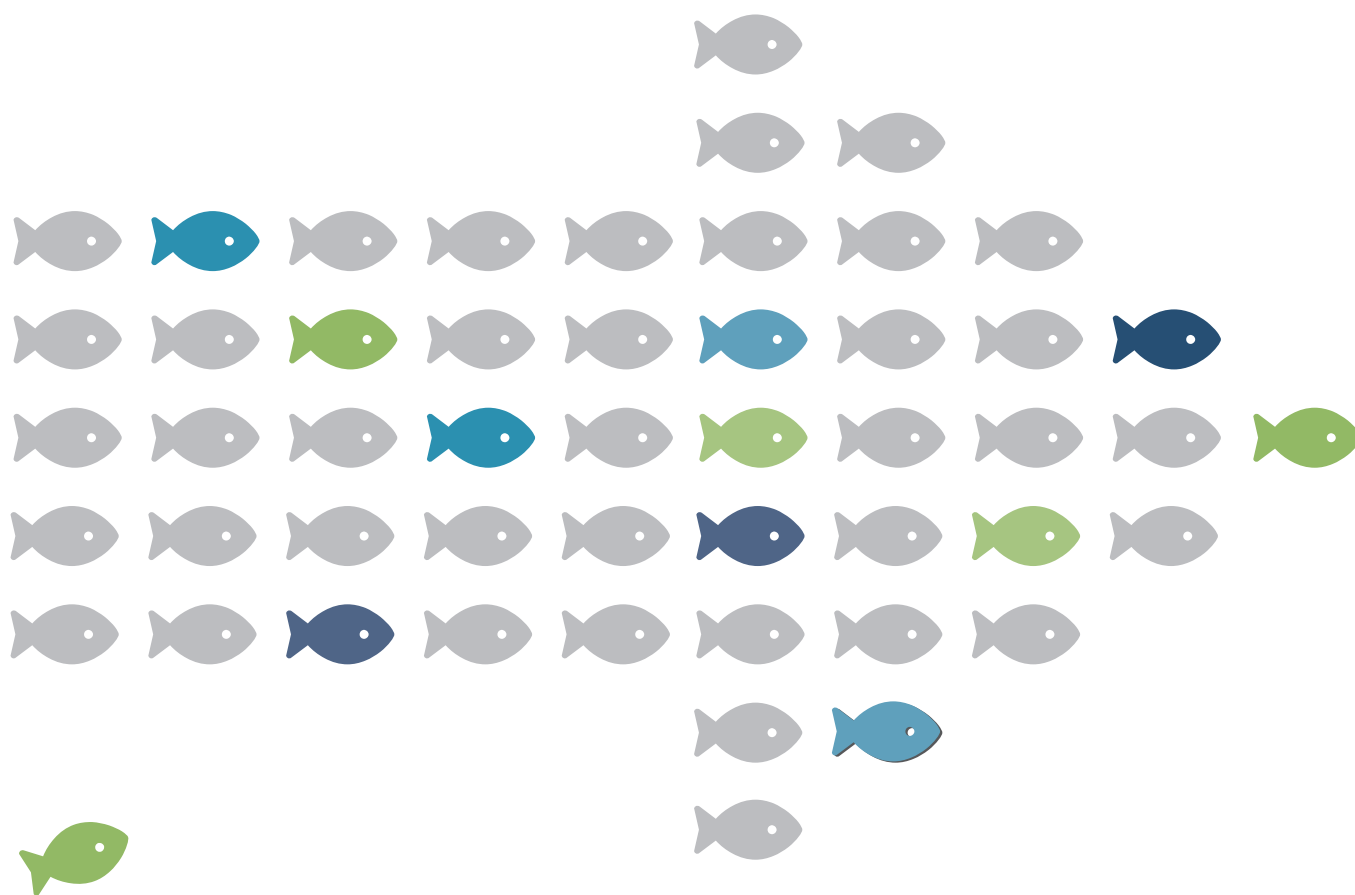
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