

MASCULINITIES AND HEALTH

in the Region of the Americas

Executive Summary



PAHO



Pan American
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Organization



World Health
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Americas

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Introduction

This document is an overview of *Masculinities and Health in the Region of the Americas*. The Pan American Health Organization (PAHO) recognized the need to examine the implications of masculinities for men’s health, explain the main concepts and relevant epidemiological evidence, and present the current and future actions needed to promote men’s health, while recognizing and addressing the consequences of masculinities on the health of women, adolescents, and children in the Americas.

The work began with a primary consultant and a multidisciplinary PAHO team who together designed the rationale, structure, and methodology of the report. A review was conducted of the available literature on the subject, and PAHO’s health databases were consulted on the selected men’s health statistics. A Masculinities and Health Survey (MyS) was also conducted with 33 experts from 12 countries. The resulting information was systematized and integrated to generate this regional report.

The report discusses the complexity of masculinities and health in a way that is accessible to decision-makers, health workers, and those working in related fields in the Americas. Despite the fact that gender remains one of the main social determinants of health, analyzing men’s health from a gender perspective is a relatively innovative approach.

- The report has six sections, covering:
1. A conceptual framework for masculinities and male socialization, and how this relates to health;
 2. Epidemiological evidence related to men’s health;
 3. Social determinants of health in this context;
 4. Policies and programs;
 5. Conclusions;
 6. Recommendations.

Annex A of the main document explains in more detail the methodology that has been used. For a more thorough examination of any aspect, or to consult sources, see the bibliographic references in the full document.

This report opens new possibilities in the Americas for a range of recommendations, laying the groundwork for implementing an integrated social response to the issue of masculinities and men’s health.



Masculinities and gender

1

1.1 Masculinities from a gender perspective

Analyzing men's health from the gender perspective would be unthinkable without the precedent of feminism in general, and the ways in which feminism has been applied to understanding women's problems in areas such as health, sexuality, reproduction, and violence. It is that background that has provided an approach to understanding men from a gender perspective.

Gender is understood to be the historically and culturally constructed set of attributes (symbols and norms) and roles (identities) that are preserved through actions in the everyday organization of society, whose objective is to differentiate women and men based on biological characteristics and on alignment with a system of sex and gender. This concept explains how those differences translate into inequality between men and women. The sexual division of labor is the substrate of these sex/gender differences.

Gender is internalized through socialization, which is understood as a complex and detailed cultural process of incorporating ways of representing the self, attributing value, and behavior in the world—a process that humans navigate throughout their life course.

Gender analysis also makes it possible to recognize the diversity of what is masculine and what is feminine. Beyond the binary opposites reflected in statistics, there is, both biologically and culturally, a continuum that stretches between extremes, which could be termed the “hypermasculine” and the “hyperfeminine.” This enables us to speak of a range of masculinities, which can include elements commonly associated with the dominant, or hegemonic, masculinity, but which also includes highly diverse ways of being a man, ways that contribute to different trajectories in the health/disease/care process.

Achieving gender equality in health means that women and men have equal conditions for realizing their full rights and potential to be healthy, to contribute to health development, and to benefit from the results.

In the Americas, albeit with national and regional variations, a culturally and historically constructed hegemonic form of socializing men (often known as machismo) has predominated. While this varies across different classes and ethnic groups, it remains a constant point of reference, even in the case of alternative or marginal forms of socialization.

1.2 Masculinities, socialization, and health

Gender makes its appearance even before girls and boys discover their biological, sexual, racial, and ethnic differences. For women, differences and inequality are constructed through processes of socialization that provide men with clear advantages. Over time, some of these become engrained, and exact a toll on the health of both men and women.

Women and men are socialized differently, with unequal access to resources, and with different risks. This leads to differing trajectories with respect to a broad range of health problems, including differences in self-care and in patterns for seeking help. In a variety of ways, inequality is reflected in women's health, while at the same time providing a unique opportunity for analyzing the high toll that male socialization exacts on men themselves.

In the field of health, it is essential to have a relational gender perspective that compares the relative situations of men and women and that sheds light on how their respective situations influence one another. We must not lose sight of the fact that women bear the differential risks associated with reproduction (pregnancy, childbirth, and puerperium) and with their status as women.

In attempting to understand and synthesize the consequences of male socialization, it is useful to consider the concept of masculinity as a possible risk factor—a synthesis that links together masculinities, their social construction, and their effect on health. Socialization in the dominant masculinity leads to a triad of risks:

1) Toward women and children (violence, substance abuse, sexually transmitted infections, imposed pregnancies, absent paternity, and lack of shared responsibility in the home).

2) Toward other men (accidents, homicides and other violence, and transmission of HIV/AIDS).

3) Toward self (suicide, accidents, alcoholism and other addictions, and psychosomatic illnesses).

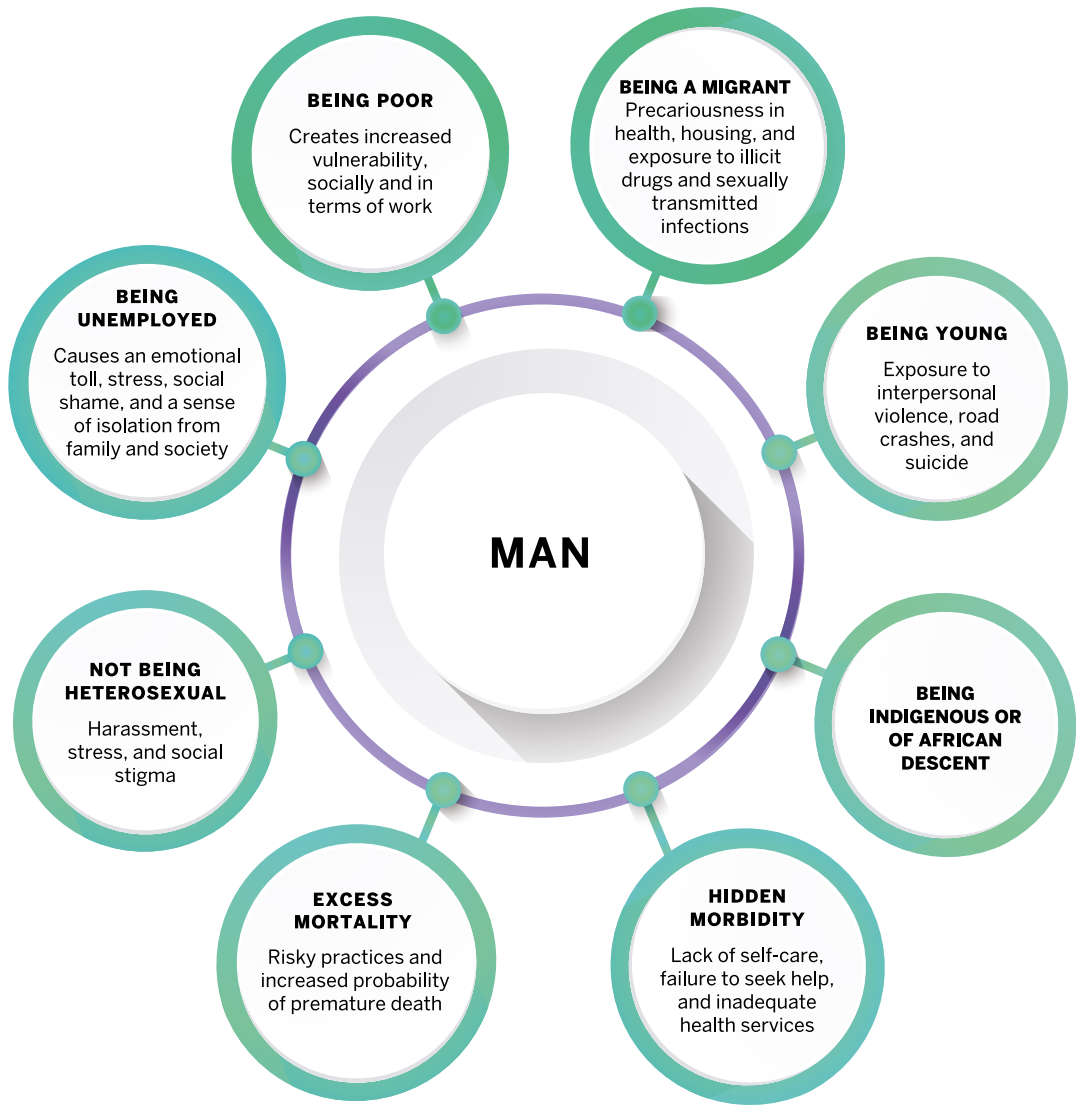
Also at stake is the issue of vulnerability in men, stemming from precarious spaces and contexts, and frequently reflected in a minority or disempowered presence; precarity intersects with ethnicity, poverty, geographic residence, or belonging to a sexual minority. Figure 1 shows how these vulnerabilities are linked.

Despite these vulnerabilities, men living under these conditions may still exercise the privileges associated with the dominant cultural model of masculinity. Accordingly, while vulnerable to discrimination or violence, they may also engage in behaviors that place themselves and others at risk.

The concept of self-care analyzes the relationship that men establish with their bodies and their health. This perspective raises questions regarding several of the mandates of masculinity, and requires, as a fundamental element, a knowledge of self and care for others. It is a concept that involves forms of interaction with one's own body and with the social and natural environment that are directed at or related to health. Thus, the subject of care involves dealing with these mandates, while assuming responsibility for one's body and taking ownership of one's health and well-being.

The dominant masculinity clearly influences not only men's health, but also the health of women and children. Although statistics have shown high and increasing excess mortality among males in recent decades, this topic has received scant attention in the field of epidemiology, which leads us to the following section.

Figure 1.
Vulnerabilities caused and experienced in relation to masculinities





Masculinities, risks, and health evidence

2

Although there are more boys than girls born in the world (105/100), this proportion is inverted in the 30-to-40-year-old population and increases from the age of 80 onwards (with 190 women for every 100 men). Women constitute the majority of older adults in all countries.

A constant in the Region of the Americas is the difference in life expectancy at birth: on average, women live 5.8 years longer than men (with a gap ranging between 4 and 7 years). This is consistent with the figures on healthy life expectancy (HALE), which shows a differential of four years in favor of women.

Mortality indicators confirm that the mortality rate for men is higher than for women (718.8 deaths per year per 100,000 population among men versus 615.1/100,000 for women). Furthermore, due to premature death, there are 18% more years of life lost (YLLs) among men than among women. Because they tend to die earlier, men have 8% fewer disability-adjusted life years (DALYs) than do women.

Figures are similar for men and women with regard to certain causes of death, such as chronic obstructive pulmonary disease (COPD), lower respiratory infections, and diabetes mellitus. However, three of the leading causes of death are linked to the exercise of masculinity, with an enormous difference in consequences, namely: interpersonal violence (homicides, with a 7:1 male/female ratio), road injuries (3:1), and cirrhosis of the liver (more than double), of which the leading cause is alcohol use. The most common causes of male mortality in the Region are ischemic heart disease, interpersonal violence, and road injuries.

These causes are associated with behaviors expected of men in the context of a dominant masculinity that takes lethal forms. While HIV/AIDS is among the 10 leading causes of male deaths in the Caribbean, two of the leading causes in Latin America are cirrhosis of the liver and interpersonal violence. In North America (Canada, Mexico, and the United States of America), Alzheimer's disease and other dementias, suicide, and prostate, colon, and rectal cancer are leading causes of male deaths.

A gender gap detrimental to men is reflected in specific problems related to daily practices of the dominant masculinity, such as risk taking in the workplace or when driving, excessive alcohol and drug consumption, unprotected sexual practices, violent interpersonal relations that result in homicide, and inability to manage emotions.

Mental illness is responsible for five of the leading causes of DALYs: depression (ranking first), anxiety (fifth), drug use (seventh), schizophrenia (ninth), and autism/Asperger syndrome (tenth). Systematic differences have been identified between men's and women's mental health: women have higher rates of mood disorders and anxiety, while men are more prone to antisocial personality disorder and alcohol and drug use.

The progression of these problems during the life course can be analyzed. The differences between women and men tend to appear at early ages and generally become more evident at later stages. Underlying these differences are risk factors (which tend to be more present in men) and protective factors (more present in women). Figure 2 shows the causes of death in men throughout the life course.

Although more males are born, male mortality is greater during the first year of life, due particularly to infectious respiratory and diarrheal diseases. Around the age of 10, differences in male and female mortality begin to emerge, with a rapid increase in male deaths from road injuries, homicides, and drowning. This peaks in adolescence and early adulthood, when male mortality doubles or even triples.

What is most striking is the spike in mortality in the young male population beginning at age 15. Here, violent causes of death predominate (homicide, accidents, and suicide), with mortality rates four to seven times higher than among young women. In addition, men's contribution to the leading causes of death among women in this age group should be noted (femicide).

Starting at age 50, chronic noncommunicable diseases take on a significant role, with a cumulative association between the social determinants of health (SDHs) and lifestyles. Hypertension and cardiac problems are followed by obesity, diabetes, COPD, respiratory illnesses, and prostate cancer. More than 20% of men die before the age of 50; in other words, one out of five men die long before reaching their life expectancy at birth.

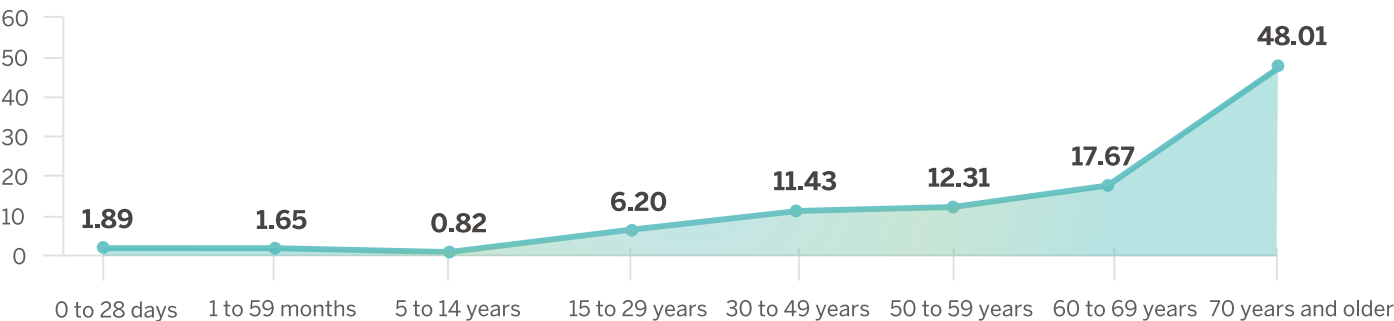
These figures contrast with the figures for women, who do not reach that percentage until the age of 60. For certain problems there is no major gender gap—or the gap impacts women more due to gender-related factors. This is evident in the context of disability-adjusted life years (DALYs). Women bear a greater burden in this category, explained in part by their longer survival. Their extra years of life do not represent more years of healthy life.

An analysis of potential years of life lost (YLL) throughout the life course shows a similar pattern. Diseases and congenital problems before age 5 rapidly give way to YLL due to violence. This remains a constant until age 50, when the consequences of patterns and lifestyles in the preceding decades of life emerge. Lastly, the disease burden in old age reflects major gender differences, consistent with the cumulative risks associated with the social roles assumed throughout the life course.

Figure 2.
Leading causes of mortality in men throughout the life course, Region of the Americas, 2015



Percentage of total deaths in men by age group



Source: Based on World Health Organization. Global Health Estimates 2015: Deaths by Cause, Age, Sex, by Country and by Region, 2000–2015 [Internet]; 2016. Available from: https://www.who.int/healthinfo/global_burden_disease/en/.



Social determinants and men's health

3

The gender perspective enables us to analyze the differences between men's and women's health. But in addition, the social determinants of health (SDH) perspective allows us to analyze important inequalities internal to each group, and to explain most health inequities. SDHs are linked and can be broken down into several components, notably the differential weight of social position (gender, income/work, ethnicity, and sexuality), known as structural determinants, and exposure to intermediate determinants.

This perspective reveals the interactions between SDHs and masculinities and men's health. It helps explain how men perceive their health problems, and accordingly, how they seek, access, and receive care in the health services.

ETHNICITY AND RACE. In the construction of the indigenous masculine identity, the prevalent mandate is to be the provider. Given their precarious conditions and lack of employment, this generates multiple frustrations and the need for migration. Indigenous migration to the cities leads to severe inequalities in socio-economic conditions and entails less access to basic quality services.

Indigenous men also have a higher prevalence of tuberculosis, and HIV/AIDS cases are on the rise. The presence of mental health problems associated with alcohol use and different forms of violence also play a prominent role. Suicide among young indigenous men is a significant phenomenon in Canada and the United States of America, where suicide rates can be up to five times higher than in their non-indigenous cohorts. This is associated with intense social stress, historical traumas transmitted from generation to generation, histories of sexual abuse, and unresolved mourning.

Afro-descendants were taken by force to the Americas, where their language and identity were subjugated by European norms. Consequently, the perceived Afro-descendant masculine identity tends to demonstrate and reconfirm a masculinity that seemingly competes with other forms of masculinity. A social perception was formed wherein the constructed identity of Afro-descendant men is hypersexual, with the body as the center of reference. Eroticism is a fundamental pillar of this construct and implies the domination and objectification of women.

There is consistent evidence that Afro-descendant men have 7 years less life expectancy at birth, fewer years of formal education, and higher rates of imprisonment than their white counterparts. All of this is compounded by constant anxiety about meeting the basic needs of life. Health policies have proven insufficient, since skin color or social class constitutes a stigmatizing factor that leads to

social exclusion within the health system. There are high levels of social, symbolic, economic, and even physical violence against these populations in their interactions with the health system, armed groups, and the police.

A quarter of the difference in income levels is attributable to belonging to an indigenous ethnic group or being Afro-descendant. Being born of indigenous parents increases the probability of growing up in a poor household. This involves significant social stress, with four variables derived from the health disparities affecting these communities:

- trauma (sexual, physical, historical, racism-related; and post-traumatic stress);
- substance abuse;
- depression; and
- violence.

These factors create a vicious cycle that hinders the full development of the potential of children in these communities.

WORK. Work is central to men's lives and identities, in addition to determining their income level.

The division of labor by sex still permeates many sectors in the Region and influences the differential patterns of disease and death. Women tend to carry a double workload (paid and domestic), with domestic work being unpaid, invisible, multifaceted, repetitive, and undervalued, while men tend to do heavier physical work, often involving greater risk to health and life.

In the masculine identity, the central role of provider clashes with increasingly unstable labor conditions, leading men to endanger their health in efforts to maintain the role of provider and head of the family.

When social and material conditions make it impossible to fulfill the provider mandate, men (particularly primary providers) experience a crisis that leads to emotional exhaustion, in turn affecting everyone around them, especially their families. This partic-

ularly affects the younger generations of men and women living in a globalized economy in which men can no longer expect to identify with their work as a life-long career.

This reality has various consequences in the sphere of occupational health, namely:

- Rates of fatal work-related injuries are eight times greater in men than in women.
- Exposure to chemicals causes occupational injuries, deaths, infertility, and cancer.
- Informal work increases problems such as musculoskeletal pain and exposure to psychosocial risk factors.

From a gender perspective, some studies identify the ways in which successful migration increases men's symbolic capital, since this is interpreted as a new form of heroic gesture in the struggle to be the provider.

Much of the ethnic and Afro-descendant population lacks a comprehensive form of social security to cover health care expenditures. This helps to perpetuate precarious economic conditions and an inequitable distribution of income and wealth. Decent work is a dimension that plays a major role in class vulnerability.

SEXUAL AND REPRODUCTIVE HEALTH. Sexuality reflects the inequities inherent in the binary representation of masculine mandates (to be active, transgressive conquerors), in contrast to feminine mandates (to be modest, submissive virgins).

Gender inequities continue to be present in persistent problems such as unplanned pregnancies and sexually transmitted infections, and in family planning that focuses its strategies on women.

Young men tend to be uncomfortable with the topic of sexuality and are reluctant to speak openly about it.

They are less motivated to question the inequalities that favor them and they try to conform to the dominant stereotypes and behaviors.

The issue of contraception continues to reflect a lack of sensitive public policy, one that calls for shared male-female responsibility. Family planning and the use of contraceptive methods remain largely focused on women. The challenge, in regard to sexuality, is for men to be co-participants in equitable decision-making.

The problem of adolescent pregnancy is acute in Latin America and the Caribbean. It is estimated that 38% of adolescent girls become pregnant before the age of 20, with a fertility rate of 76 per 1,000 between 1991 and 2014, the second highest in the world.

This situation prompts questions concerning the participation of men. However, men's connection with these pregnancies and their participation in contraceptive strategies are topics largely absent in both international and national reports. Boys tend to be raised without parenting responsibilities, and little or no effort is made to teach them about caring for and raising children—responsibilities that fall to women.

Through conscious or unconscious actions, families, schools, and the health system support this view, at times punishing girls—but not their partners—for early pregnancy.

One country reports that of the 7,000 births to mothers under age 15, only 40% of the fathers were under the age of 20. In a large proportion of such cases, the age difference between mother and father is so great that it is hard to imagine that the pregnancy is not the result of sexual abuse perpetrated by an adult.

SEXUAL ORIENTATION. Men have diverse sexual orientations (heterosexual, homosexual, transsexual,



men who have sex with other men, etc.). This has important implications for the state of health in cases of emotional and physical abuse, or when there are difficulties in obtaining health services. It has been confirmed that lesbian, gay, bisexual, transsexual, transgender, and intersexual (LGBTTI) persons who are living with HIV and subject to high levels of stigmatization are 2.4 times more likely to delay seeking medical care.

Many health services are not clear on the specific and comprehensive needs associated with institutionalized homophobia and gender stereotypes, leading to a failure to recognize that each man's reality differs in relation to this determinant.

PARTICIPATION OF MEN IN BIRTH AND PARENTING. Many fathers do not live with their partners or children; thus, the relationships are characterized by physical, social, and emotional distance. Employment or lack of employment is one of the constraints on full participation in parenting. However, as a result of awareness, work, and generational changes, there is growing interest on

the part of men in accompanying and participating actively in pregnancy and childbirth.

When such participation is recognized as a right, young men participate more actively in childbirth, leading to greater benefits for mothers, children, and men themselves. In the countries of the Americas, paternity-leave legislation is increasingly frequent, though still insufficient. Only 15 of the countries in the Region provide paternity leave. Of these, seven provide one to three weeks; four allow five to seven weeks; and four others, more than eight weeks.

In areas such as contraception and family planning, adolescent pregnancy, and parenting, clear disparities can be seen. Men are not called upon to assume comprehensive shared responsibility for sexuality and reproduction. This exemplifies a gender culture that focuses on reproduction as an exclusively female phenomenon. Unless men, and especially young men, are educated and made co-participants in the area of sexuality, they will be even less responsible in the area of reproductive health.





Men in health policies and programs

4

The issue of masculinities has been extensively researched, but this knowledge has not yet become a part of public policies, programs, and projects. Public policies have focused on bridging the gender gaps that affect women, with only limited, specific interventions directed at men.

The term “gender” has been taken as a synonym for “women,” while masculinities have been rendered invisible or interpreted as part of the natural order of things. The differences and inequalities between and within the genders have not been effectively addressed.

In efforts to overcome this situation, there have been proposals for transformative or redistributive gender policies that consider the needs of women and men and that facilitate a redistribution of responsibilities, resources, productive and reproductive roles, and decision-making.

Governmental initiatives on the issue of masculinities have begun to appear, each preceded by the work of civil society organizations. But programs whose work focuses on masculinities tend to be of limited scope (individual, group, community), of short duration, and not part of the public policy agenda, which excludes long-lasting, sustained interventions capable of producing significant changes. Accordingly, it is imperative to mobilize the political will and economic resources needed to increase the scale and impact of work promoting gender equity and health for men and boys.

Frequently, men are not seen as allies, but rather as obstacles to gender policies. As a result, initiatives for men’s health tend to be marginal, insufficient, and late.

Various barriers have also been documented, such as logistical barriers (hours of operation open to the public, absence of services in remote areas, etc.) or those deriving from the construction of masculinity (mandates, associated risks, and lack of self-care). These barriers make it urgent to highlight the need for a comprehensive approach that places equal value on the needs of men and women.

There is a common and usually negative dialectic in which the health services have a lack of clarity with regard to men, and men are either disinterested in or fearful of the health services. This leads men to neglect care and self-care in a context of insufficient health coverage in the majority of the Region’s countries. The situation is even more problematic in terms of health coverage for indigenous and Afro-descendant populations, who have even fewer opportunities for care than the general population.

The SDH approach reminds us that it is necessary not only to promote health policies with a gender perspective, but also to focus on healthy policies (with concern for health in all policies) in areas such as education, work, living conditions, and combating discrimination based on gender, race, and sexual orientation.

The failure to see men in terms of gender is a blind spot in health policies, programs, and services, and in the university curricula for the various health professions. Such blindness also limits the possibilities of taking responsibility for problems in the health sector, such as the various forms of obstetric violence and the hushed-up problem of sexual harassment. These subjects represent both a challenge and an opportunity for men to exercise more horizontal forms of power and to play a proactive role.



Conclusions and recommendations

5

5.1 Conclusions

- There is a close relationship between masculinity and health. The roles, norms, and practices socially imposed on men demand or reinforce a lack of self-care and the neglect of their own physical and mental health. This has generated a culture of risk, with lifestyles and associated behaviors that have a negative effect on the lives of men in a variety of areas.
- As a result of this situation, men's average life expectancy at birth is 5.8 years less than women's, and men have a higher risk of dying at a younger age, with one out of five men dying before the age of 50.
- When masculinities and health are analyzed, and the SDHs and life course approach are taken into account, it becomes evident that the subordinated masculinities are greatly stigmatized by society and the health systems in the Americas.
- The LGBTTI population must confront institutional stigmatization, unequal access to services, and staff training that is inadequate to their needs.
- Afro-descendant and indigenous populations suffer from greater health inequities than the rest of the population, and they are invisible in the statistical databases. The men in these populations have higher rates of mortality and lower life expectancies.
- The practice of sexuality based on dominance, with little autonomy, limited information, and poor access to health care and sexual health resources, endangers men and their partners, as well as the LGBTTI population.
- The lack of universal health coverage in the majority of the countries of the Region is related to the fact that men make limited use of health services or use them late, not only due to their own resistance, but also because of the barriers they encounter in accessing care.
- The health sector addresses the multiple consequences of dominant male socialization in fragmented fashion and generally does so without a preventive and gender-based approach. Together with the gender-based inequalities that women confront, this exacts enormous costs and shapes the development and funding of health policies and programs.
- Civil society and academia have proposed various solutions to address these problems. However, the initial responses have been marginal, insufficient, and slow. Such initiatives must be scaled up to ensure their continuity and systematic evaluation.

5.2 Recommendations

The following recommendations are based on a review of the literaure, the contributions of experts, and the epidemiological evidence:

1. Improve, systematize, and disseminate the quantitative and qualitative knowledge on masculinities and health, as well as the costs. Conduct more studies on the diversity among men, the relationship with the SDHs, and the barriers to improved health outcomes for men.

2. Develop public health policies and programs for the comprehensive prevention and targeting of the main problems affecting men throughout the life course based upon an understanding of men’s health problems intertwined with the SDHs, interculturalism, and a relational approach to gender. National responses must define meaningful integrated strategies that involve ongoing dialogue with the women’s movement and the active participation of men.

3. Eliminate the barriers that prevent boys and young and adult men from seeking health care and intensify efforts to ensure equitable access to health for those who have masculinities that are subordinated due to ethnicity/race or sexuality.

4. Develop a national intersectoral initiative to improve public education efforts which address gender equality and gender-equal masculinities; framed by the SDHs, the health in all policies approach and, the significant monetary and social cost of dominant masculinities.

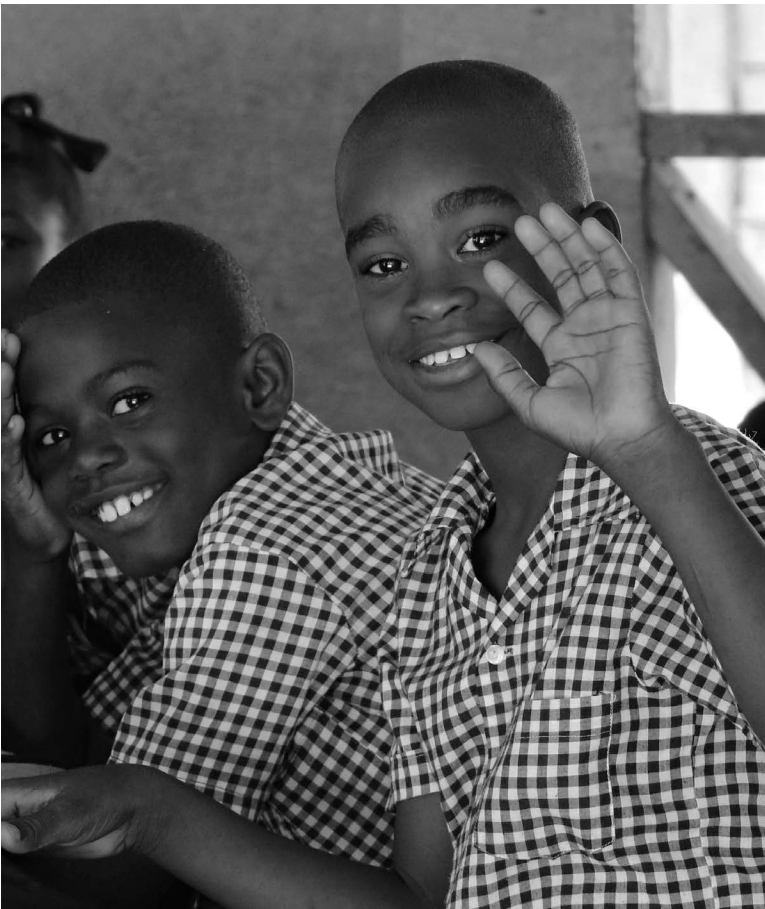
5. Seek a deeper understanding of existing health resources and positive health practices that already target and engage men, in order to strengthen knowledge and create best practices.

6. Ensure that health promotion and community participation efforts have defined inclusive methods to conduct health communication and self-care education with diverse groups, based on gender-equal, intercultural, and empowerment approaches.

7. Expand competencies of health providers, teachers, academia, and the media on gender, masculinities, interculturality, and human rights.

8. Implement health promotion programs directed at children and youth, addressing health issues while emphasizing nonviolence, gender equality, parenting, a comprehensive view of sexuality, and shared responsibility for care.

9. Forge wider synergies with international partners, the health sector, universities, and civil society to prevent the impact and costs—both for women and men—of rigid and dominant masculinities on health and well-being. Thus, gender equality moves beyond a matter of mere rhetoric and becomes a daily practice for both men and women.



Life expectancy at birth has increased in the Region of the Americas in recent decades. However, women live 5.8 more years on average than men: excess mortality in men begins in adolescence and triples in early adulthood. What are the reasons for this situation? The leading causes of mortality in men include interpersonal violence, road traffic injuries, and cirrhosis of the liver, all associated with the exercise of a hegemonic masculinity.

Masculinities and Health in the Region of the Americas describes how men's health and well-being is a product of multiple factors, in particular the construction of masculinity. The report details how the various masculinities impact men's health as well as the health of women, adolescents, and children. It also documents how social determinants such as gender, ethnicity, age, and education exacerbate the inequities and barriers to health that certain groups face. Based on an exhaustive analysis of the available literature, surveys, and expert opinions, the report reveals the complexity of the issue of masculinities and health, and the failure to address this issue in the policies and programs of the Region's countries.

It would be unthinkable to analyze men's health from the gender perspective without feminism as a forerunner. It is time to mobilize the political will and the resources necessary to adopt an approach that encompasses both men's and women's needs. To help achieve this objective, the report concludes with nine innovative recommendations aimed at helping to integrate the relational gender perspective into a multisectoral strategy of coordinated policies to improve the health of men and boys.

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