

MASCULINITIES AND HEALTH

in the Region of the Americas



PAHO



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Contents

Foreword.....	v
Acknowledgments.....	vii
List of abbreviations and acronyms.....	viii
Summary.....	1
Introduction.....	5
1. Gender and masculinities	6
1.1. Masculinities from a gender perspective.....	7
1.2. Masculinities, socialization, and health	9
1.3. Men and health: risks, vulnerabilities, and self-care	12
2. Masculinities, risks, and health evidence	16
2.1. Morbidity/mortality, by cause	18
3. Social determinants and men's health	26
3.1. Health and life course.....	27
3.2. Ethnicity	33
3.3. The work dimension	35
3.4. Men and sexual and reproductive health.....	37
3.5. Masculinities in a diverse, globalized, and changing world	41
4. Men in public policy and health programs	44
5. Conclusions	50
6. Recommendations	58
7. References	64
8. Glossary	76
ANNEXES	78
Annex A. Methodology.....	78
Annex B. Development and diversification of the masculinities field	81
Annex C. National advances on work with masculinities and health	84

List of tables and figures

Figure 1.	Ecological model of gender.....	10
Figure 2.	The Man Box	11
Figure 3.	Healthy life expectancy at birth, by sex, Region of the Americas, 2015	17
Figure 4.	Percentage distribution of mortality, years of life lost (YLLs), and disability-adjusted life years (DALYs), by sex, Region of the Americas, 2011-2015	18
Table 1.	Ten leading causes of death in men, Region of the Americas, 2015	19
Figure 5.	Percentage distribution of mortality in men and women, according to selected causes that mainly affect men, Region of the Americas, 2011-2015	20
Table 2.	Main causes of years of life lost (YLL) for men and for women, Region of the Americas, 2015	24
Figure 6.	Conceptual framework of the social determinants of health ..	28
Figure 7.	Leading causes of death in men throughout the life course, Region of the Americas, 2015, and percentage of total YLLs in men, by age group	29
Figure 8.	Leading causes of death between 15 and 29 years of age, by sex, Region of the Americas, 2015	30
Figure 9.	Leading causes of years of life lost (YLLs) in men throughout the life course, Region of the Americas, 2015	32
Figure 10.	Contraceptive methods used by men and women between the ages of 15 and 49, 15 countries of Latin America and the Caribbean, according to available information (%), 2006-2013	39
Figure 11.	Causes and experiences of vulnerabilities associated with masculinities	53
Table C1.	Maternity and paternity leaves in Latin America and the Caribbean	87



Foreword

It is a constant finding that women, on average, live longer than men. Globally, life expectancy at birth for women is 4.4 years higher than for men. In the Region of the Americas, the difference is even greater at 5.8 years. The spike in mortality for males first peaks around age 15, when boys are in the last stage of puberty and when differences in male and female socialization have become fully pronounced. This poses a critical question for public health: How do these differences in socialization—established in childhood and carried and further developed into young adulthood and beyond—affect men’s health behaviors, health risks, and access to health resources?

Addressing this question is indeed overdue, as considerable evidence has already emerged about the differences in morbidity and preventable mortality between men and women. Much has been written about how women’s socialization creates gender inequalities that negatively impact their health, especially their sexual and reproductive health and vulnerabilities to violence. Yet there is growing evidence that differences in socialization also contribute to a broad range of health behaviors that adversely affect men’s health. For example, three of the leading causes of death for men—interpersonal violence, road traffic injuries, and cirrhosis of the liver—are linked to the exercise of masculinity, as are substance abuse and mental health problems.

This report provides a gender-sensitive framework—the “masculinities” approach—for identifying how masculine norms translate into important and persistent barriers to men’s health. The report reviews the existing literature on masculinities and critically examines health data to provide a fuller view of men’s health status, its interrelations with gender constructs, and how new and better models of care can be developed by using the masculinities framework.

In this Region, initiatives do exist that integrate gender and masculinities perspectives into public health policies and programs in several countries. However, these are often driven by civil society organizations rather than governments, and tend to have limited scope, focusing on later stages of the life cycle as opposed to adolescence and youth.



This report aims to move the agenda forward for masculinities and health, promoting further studies while fomenting both discussion and action among decision-makers, health workers, and other partners. The report reflects PAHO's ongoing commitment to the achievement of gender equality in health outcomes, which is absolutely critical to achieving health for all people in the Americas.

Dr. Carissa F. Etienne

Director



Acknowledgments

This report on *Masculinities and Health in the Region of the Americas* was prepared by the consultant Benno de Keijzer Fokker, in collaboration with Fernando Mendoza Melchor, Alexis Valenzuela, Ivan Ovando, Edna Cortés Ramírez, and Alejandro Loya Jiménez.

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List of abbreviations and acronyms

DALYs	Disability-adjusted life years
HLE	Healthy life expectancy
HPV	Human papilloma virus
LAC	Latin America and the Caribbean
LEB	Life expectancy at birth
LGBTTI	Lesbian, gay, bisexual, transsexual, transgender, and intersex
M+H	Masculinities and Health Survey
PAHO	Pan American Health Organization
SDH	Social determinants of health
STI(s)	Sexually transmitted infection(s)
WHO	World Health Organization
YLLs	Years of life lost



Summary

This document addresses a need identified by the Pan American Health Organization (PAHO), specifically, a lack of documentation on the implications of masculinities for men's health, on the main concepts and epidemiological evidence, and on present and potential actions both to promote men's health and to address the impact of masculinities on the health of women, adolescents, and children in the Region of the Americas. This work deals with a problem that has long been “hiding in plain sight” (Baker, 2018).

Analyzing men's health from the gender perspective would be unthinkable without the precedent of feminism and gender studies. Gender is understood as a form of social organization, a historically and culturally constructed set of attributes and roles. These are preserved through actions in the everyday organization of society; their objective is to differentiate women and men based on biological characteristics and in alignment with a sex/gender system (Núñez, 2017) that is internalized through socialization (Sáez, 1990).

Masculinity is a complex set of attributes, values, functions, and behaviors that are understood to be essential to men in a given culture. However, it is necessary to consider the concept of “diverse masculinities,” which can share elements in common with the dominant masculinity, but containing very different ways of being a man that also contribute to variants in the trajectories of the health/disease/care process based on social determinants of health (SDH), such as ethnicity, class, age, migration, sexual orientation, work, and education, among other factors (Connell, 1995; Figueroa, 1998). In general, both the Afro-descendant and indigenous populations are subject to greater health inequities than the rest of the population. At the same time, these populations are subject to an intertwined complex of discriminations associated with gender, ethnicity, income level, and other factors, making it necessary to address the intersections of these types of discrimination.

Hegemonic masculinity is based on the sexual division of labor and permeates the lives of both men and women. This system provides clear privileges for men. Over time, some of these prerogatives become inflexible, becoming vulnerabilities for men's own health and risks for women and for other men. Some of the most significant features of the dominant masculinity are systematized in mandates such as self-sufficiency, strength, competitiveness, leadership, rigid gender roles, heterosexuality and homophobia, control, aggression, and the provider role. Some characteristics, such as aggressiveness and competitiveness, contribute to addic-

tions, dysfunctional family relationships, unprotected sexual practices, and violent and reckless behaviors at the wheel of motor vehicles.

In the course of the last few decades, life expectancy at birth (LEB) has increased overall. However, a 5.8-year gap remains between women and men. The prevalences of the leading causes of death are very similar in the two sexes (chronic obstructive pulmonary disease [COPD], lower respiratory tract infections, diabetes mellitus, ischemic heart disease, and lung cancer). However, some of these causes—linked to the exercise of hegemonic masculinity and its consequences—show greater differentials: interpersonal violence¹ (with a mortality ratio of seven men to one woman), road injuries, suicide (three times as many among men as among women), and HIV/AIDS, drug use, and cirrhosis of the liver (more than twice as many male deaths).

The leading causes of death in men are noncommunicable diseases. The majority of these deaths occur between the ages of 15 and 49. Even mortality due to specifically male diseases such as prostate and testicular cancer has increased. A high proportion of these deaths occur years after exposure to various risk situations. Realities such as this make it necessary to examine the construction of masculinities and their specific effects on men's health (Barker, 2005).

From a life course perspective, we know that at around age 10, the difference in mortality between boys and girls increases as a result of deaths from road injuries, homicides, and drowning. This disparity peaks during adolescence and early adulthood, with male

death rates doubling and even tripling, primarily as a consequence of violent causes and suicide, which appear at this time of life. Over 20% of men die before the age of 50, amounting to an alarming one out of five men. This contrasts with the figures for women, which only reach that proportion at 60 years of age.

The idea persists that men are providers who lack specific needs. They are basically considered productive agents, thus perpetuating and reinforcing the sexual division of labor (Jiménez and Tena, 2015), despite the fact that more and more women are entering the labor market. This masculine mandate runs up against the reality of increasing job instability and leads men to risk their health in order to maintain their provider role (Valenzuela, 2008; Olavarría, 2013, 2017).

Analysis of the health/disease/care process in men from a life course perspective makes it possible to identify and address a variety of risks and problems in a timely manner. It is also a way of identifying opportunities to put in place the necessary resources (Hernán et al., 2010) for prevention and health promotion, in seeking to establish of a comprehensive health policy.

With regard to sexuality, according to the IPAS-Bolivia (2016) report, men tend not to acknowledge their problems, due to embarrassment or because they do not know how to articulate their problems and feelings. Rather, they base the exercise of their sexuality and reproduction on the beliefs and attitudes that they have acquired in the process of constructing “how to be men.” Their participation in contraception and family planning is important for managing their sexual, emotional, and reproductive life. Historically, however, this has been considered a matter for—and the responsibility of—women. The use or non-use of contraceptives is one of the conditions limiting full participation in child rearing (Molina, 2011). Another central reproductive issue is men's participation in

1 Interpersonal violence includes violence against a family member or partner, as well as community violence between unrelated people who may or may not know each other, the latter generally occurring outside of the home. What distinguishes collective violence is the number of individuals involved, including groups with numerous members, or, in some cases, violence perpetrated by the State (WHO, 2003).

birth and parenting. Young fathers, in particular, are showing increasing desire to participate actively in the birth and raising of their children.

This report describes how the health and well-being of men in the Region is the product of multiple factors, one of which is the construction of masculinity or masculinities. Men of the subordinated masculinities (for example, members of the indigenous, Afro-descendant, and lesbian, gay, bisexual, transsexual, transgender, and intersexual [LGBTTI] communities) are stigmatized not only by society, but also by the health system, as indicated by Escobar in the Masculinities and Health Survey (M+H survey; see Annexes). Moreover, health teams have not been trained to provide care specific to these groups. Homosexual men suffer from institutionalized homophobia, which makes it more likely they will contract human immunodeficiency virus (HIV).

Historically, the scientific literature has viewed men as an obstacle to the implementation of gender policy (Barker et al., 2012). Civil society, however, along with support from various organizations, has produced strategies for working with men that address issues such as violence, sexual and reproductive health, and parenting. These strategies have produced results that should be taken into account in government policies. Due to limited resources and coverage, many of the policies that do address men's health continue to be marginal, insufficient, and too late. Some of the

main conclusions set forth in this document point to the fact that the enormous excess in male mortality is clearly linked to the exercise of hegemonic masculinity, to the social determinants of health, and to lack of a comprehensive social response capable of addressing and preventing this situation.

It is widely recognized today that prevention and health promotion for men extends beyond the realm of the health sector. It is therefore important that an understanding of the relational gender perspective² be part of a broad approach in which coordinated policies are directly and indirectly related to other areas, such as labor, environment, security, and, of course, health. The goal is to produce healthy policies, also known as “health in all policies”—in other words, policies in other sectors that have positive impacts on health, with special attention to the SDHs that directly or indirectly affect men's health. This requires gaining wide participation by men themselves.

The recommendations presented at the end of this document point to the need for a greater number of research projects, the creation of relational gender policies and programs in health that address the SDHs, training of human resources for health, and the integration of this perspective in the functioning of the health sector itself.

² A perspective that examines the inter-relation between the experiences of women and men—in this context, in the field of health.



Introduction

This document responds to a call by the Pan American Health Organization (PAHO) to generate a concept paper on masculinities and their health implications. The premise was to include the specific areas needed to deepen the analysis of men's health and suggest potential interventions to improve it, as well as 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. Once the project was approved, an exhaustive review was conducted of epidemiological information from the databases of PAHO, the World Health Organization (WHO), the World Bank, and other sources, as well as a review of the available bibliography on the subject. The Masculinities and Health (M+H) survey was also conducted, with 32 experts from 12 countries. The resulting information was systematized and integrated into the different sections of the document. The final draft was revised again by a team of experts to produce the final version. Annex A provides additional details on the methodology used and on the people who participated in the survey.

This report reflects the complexity of the masculinities and health in a way designed to be accessible to decision makers, as well as people working in health and related fields in the Americas. Analyzing men and their health from a gender perspective is a relatively innovative approach, despite the fact that gender is one of the main SDHs.

The document has six sections: (1) a conceptual framework for masculinities and male socialization and its relation to health; (2) epidemiological evidence concerning men's health; (3) SDHs related to the subject; (4) policies and programs; (5) conclusions; and (6) recommendations. At the end of the document, a list of bibliographic references is provided. Given the volume of information consulted, several annexes have been included to allow for a more in-depth look at specific aspects.

Producing this document provided the opportunity to construct a collective approach to a set of problems of enormous scope and complexity. The content presented here enabled us to make a variety of recommendations aimed at implementing a comprehensive social response in the Region of the Americas.

Gender and masculinities

1



1.1 Masculinities from a gender perspective

The present analysis of 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 in these various fields.

The concept of gender goes beyond the biological and reproductive and is understood as the set of historically and culturally constructed attributes (symbols and norms) and roles (identities) that are preserved through actions in the everyday organization of society, and whose objective is to differentiate women and men based on biological characteristics and in alignment with a sex/gender system (Núñez, 2017). This sex/gender system is understood as the set of ways in which a society transforms biological sexuality into products of human activity, and in which those transformed human needs are met (Rubin, 1975, quoted in Lamas, 1996). This concept explains how differences translate into inequality between men and women, and how the subordination of women occurs. The sexual division of labor is the substrate of these sex/gender differences (Olavarría, 2017). 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 acting in the world—a process that involves human beings throughout their life course (Sáez, 1990).

The concept of gender goes beyond the biological and reproductive and is understood as the set of historically and culturally constructed attributes (symbols and norms) and roles (identities) that are preserved through actions in the everyday organization of society.

The sudden emergence of gender as a category makes it possible to question and look anew at the persistent binarism of today's cultures. This binarism is understood as the tendency of most societies to classify nearly everything in two groups of elements that are both differentiated from and opposed to each other. This is what happens when "masculine" and "feminine" are polarized and a series of characteristics, attributes, functions, and values are associated with these poles

and classified in different ways by different cultures and at different times.³ Vicent (2008) states that almost all human characteristics (ranging from functions and emotions to perception of colors) are fundamentally neutral, but different cultures attribute one or the other gender to them. This rigid polarization has been increasingly questioned by the broad-based women's movement, the LGBTTI movement, and the initial analysts of masculinities, as an element that limits the development of people's potentials and rights.

The gender perspective emerged in the 1980s as a response to the need to understand and denounce the subordinate condition of women, opening the door to an understanding of the male condition (Kimmel, 1992). The Fifth International Conference on Population and Development, held in Cairo in 1994, and the Fourth World Conference on Women, held in Beijing in 1995, concluded with a call for men to participate, and international health policies shifted their focus to aspects such as reproductive health, and efforts to combat HIV/AIDS and domestic violence. All of this created a foundation for a relational gender perspective, allowing for an understanding of the specific conditions of women and men, while also providing the opportunity to recognize and overcome inequalities.

Parrini (2000) used the metaphor of "Eve's rib" to describe how the study of masculinities was born. As a field of knowledge, these studies have undergone ma-

The range of masculinities can include elements commonly associated with the dominant, or hegemonic, masculinity. But it also includes highly diverse ways of being a man—ways that contribute to different trajectories in the health/disease/care process.

For development and thematic diversification, first in the European and English-language literature, then in the literature from Latin America and the Caribbean (LAC). This topic is explored further in Annex B, which serves as a brief guide to this field.

Gender analysis also reveals the diversity of the masculine and the feminine. Beyond the binary opposites reflected in statistics, a continuum that stretches both biologically and culturally

between extremes that could be termed "hypermasculine" and "hyperfeminine." This implies a range of masculinities that can include elements commonly associated with the dominant, or hegemonic, masculinity. But it also includes highly diverse ways of being a man—ways that contribute to different trajectories in the health/disease/care process.

Based on the above, masculinity can be defined as a set of attributes, values, functions, and behaviors that are considered to be essential to men in a given culture. Connell (1995) points to the existence of a hegemonic model⁴ of masculinity, defined as a culturally constructed pattern in which men are dominant. This model serves as a basis for discriminating against and subordinating women and other men who do not or cannot adapt to this model. This hegemonic masculinity leads to gender practices that reinforce the legitimacy of patriarchy, guaranteeing the dominant position of men and the subordination of women. This oppresses not only women, but also men with other masculinities, who are subordinated because of their age, class, race, sexual orientation,

3 For example, some of the male fashions of the 18th century gentleman would be considered "effeminate" today, as would the use of the kilt, which in Scotland was an unquestionably masculine "skirt."

4 Here we approach hegemony as a form of domination, linked with the generation of certain degrees of consensus among men and women, the consequences of which tend to be toxic.

etc. (Figueroa, 1998). As a result, each man is on a continuum that he shares to varying degrees with other men, having common and diverse elements. In a later section, further consideration will be given to the SDH perspective, which helps us understand these other dimensions that interact with gender in men's lives, and which lead to intersectionality.

In the Americas, with its national and regional variants, a culturally and historically constructed hegemonic form of socializing men has predominated, often referred to as machismo. While it 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. A boy or young man socialized in a family in which differentiated gender roles are absent will ultimately be exposed to the hegemonic masculinity in settings such as school, other families, young people's networks, or work, or in the process of migrating to other regions (De Keijzer, 2010).

Considering men from a gender perspective means combining gender specificity (in which men's specific needs are taken into account) with gender sensitivity (aimed at achieving the equal exercise of rights by women and men) (Medrado and Lyra, 2008). The present document assumes that the condition of men is socially and culturally constructed (with a strong gender-oriented basis). As a result of this construction, men's actions affect their own health and that of others. Moreover, men can be a driving force in bringing about changes that can improve their health and the health of others.

Another important background element in understanding masculinities is the development of so-called gay studies. As a movement, these studies reflect the men who first began to question their identity and to break away from hegemonic masculinity, primarily in terms of sexuality. Even as societies,

policies, and programs are still in the early stages of assimilating the demands and lessons of feminism, powerful challenges are being posed by other forms of sexual diversity, including transgenderism and intersexuality. This causes confusion and resistance in a large proportion of men, though this varies from country to country. However, observing and analyzing men from the gender perspective also provides the opportunity for thought and change. This is where we see the great richness and potential of the gender perspective.

1.2 Masculinities, socialization, and health

Men have historically dominated the sciences and the historical narrative. The idea that both science and history are presented from a patriarchal male perspective was raised as early as 1993 by Castro and Bronfman. Analyzing men from a gender perspective brings a new critical perspective to the construction of masculinities. Although men have been present in much of the feminist literature as oppressors, until very recently there was no movement to understand men in terms of their own situation and social construction (Kaufman, 1997; Kimmel, 1997; Núñez, 2017).

Through the sexual division of labor, hegemonic masculinity permeates the life of both men and women:

The power of the male order lies in the fact that it dispenses with any justification: the anthropocentric vision is imposed as neutral and feels no need to explain itself in discourses that would legitimize it. The social order functions as an immense, symbolic machine that justifies the male domination on which it is founded: the sexual division of labor, a very strict distribution of activities assigned to each of the sexes and their time, space, and tools (Bourdieu, 2000, p. 22).

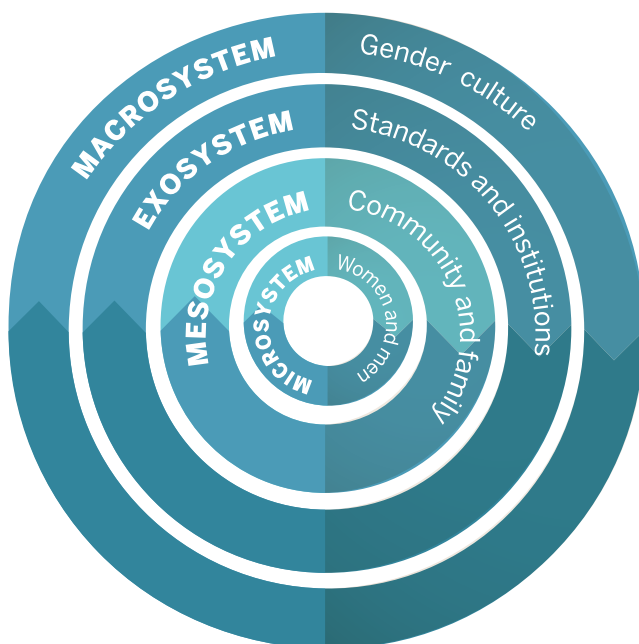
This order of inequality is constructed through processes of socialization that provide clear advantages to men. Over time, through rigorous normalization, some of these can gradually exact a toll not only on a man's health but also on that of women and other men. Many of these assigned characteristics end up being naturalized, along with the differences between men and women. Thus, "gender is a constitutive element of social relationships based on perceived differences between the sexes, and gender is a primary way of signifying relations of power" (Scott, 1986, quoted in Lamas, 1996). Gender differences appear before children discover their biological differences or those associated with race or ethnicity (Fuller, 1997).

Those characteristics are assigned to children from the earliest age through the family and through a variety of networks and institutions (Figure 1). Children incorporate them because they seem advantageous for inter-gender relationships. In other words, they are socially valued characteristics. These advantages tend to be invisible, and partially or totally denied,

especially by men. Rather than rigid socialization that automatically creates a certain type of man, it is more useful to consider how pressures and limits are established that intervene in the lives of specific men (Williams, 1977). The means of incorporating hegemonic male practices is facilitated, or is established through pressure, while limiting other, divergent practices. These pressures and limits can be accepted, modulated, or contradicted to differing degrees and at different times. One example of this type of pressure on men is the need to always appear sure of themselves and invulnerable in areas as diverse as health, work, and sexuality. Examples of prohibitions include not crying, not being afraid, and not fleeing (Bonino, 1989; Valdes and Olavarría, 1998; Connell and Messerschmidt, 2005; Valenzuela and De Keijzer, 2016).

It is striking that many of the rites of transition to "manhood" involve risk for boys and young men, and sometimes even for other people. This suggests the possibility of creating another type of ritual that does not have that potential cost (De Keijzer, 2004).

Figure 1. Ecological model of gender

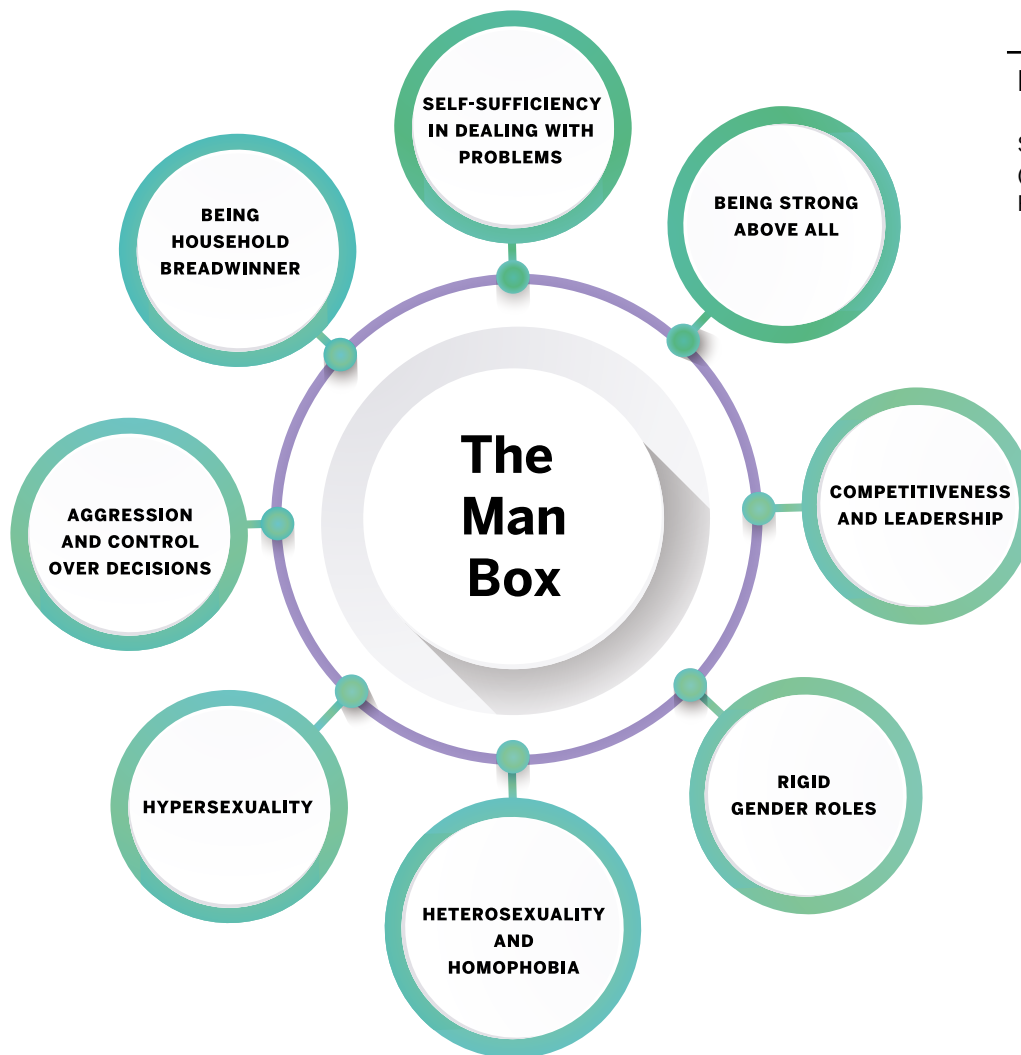


Source: Reproduction authorized by GENDES and other organizations, 2018 (p. 42).

Note: This graphic is based on the ecological model of Bronfenbrenner, cited by Heise et al. (1994). It provides a more systematic view of the processes, in an effort to facilitate an understanding of the complexity of both the problems and changes, ranging from the microlevel (individuals) through the mesosystem (family and community) to the two broadest systems: institutions and laws (the exosystem) and gender culture as a whole (the macrosystem).

Figure 2. The Man Box

Source: Based on Heilman (2017), Jiménez (2015), and Reddock (2004).



Indeed, “[men] learn from an early age that violence is an attribute that can define us as men” (Guzmán, 2014, p. 4). For those trapped in masculine identities they do not identify with, Seidler (2006) points out the conflicts between the emotional life of young men and their public expression. Bonino (1995) coins the term “micromachismos” to refer to the “invisible” behaviors of violence and domination expressed by almost all males in their daily relations with women, and which have an effect on their autonomy and psychological state.

Some of the most significant characteristics of hegemonic masculinity have been systematized in the research known as the Man Box. Enriched with convergent research, it is illustrated in Figure 2, above.

Characteristics such as aggressiveness and competitiveness contribute to men’s violent and reckless behaviors in driving, family relationships, and sexuality, as well as in addictions, something that Bonino (1989) and De Keijzer (1998) mentioned as early as the 1990s. This is reflected in the over-representation of men in prison, where there is a synergy with negative effects on their health (Sabo, 2000).⁵ These consequences are dealt with in greater depth in the section below.

A number of authors from the English-speaking Caribbean speak of the existence of a colonial, capitalist, and white patriarchy linked to norms

⁵ This situation is represented dramatically in the documentary *The Mask You Live In*, directed by Jennifer Siebel Newsom.

of masculine heterosexuality, consumption, beliefs about white racial superiority, and compliance with external forms of identity. This system is frustrating for young men who are not white, who feel dissatisfied with the place they occupy, and who devote a great deal of energy to trying to participate in the latest fashions and trends. Such young men are captivated by the image

of themselves as sexually aggressive, and are anxious to show their prowess (Bennett, 2014), a reflection of the hyper-aggressive and hypersexual hegemonic masculine norm. This is a serious problem that is evident in increasing violence, above all in the young population, with excess male mortality serving as an alarm bell (Bennett, 2014; James and Davis, 2014).

Many stereotypes and mandates are clearly transmitted through families, but they can also be seen at the different levels of a society. The ideas outlined above help to contextualize those influences in the ecological framework proposed by Heise et al. (1994), which points to a more complex analysis of all these problems (see Figure 1). This approach focuses on what happens at various levels: personal, interpersonal relationships (including couples), institutional (school, church, etc.), and public policy. The gender perspective makes it possible to go from the subjective to the social and structural levels, with complex links to intermediate levels. It also helps us examine different levels of intervention when we want to work toward achieving gender equality.

1.3 Men and health: risks, vulnerabilities, and self-care

In the area of health, it is essential to have a relational gender perspective that compares men's and

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women's situations in specific contexts, and that reflects how these situations influence each other in a reciprocal fashion. Men and women experience different forms of socialization according to their sex, which leads them on different paths in terms of access to resources, divergent vulnerabilities, and different forms of self-care, as well as in different patterns in seeking help. Various

areas of health show that inequality has consequences for women, while masculine socialization has high costs for men (De Keijzer, 2016).

In the field of health, these considerations point to the achievement of a goal in relation to gender equality. Gender equality in health means that women and men have equal conditions for realizing their full rights and potential to be healthy, contribute to health development, and benefit from the results. Achieving gender equality will require specific measures designed to eliminate gender inequities (PAHO, 2005).

It has been demonstrated that women are subject to a different degree of vulnerability due to the various problems associated with reproduction (pregnancy, childbirth, and puerperium) and the numerous inequities associated with these processes. They are also vulnerable due to sexually transmitted infections (STIs), gender violence (ranging from psychological violence to femicide), and their status as women. In addition, the quality of care for women these problems is insufficient, a situation that can be further aggravated by social class or ethnic origin. Men, for their part, experience higher morbidity/mortality, along with numerous other public health problems, as is made clear in the following section.

It is a relatively new phenomenon that civil society, academia, some international organizations, and certain government programs in the health sector are beginning to see men's health from a gender perspective. Men continue to be seen from the perspective of the hegemonic medical model (Menéndez, 1990) and the current culture, and from a traditional and male-centric perspective (Castro and Bronfman, 1993). In other words, they are seen as providers without specific needs beyond those of *Homo faber*, the productive man. Paradoxically, this occurs in a context in which formal work is increasingly scarce, thereby reducing the possibility of men being the main providers (Burin and Meler, 2000; Jiménez and Tena, 2007).

This view, permeated by biology and scientism, sees human beings, both men and women, through the lens of medical specialties. Thus, it analyzes and separates them, denies their integral nature, and loses sight of the elements that unite and explain their differing health problems. The gender perspective makes it possible to consider and connect these issues. It is paradoxical that while men have served historically as the benchmark and paradigm, their own vulnerabilities have tended to become invisible.

First medicine and later epidemiology, from an analytic biological perspective, observed the different patterns of disease and death in the two sexes. The gender perspective strives to explain the different trajectories of women and men from a social and cultural perspective in which power relationships play a role. The gender perspective does not ignore the fact that there are diseases or predispositions in which biological sex is the dominant factor, although the experience of them and the action taken to confront them tend to be different in women and men (Garduño, 2011). In this area of analysis, Courtenay (1998) and Sabo (2000) presage the analysis of men's health in the literature produced in the United States of America.

Gender is one of the major structural determinants of health, disease, and death, linked with other dimensions such as class and ethnicity. For the purpose of this analysis, the concept of intersectionality has been used. Its origin is in feminist sociological theory (Crenshaw, 1989); it permits us to analyze and discuss the ways in which different aspects of oppression often intersect, creating unique and varied experiences of discrimination. For example, vulnerability to STIs in men who have sex with men is even greater in young, poor, and indigenous and Afro-descendant men (Centers for Disease Control and Prevention, 2017; Frasca et al., 2013). These forms of intersection are addressed in the section on SDHs.

Gender study has not yet realized its full potential in attempts to understand the differential processes of health in women and men. It is difficult to imagine a field or problem in health in which gender is not present to some degree, whether in the origin of a problem or in its evolution and in regard to care. Through analysis of the health/disease/care process in men from a life course perspective, it is possible to identify various vulnerabilities and problems, provide timely care, and identify opportunities to put in place the necessary resources (Hernán et al., 2010) for prevention and health promotion, in furtherance of a comprehensive health policy.

To understand and synthesize the consequences of masculine socialization, the concept of masculinity as a risk factor is useful (De Keijzer, 1998) when working with masculinities, their social construction, and the way in which they affect women's lives. Revisiting the "triad of violence" proposed by Michael Kaufman (1997), in the context of socialization in the hegemonic masculinity, men represent a risk triad, also referred to at times as "toxic masculinity":

- 1) toward women and children**, through the various types of violence, psychoactive

substance abuse, STIs, forced pregnancies, absent fatherhood, and lack of co-responsibility in the domestic realm;

2) toward other men, in the form of accidents, homicides, and other forms of violence, as well as through the transmission of HIV/AIDS; and

3) toward themselves, through suicide, accidents, alcoholism, other addictions, and psychosomatic illnesses.

Vulnerability in men has its origin in precarious environments and contexts, frequently reflected in a minority presence or limited power. Precariousness is linked to ethnicity, poverty, geographic dispersion, rurality, or being a member of a sexual minority. It is worth noting that men who live under these conditions are not excluded from exercising the privileges associated with the cultural model of hegemonic masculinity.

Thus, while suffering from discrimination or violence, they may also engage in practices that are risky for themselves or others, aligned with the hegemonic masculinity. Masculinity therefore involves synergy (Sabo, 2000) between the assumption of risks and vulnerability,⁶ with high costs in terms of men's well-being and health. One example of this, involving road injuries, is a man who, while driving fast after drinking, uses his cell phone and runs down a vulnerable man who is returning from work after a double shift, crossing the road to his home in a poor neighborhood.

Rivas (2006) warns that the notion of the risk triad should not lead us to generalize, and that it is important to take into account other ways of being a man,

⁶ Risk is understood as those acts or conditions in the society or environment that increase the likelihood of disease or injury, while vulnerability refers to susceptibility to harm attendant on exposure to social and environmental tensions, and to the ability to respond and recover. It is an indicator of social inequity and inequality (Araujo, 2015; Neil, 2006).



and other potentially constructive dimensions of masculinity. It is clear that not all men pose a risk, and that those who do, do not pose a risk all of the time. A salutogenic view must be developed, examining the causes of health, and focusing on ways of being a man in which self-care and care of others predominates (Antonovsky, 1996). This includes masculinities that embody, for example, sensitivity, respect, and commitment to active and full parenting (Aguayo and Kimelman, 2014), as well as masculinities where men are professionally involved in health care and choose careers that have historically been feminine, such as nursing, occupational therapy, and social work (Valenzuela, 2016). However, a path that leads away from disease and pathology remains largely elusive.

This perspective prompts a number of questions about men who do care for their health. How were they socialized? What is their history and experience? Indeed, who are these men? Where are they? What can we learn from them? Obviously, they do not appear in the mortality and morbidity tables. Public health, which is very attentive to early prevention and detection of disease, tends to ignore them. An examination of these questions is important for our thinking in the field of health, particularly when designing initiatives for prevention and health promotion that are sensitive to the various realities that foster healthy behaviors (De Keijzer, 2016). How, for example, is a healthy and creative life constructed in youth, or a full and successful old age? From his salutogenic perspective, Antonovsky (1996) notes that “upstream,” which is to say early on, we must ask new questions, with a view to proposing programs and policies focused on health, rather than focusing solely on disease and disease prevention. This perspective is present in civil society initiatives, such as Program H (Health and Gender, 2010), MenEngage,⁷ and MenCare.⁸

7 See www.MenEngage.org and its regional networks: Latin America, North America, and the Caribbean.

8 <https://men-care.org>.

Another concept to consider along these lines is that of self-care proposed by Foucault, which Muñoz (2013) employs to analyze men’s relationship with their bodies and their health. This perspective runs counter to the demands of hegemonic masculinity, which calls for risk-creating behaviors as a pathway to identity (although these behaviors are not perceived as risky, or the degree of risk is disregarded). Self-care challenges several of the mandates of masculinity, such as the provider role, in which men renounce caring for themselves or seeking care, since they are required to work in the face of constant uncertainty or in fear of losing their employment (Schraiber et al., 2005).

Self-knowledge is a fundamental element of self-care. It means developing a special kind of attention to subjective experience and to behaviors that affect oneself. Caring for self is also caring for others. The need to care for oneself is connected with the exercise of power (Foucault, 1987). Self-care is a concept that involves forms of interaction with one’s own body and with the social and natural environment. It involves being attentive to what is going on in one’s mind, to everyday actions that affect oneself, and to actions at the social level that affect or involve health (Muñoz, 2013). Self-care is a matter of positioning oneself in relation to these needs, assuming responsibility, and taking ownership of one’s own body, health, and well-being.

Hegemonic masculinity clearly affects the health not only of men, but also of women and children in many ways. The following section highlights men’s health problems where gender is present or is a determining factor. Although the statistics of the last several decades have shown a large and increasing excess in male mortality, the epidemiological aspects of this problem remain largely unexamined from a gender perspective (Ministry of Health of Chile, 2011; Cabieses et al., 2016; Ministry of Health of Brazil, 2017).

**Masculinities, risks, and
health evidence**

2



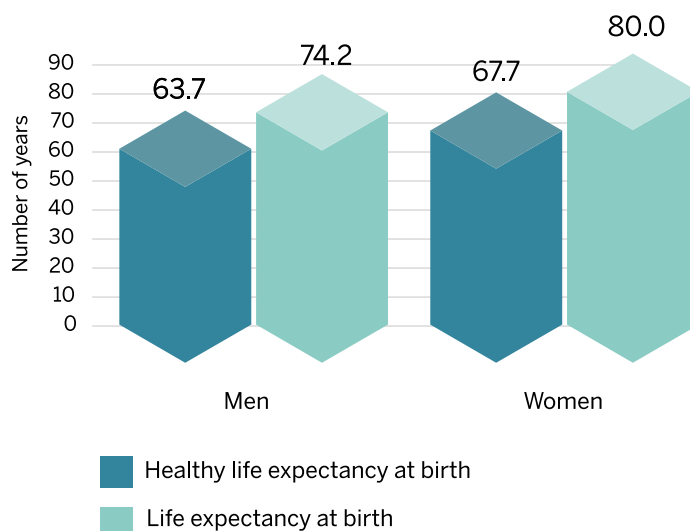
A broad review of epidemiological information was conducted to assess the state of health/disease in men in the Region of the Americas. Morbidity and mortality statistics, years of life lost (YLLs), and disability-adjusted life years (DALYs) from the last 15 years were analyzed, along with the trends in these figures specific to the three subregions being studied: North America (Canada and the United States of America), Latin America, and the Caribbean.⁹ Many health problems are more prevalent and have higher incidence in men than in women. Below is a summary of statistics useful in examining the relation between masculinities and health.

Although more boys are born in the world than girls (105/100), this proportion is inverted in the 30- to 40-year-old population. Over the age of 80, there are 190 women for every 100 men. Women constitute the majority of older adults in all countries, a phenomenon known as the feminization of aging (Salgado de Snyder and Wong, 2007).

A constant in the Region of the Americas is the striking difference in life expectancy at birth between men and women, who live 5.8 years longer, on average (4-7 years longer, depending on the country). This is consistent with the figures on healthy life expectancy (HALE), which show a differential of 4 years in favor of women (Figure 3).

Figure 3. Healthy life expectancy at birth, by sex, Region of the Americas, 2015

Source: Based on data from WHO (2016a) and World Bank (2017a).



⁹ There are major differences between subregions, between countries, and within countries. Therefore, it is important to consider conducting analyses at the national level and in specific populations.

Mortality indicators confirm that the average 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, there are 18% more YLLs due to premature death in men than in women. Because they tend to die earlier, men have 8% fewer DALYs (Figure 4).

2.1 Morbidity/mortality, by cause

This section focuses on the causes of death and disease in men, with special attention to those that show a large gender gap. Overall data for the Americas are presented, with some comment on subregions and on periods in the life course when these causes have the greatest impact. Table 1 shows the 10 leading causes of death in men in the Americas in 2015.

Some causes of death have highly comparable figures for the two sexes, for example, COPD, lower respiratory infections, and diabetes mellitus. However, male mortality is greater for ischemic heart disease and respiratory tract cancers. Three leading causes of death show enormous disparities clearly associated with the exercise of hegemonic masculinity and its consequences: interpersonal violence (notably

homicide victims, with a male-female ratio of 7:1), road injuries (3 times higher for men), and cirrhosis of the liver (more than twice as high in men than in women), where the direct primary cause is alcohol consumption.

The most common cause of male mortality in the Region is ischemic heart disease. Interpersonal violence and road injuries are among the 10 leading causes of death for men in Latin America and the Caribbean. These causes are associated with behaviors expected of men, by virtue of a hegemonic masculinity with toxic manifestations (Sinay, 2006). There are epidemiological differences between subregions. While HIV/AIDS is among the 10 leading causes of death in Caribbean men, cirrhosis of the liver is among the top 10 in Latin America. 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 among the leading causes.

Figure 5 shows, in descending order, the leading causes of excess mortality in men. The gender gap, which places men at a disadvantage, is reflected in specific problems related to everyday practices that are part

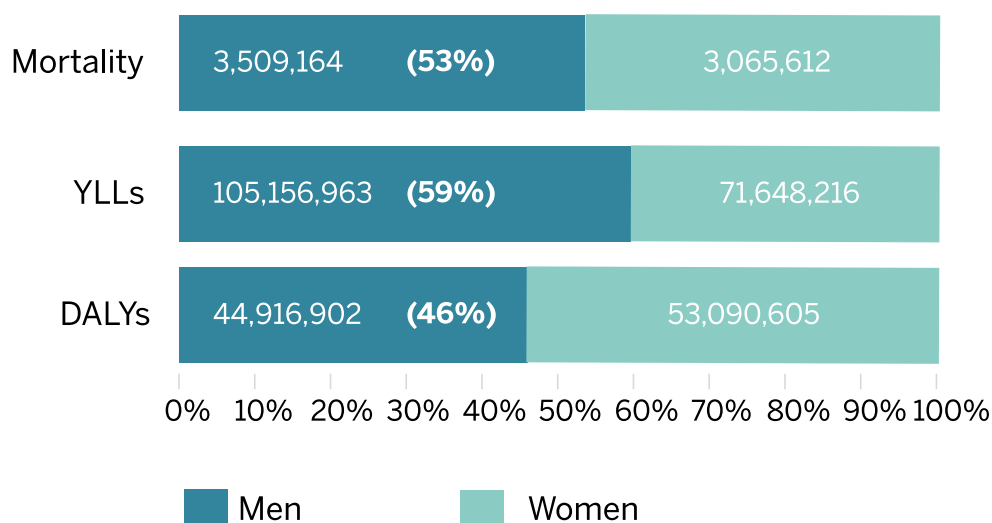


Figure 4. Percentage distribution of mortality, years of life lost (YLLs), and disability-adjusted life years (DALYs), by sex, Region of the Americas, 2011-2015

Source: World Health Organization (2016a, 2016b, 2016c).

Table 1. Ten leading causes of death in men, Region of the Americas, 2015

	Causes	Number of deaths in men	Percentage of deaths in men	Number of deaths in women	Percentage of deaths in women	Rate of deaths in men (per 100,000)	Rate of deaths in women (per 100,000)	Male-female ratio
1	Ischemic heart disease	569,936	16	476,383	16	116.8	95.6	1.2
2	Stroke	197,143	6	225,032	7	40.4	45.2	0.8
3	COPD	177,798	5	168,653	6	36.4	33.8	1
4	Interpersonal violence	160,848	5	22,617	1	33.0	4.5	7.3
5	Lower respiratory infections	159,231	5	159,091	5	32.6	31.9	1
6	Diabetes mellitus	158,727	5	167,854	5	32.5	33.7	1
7	Trachea, bronchi, lung cancers	146,671	4	110,820	4	30.0	22.2	1.3
8	Alzheimer's disease and other dementias	117,828	3	235,617	8	24.1	47.3	0.5
9	Road injury	117,803	3	37,842	1	24.1	7.6	3.1
10	Cirrhosis of the liver	103,774	3	43,964	1	21.3	8.8	2.4

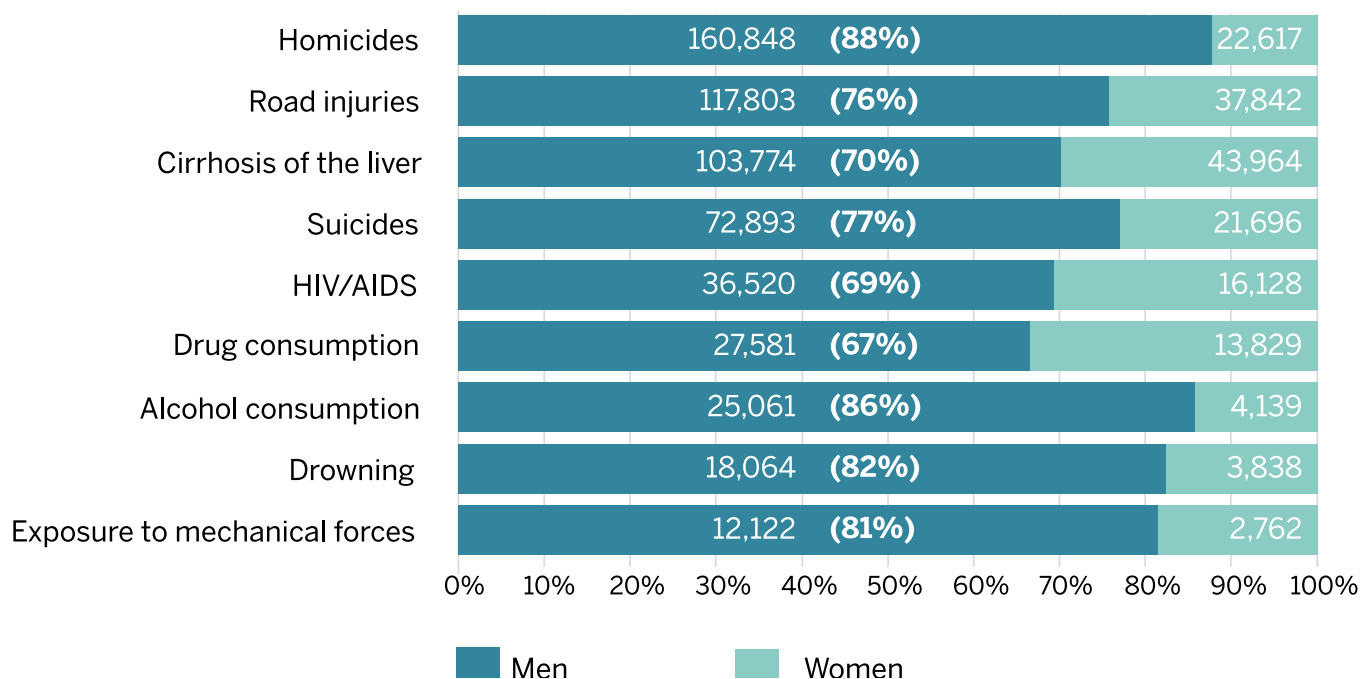
Source: Based on World Health Organization data (2016a).

of hegemonic masculinity, such as risk-taking at work or at the wheel, psychoactive substance abuse, unprotected sex, violent interpersonal relations that result in homicide, and poor management of emotions.

With regard to some of the main health-related problems and challenges among men, HIV/AIDS is second only to respiratory infections as the leading cause of death due to infectious disease in the Region of the Americas, and it is a clear example of men's lack of

care in the area of sexuality. Between two and three men die from this cause for every woman, though the gap has diminished in the last 10 years because of increased transmission of HIV from men to women. The rate of HIV incidence in the Region in 2015 was 15.5/100,000, with 22.1/100,000 new cases in men and 11.5/100,000 in women (World Health Organization, 2016a). In North America and the Caribbean, the incidence of HIV cases is higher (WHO, 2016a) and the leading cause of transmission is unprotected sex

Figure 5. Percentage distribution of mortality in men and women, according to selected causes that mainly affect men, Region of the Americas, 2011-2015



Source: Based on World Health Organization data (2016a, 2016b, 2016c).

between men (World Health Organization, Joint United Nations Program on HIV/AIDS, UNICEF, 2011). The risk of contracting HIV is 27 times greater for men who have sexual relations with men than for men who don't; 23 times greater for persons who inject drugs than for those who don't; 3 times greater for sex workers than for the general population; and 12 times greater for transgender women (Joint United Nations Program on HIV/AIDS, 2018) than for the general population. There are also major differences according to ethnicity. In the United States of America, Afro-descendant men accounted for 38% of all new diagnoses, followed by Latino men (29%), and white men (28%) (Centers for Disease Control and Prevention, 2017). In all of these groups, the greatest number of cases was in the 25- to 34-year-old age group (Centers for Disease Control and Prevention, 2012).

Among noncommunicable diseases, mortality due to mental illness and consumption of illicit substances accounted for 72,799 deaths in the Region of the Americas in 2015, 74% of them men. In the same year, men accounted for 86% of deaths due to alcohol-related disorders, led by Latin America and followed by the Caribbean, with the highest number of deaths in the 30- to 49-year-old age group. Hegemonic masculinity is a key risk factor for male vulnerability in the area of mental health, since it promotes confrontational strategies associated with emotional detachment, such as the absence of emotional expression, reluctance to seek help, and alcohol abuse (Möller-Leimkühler, 2003). It is important to keep in mind that mental illness is a factor in five leading causes of DALYs.

The model in which men are the model for human “normalcy” and for mental health has made male anomalies and psychopathologies invisible, relegating them to the criminal/judicial sphere, while generally attributing mental imbalance to women (Bonino, 2000). In the United States of America, Eaton et al. (2012) have identified systematic gender differences. Women show higher rates of mood disorders and anxiety (depression, dysthymia, generalized anxiety disorder, panic disorder, social phobia, and other specific phobias), while men have higher rates of antisocial personality disorder and alcohol and drug dependency. These tendencies appear similar in studies conducted in Brazil, Chile, Colombia, Mexico, and Peru, as systematized by De Jesús et al. (2009).

Eaton et al. (2011) explain these differences in terms of what appears to be a tendency of women to internalize experiences (anxiety, fear, and negative affect) and men’s tendency to externalize them (antisocial personality disorder, and drug use and drug dependency correlated with a lack of inhibition). Added to this is men’s greater reluctance to seek help, the greater number of men than women in psychiatric hospitals and increasing detection of depressive problems in the male population.

Alcohol consumption among women is increasing, although it remains higher in men, both in quantity and frequency, while problematic or compulsive alcohol consumption is twice or three times higher in men (Inter-American Drug Abuse Control Commission/Organization of American States, 2015). Start-

The gender gap, which places men at a disadvantage, is reflected in specific problems related to everyday practices: risk-taking at work or at the wheel, psychoactive substance abuse, unprotected sex, violent interpersonal relations that result in homicide, and poor management of emotions.

ing with his initial studies, Menéndez (1990) pointed to alcohol as an integral part of male culture and identity—a substance that is linked to masculinity through symbolic and social functions. There are social patterns that incite men to abuse alcohol and that tend to limit or penalize it in women. Drinking alcohol is proof of masculinity, it exacerbates machismo, and it affirms a “womanizing” and “daring” behavior (Góngora, 2005). This is not only the behavior of isolated individuals; it is a collective ideological structure that serves as a basis for how such behavior is manifested and modeled (Duan and Hernández, 2012). Alcohol consumption is associated with greater risk of unintentional injury, injury due to physical violence, risky behavior (including sexual), breast cancer, loss of productivity, family problems, and cognitive deterioration at advanced ages (Guerrero-López, Muños-Hernández, 2013).

Mortality due to cirrhosis of the liver is also closely linked to alcohol consumption. Between 2000 and 2015, men accounted for 71% of all reported cases (World Health Organization, 2016a), predominantly in the 30- to 49-year-old age group. The leading causes of cirrhosis of the liver are alcohol consumption, hepatitis B, and hepatitis C, in that order, with higher mortality in men than women.

Deaths due to the consumption of illicit drugs in the Region have increased strikingly (by 110% between 2000 and 2015), with higher rates in men and in the 15- to 29-year-old age group (usually preceded by tobacco and alcohol use at early ages), and with the highest rates in the 30- to 49-year-old age

group. The Caribbean and North America are the subregions that showed the greatest increase in mortality from illicit drug use, while Latin America has seen a decline (World Health Organization, 2016a). Related morbidity is also higher in men, who tend not to seek help with the problem, which also affects families and communities.

In the Region, 21.9% of men are tobacco users, versus 13.2% of women (Pan American Health Organization, 2016). In addition to being a frequent first-use drug, tobacco causes 71% of lung cancers, 42% of chronic lung diseases, and 10% of cardiovascular diseases, making it the leading preventable cause of death in the world (Guerrero-López, 2013). In the case of death due to all types of malignant neoplasms, the rate is slightly higher among men than among women (138/125). Tracheal, bronchial, and lung cancers account for the most deaths. In 2015, excess male mortality stood at 37% and was highest for the cancers that affect both sexes (WHO, 2016a). Most notably in men, tobacco is also associated with COPD, the third leading cause of death, with workplace and environmental factors also playing a role.

Other diseases, such as prostate and testicular cancer, have also shown increased male mortality. Thirty-eight percent of cases of testicular cancer occur in the 15- to 29-year-old age group, while 37% are in men 30 to 49 years of age (World Health Organization, 2016a). Prostate cancer has increased by 25% and takes its greatest toll in the final stage of life, beginning at age 50 (World Health Organization, 2016a). Various studies point to late diagnosis of the disease in Latin America and the Caribbean, and among the Latino population in the United States of America, for reasons linked to “manliness.” In this re-

Hegemonic masculinity is a key risk factor for male vulnerability in the area of mental health. It is important to keep in mind that mental illness is a factor in five leading causes of DALYs.

gard, men tend to be reluctant to undergo screening to detect prostate cancer because male identity typically disdains preventive care (though it is all right to seek help for existing problems), because of beliefs about the possibility of becoming impotent, and due to a lack of guidance on dealing with the side effects of treatments,

such as incontinence and erectile dysfunction (Paiva, 2011; Rivero and Berrios, 2016; Roth, 2008). In addition, economic barriers and difficulties in accessing the health system can also play a role in men not seeking preventive care.

An especially worrisome issue in the Region of the Americas is excess male mortality due to intentional and unintentional causes. Men accounted for 69% of unintentional injuries in the Region in 2015, with the highest prevalence in the 15- to 29-year-old age group. Also in 2015, intentional deaths in this age bracket spiked alarmingly. Men dying by homicide accounted for 88% of all homicide deaths, representing nearly nine men for every woman. In terms of male deaths by homicide, the situation in Latin America is particularly serious: men are six times more likely to die from this cause than men in North America. Lastly, figures for deaths due to collective violence and institutional violence show that, in 2015, men accounted for 84% of such deaths, led by the 15- to 29-year-old age group (World Health Organization, 2016a). This is yet another example of how hegemonic masculinity is a killer of men themselves.

Men play a major role in the phenomenon of femicide and in hate crimes toward LGBTTI persons—two of the most toxic manifestations of hegemonic masculinity. In the case of femicide, an estimated 50% of murdered women are killed by their domestic partners or family members, in marked contrast with only 5% of

men (Quiñones Giraldo, 2017). According to Brazil's "violence map" (Mapa da Violência), which covers 83 nations, 6 of the 10 countries with the highest femicide rates are in Latin America. El Salvador leads with 8.9 deaths per year per 100,000 women; Colombia is second (6.3/100,000); Guatemala, third (6.2/100,000); Brazil, fifth (4.8/100,000); Mexico, sixth (4.4/100,000); Suriname, eighth (3.2/100,000); and Puerto Rico, tenth (2.9/100,000) (Waiselfisz, 2015).

Mortality due to suicide rose between 2000 and 2015 in the Region of the Americas, with a gender gap (77% of suicides were male) and an increase in the frequency of suicides in the 15- to 29-year-old age group, peaking between ages 30 and 40. The subregion with the highest suicide mortality rate is North America, followed by the Caribbean and Latin America. The ratio of male to female suicides is approximately 3.5 to 1. However, women account for a greater number of suicide attempts (Pan American Health Organization, 2014), which often constitute a desperate plea for help, something that men are reluctant to do.

Road injuries have seen a sustained 5-year rise, with men accounting for 76% of deaths in 2015, with a high plateau between the ages of 15 and 49 years. Latin America has the highest rate of mortality due to road injuries, followed by the Caribbean, while the rate in North America is lower. Of the 24% of victims who were women, data are not available on whether they were driving or were collateral victims. Reckless behaviors at the wheel are described by a series of authors (Bonino, 1989; De Keijzer, 2004; Sinay, 2006) as conduct typical of men, who even make fun of the caution that women and older adults tend to take when driving. This recklessness and a feeling of invulnerability are associated with four factors commonly

Men play a major role in the phenomenon of femicide and in hate crimes toward LGBTTI persons—two of the most toxic manifestations of hegemonic masculinity.

present in road crashes: speeding, alcohol or drug use, failure to use seatbelts, and cell phone use while driving.

Men accounted for 82% of deaths by drowning in 2015. The greatest number of drowning deaths is in the 15- to 29-year age group (although drowning is a significant

cause of death beginning at age 5). The subregion with the highest rate of deaths by drowning is the Caribbean. Indeed, studies show that places closest to bodies of water have a higher proportion of drownings, with additional contributing factors that include risky alcohol-related behaviors and boating activities (World Health Organization, 2016d). Men are four times more likely to die by drowning than women, especially between the ages of 15 and 29 (World Health Organization, 2016a).

The burden of mortality due to exposure to mechanical forces is high for men, generally associated with work in the productive stage of life. Men accounted for 81% of total deaths from this cause in 2015, with greater frequency in the 15-29 and 30-49 age groups (World Health Organization, 2016a). Work and the provider role are basic to the male identity, which, in its toxic manifestation, exposes men to a series of risks such as working without protective gear (either because employers do not provide it or workers do not use it), double shifts, and lack of adequate health care.

Men die mainly as a result of noncommunicable causes. The majority of these deaths occur between the ages of 15 and 49, except for those due to prostate cancer, cirrhosis caused by hepatitis C, and falls, which are most prevalent in older adults, as will be seen later (Figure 7). Mortality due to intrinsically male diseases such as prostate and testicular cancer

has also increased. A high proportion of these deaths occur after years of exposure to various risk situations, which should prompt us to reflect on the construction of masculinities and their effect on men's health (Barker, 2005). Men put themselves at risk to affirm a hegemonic masculine identity. And while not all embrace this form of masculinity (Connell, 2000), it is inculcated in them during a long process of socialization, pressure, and rewards in the family, school, work, mass media, and culture in general (Olavarria, 2013; Parrini, 2000).

In addition to differential mortality data, it is important to detail the consequent cost, particularly in terms of years of life lost (YLLs), since many male deaths occur in adolescents and young men (Table 2).

Premature deaths due to violence, road injuries, cir-

rhosis of the liver, and suicide are of high importance, since they all clearly show excess mortality. In 2015, the number of YLLs due to unintentional accidents was four times higher in men than in women, led by road injuries (three times higher in men), drowning (five times higher), and falls (two times higher) (World Health Organization, 2016c). In the LAC subregion, homicide and accidents contribute the largest number of YLLs, while HIV/AIDS and drowning do so in the Caribbean subregion. The YLL figures for cirrhosis of the liver are high in Latin America, while in North America, respiratory cancer, suicide, accidents, and homicides are contributors, the latter two at lower rates than in Latin America and the Caribbean.

A series of problems has also been identified in which there is no major gender gap, or where the women suffer the gap, due to gender-related conditions.

Table 2. Main causes of years of life lost (YLLs) for men and for women, Region of the Americas, 2015

	Causes	YLLs in men (millions)	YLLs in men (%)	YLLs in women (millions)	YLLs in women (%)	Men/women ratio
1	Ischemic heart disease	12.4	12	7.8	11.0	1.5
2	Interpersonal violence	9.5	9	1.3	2.0	7.3
3	Road injury	6.1	6	1.8	3.0	3.4
4	Lower respiratory infections	4.4	4	3.6	5.0	1.2
5	Stroke	4.3	4	4.0	6.0	1.0
6	Cirrhosis of the liver	3.5	3	1.3	2.0	2.7
7	Suicide	3.4	3	1.04	1.0	3.2
8	Trachea, bronchi, and lung cancer	3.3	3	2.5	4.0	1.3
9	Chronic obstructive pulmonary disease	3.2	3	2.8	4.0	1.1
10	Complications due to premature birth	2.3	2	1.8	3.0	1.2

Source: Based on World Health Organization data (2016c).

This is evident in DALYs. Unlike with YLLs, the analysis of the 10 main causes of disability shows a heavier burden for women. This is partly attributable to their longer life span, though the extra years are not necessarily healthier years. When the 10 leading causes of

DALYs in men are grouped, women fare notably better in most categories. The heaviest toll on women is in their mental health—a result of living in a patriarchal culture—and this is reflected in high rates of depression. Some of the main causes of disability in men are also related to mental health: depression (ranking first), anxiety (fifth), drug use (seventh), schizophrenia (ninth), and autism and Asperger syndrome (tenth). In the category of drug use, rates for men are double that of women.

In 2015, the number of DALYs due to accidents of all kinds was greater in men (almost 2.5 million) than in women (almost 2 million). The main difference appeared in road injuries (two times greater in men) and exposure to mechanical forces (2.5 times great-

A comparison of YLLs and DALYs shows higher premature mortality in men than in women.

However, women have more years of disease and disorders.

er in men) (World Health Organization, 2016b).¹⁰ Overall, the global burden of disease reflects what we have discussed here.

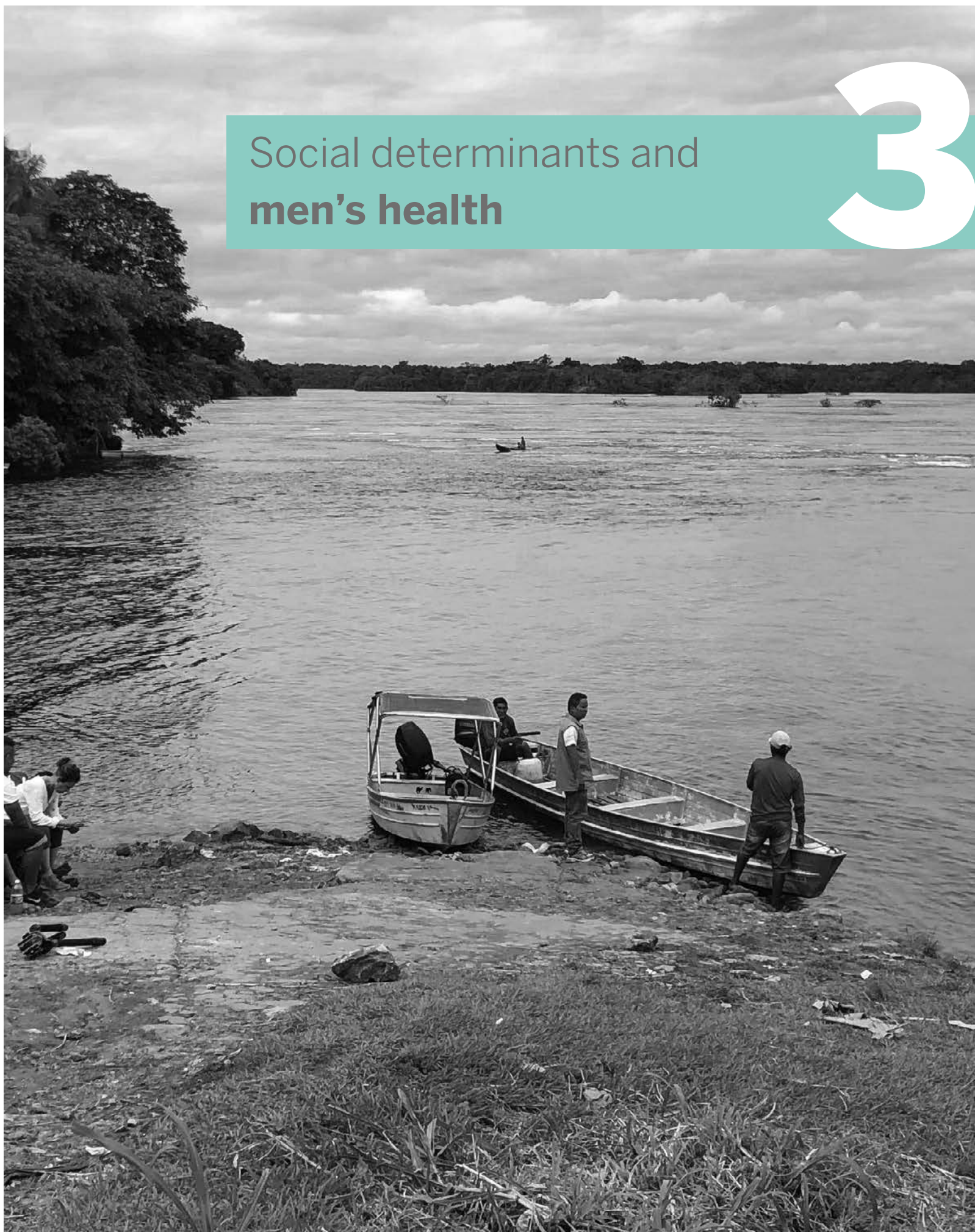
In general terms, a comparison of YLLs and DALYs shows higher premature mortality in men than in women. However, women have more years of

disease and disorders. This is closely linked to normative patterns in which hegemonic masculinity is damaging to the health and life expectancy of men—a result of their indulging in risky behaviors. For women, subordination and care-giving are the norm, providing them a “protective” factor that tends to preserve and extend life, though not always with quality.

¹⁰ In its report *Traumatismos causados por el tránsito y discapacidad*, the Pan American Health Organization (2011) indicated that 5 million people suffer traumas caused by road injuries (33 injured persons for each person killed). Of these, at least two will have serious secuelae and be unable to reenter work and social life. The injury rate in men is higher than in women and the main types of disabilities caused are motor (66.1%), auditory (16.5%), visual (12.6%), and mental (4.2%).

Social determinants and **men's health**

3





In the previous chapters, we have presented general data on health, disease, and death in men and compared it with the data on women. The SDH and gender equality approach allows us to analyze important differences.

The social determinants of health are the circumstances in which people are born, grow, live, work, and age. This includes the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen between and within countries (World Health Organization, 2009).

These determinants include a number of elements. Figure 6 distinguishes the structural determinants from other intermediate elements with specific vulnerabilities.

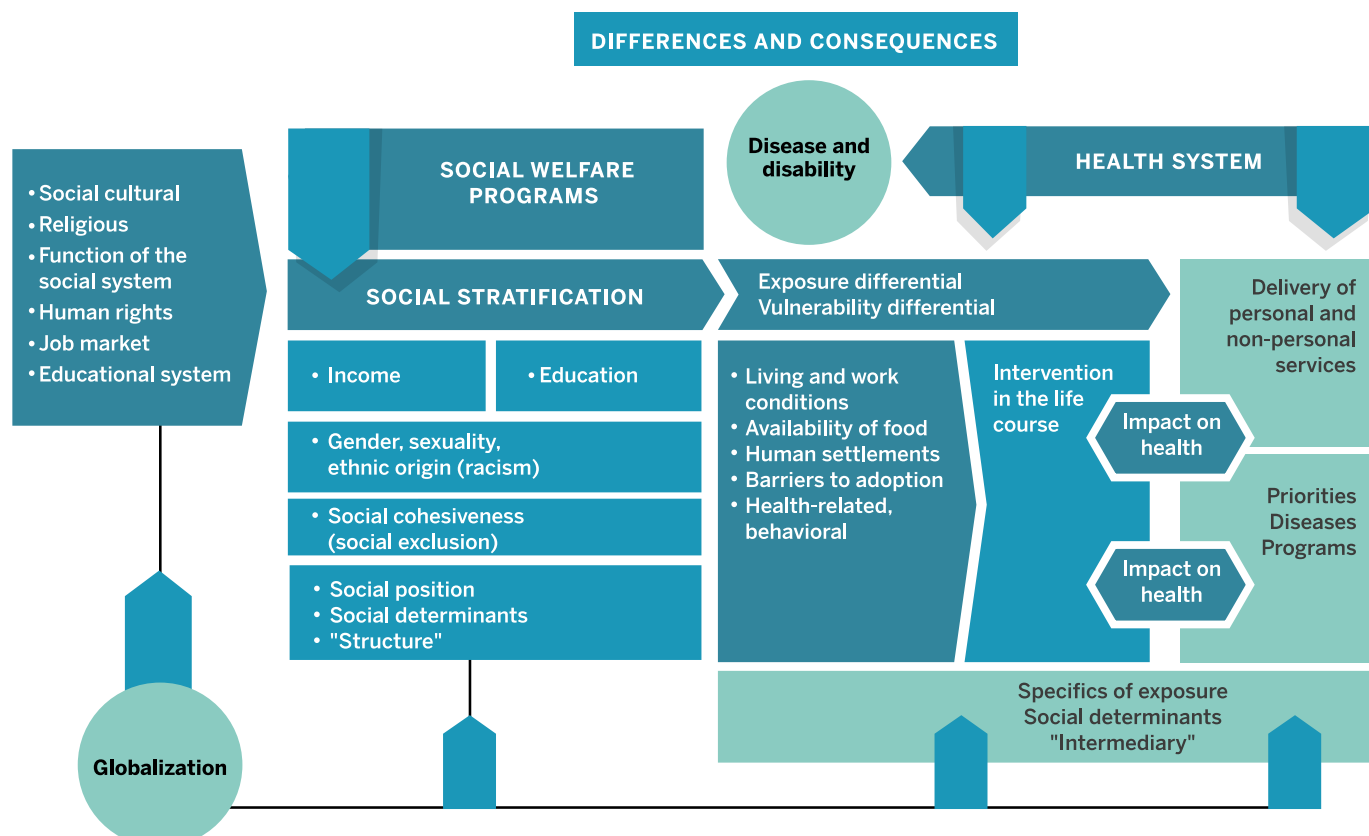
Gender is a structural SDH, with initial emphasis on the situation and condition of women. Gender has not yet been taken into account as a determinant of men's health. Doing so would make it possible to recognize the intersection of the SDHs (ethnicity, sexual orientation, poverty, life course, social class, work, education, etc.) with masculinities and men's health. Aedo (2010, p. 7) recalls that “along with biological differences and socioeconomic and environmental components, gender determines risk factors and health conditions in women and men, the frequency with which they use health services, the way in which care is provided to them, the relations that they establish with medical personnel, adherence to treatments, use of medications, and self-care practices.”

The SDHs also help us understand how men perceive their health problems and, based on this, how they seek health services, their access to services, and the care they receive. For example, as reflected in the M+H survey, men of limited economic means will find it more difficult to access the health system, particularly preventive services (routine checkups, tests, and immunizations). This section examines the SDHs associated with life course, ethnicity/race, work, and the dimension of sexuality and reproduction, all of which are relevant to understanding the health of men from the masculinities perspective.

3.1 Health and life course

The life course model “suggests that the health outcomes of individuals, families, and communities depend on many variables... that can improve health (protective

Figure 6. Conceptual framework of the social determinants of health



Source: Reproduction authorized by Urbina, 2012 (p. 110).

factors) and things that can worsen it (risk factors) throughout life" (Pan American Health Organization/ World Health Organization, 2017a). This concept is particularly useful in analyzing masculinities and health. Moreover, it recognizes that health at a given time of life is influenced by dynamic and cumulative risks, as well as by protective factors in previous stages of the life of individuals, families, and communities, including in the previous generation. The actions or events of a particular stage of life will have a positive or negative effect on the following stages and generations.

Over the life course of women and men, health differences can be seen from the time of birth. They generally become more apparent in later stages, reflecting vulnerabilities or protective factors. Figure 7 shows a

continuous, longitudinal perspective on the causes of death throughout men's lives.

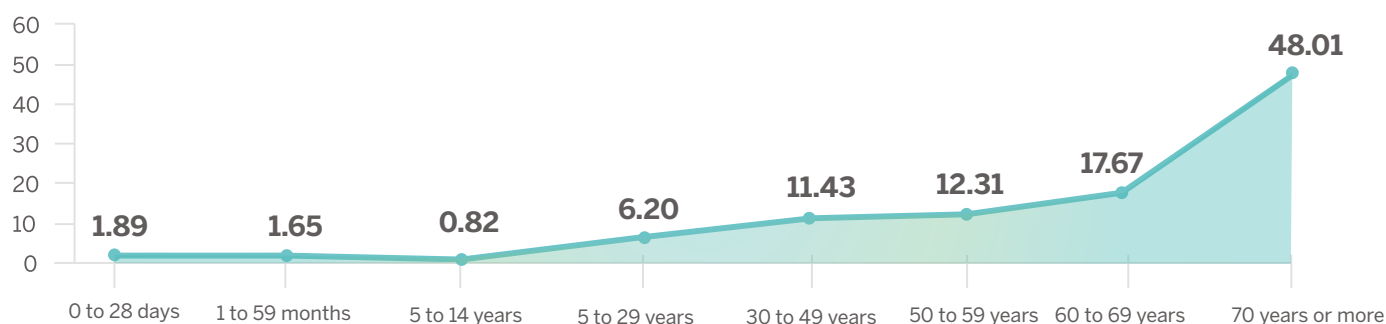
Male mortality is higher from the first year of life, in particular due to respiratory and diarrheic diseases of infectious origin. In much of the Americas, where gender inequity prevails, especially in rural areas and in indigenous populations, male newborns are more welcome and more valued than females. This reception is typically accompanied by a more prolonged nursing period and earlier visits to health facilities in case of illness.

Around age 10, the difference between boys and girls begins to be seen in the rapid increase in male deaths due to road injuries, homicides, and drowning. This peaks in adolescence and early adulthood, with

Figure 7. Leading causes of death in men throughout the life course, Region of the Americas, 2015



Percentage of total YLLs in men, by age group



Source: Based on World Health Organization data (2016a).

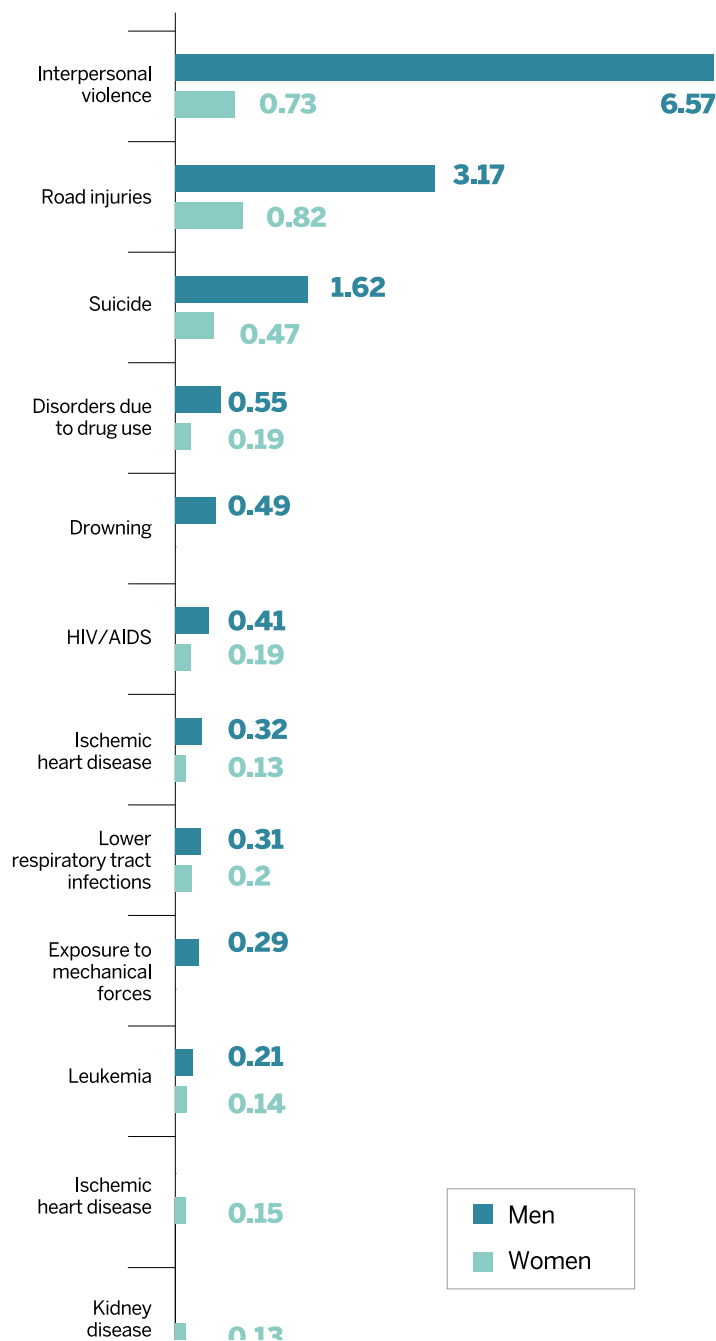
double and even triple the number of deaths in men, mainly due to violent causes, including suicide. These factors significantly reduce the proportion of men in the succeeding decades. As shown in Figure 7, slightly over 20% of men (one out of five) die before the age of 50, far earlier than indicated by their LEB. Women do not reach that 20% figure until age 60.

Most striking is the spike in male mortality at age 15, with violent causes of death predominating, and with a mortality rate nearly three times higher than in young women (Figure 8). Also in this age group, the male component is evident in the main causes of death in women. Adolescence and young manhood are decisive periods for the onset and establishment of risk behaviors (such as excessive consumption of alcohol and other drugs, and unprotected sex), the effects of which will emerge in later stages of the life course. The Man Box is a report that sheds light on the links between these stereotypical conceptions of dominant masculinity and the adoption of sexual risk behaviors, and on how these affect men themselves as well as their partners. In addition, there is an increase in suicidal thinking among men who are vulnerable due to their mental health, according to Shand and Escobar in the M+H survey.

The epidemiological profile of a large proportion of adolescent males features an intersection of poverty, lack of opportunities to study or work, propensity to consume toxic substances, and risk-taking as a means of social inclusion (The Lancet, 2015). And because young men of low socioeconomic status avoid talking about their health or do not see the need to use health services, the result is an environment that fosters poor quality of life and greater morbidity and mortality (Bernales, 2016).

Chronic noncommunicable diseases play a significant role starting at age 50, with an accumulating combination of SDHs and lifestyles often associated with a

Figure 8. Leading causes of death between 15 and 29 years of age, by sex, Region of the Americas, 2015



Source: Based on World Health Organization data (2016a).

lack of self-care. Hypertension and heart problems, obesity, diabetes, and COPD are followed by respiratory and prostate cancers as causes. Closely linked to these are the addictions that take a heavy toll on

individual health (with numerous DALYs) and on society (high disease burden).

This combination of factors brings us to another measure of potential years lost in the life course (Figure 9). While congenital diseases and other related problems account for YLLs in the first five years of life, violent causes quickly become predominant, remaining so up to age 50, after which the consequences of lifestyles and behaviors in previous years take their toll.

Economically productive middle-aged men in families have better self-care practices than other men, due to their position of authority and their control of economic resources. However, they are also the men who are most reluctant to talk about themselves and their health, and who most delay seeking medical care, due to fear of how a diagnosis might affect their functions within the family (Trujillo, 2011). In families, health care for men and for the children under women's care is given priority over women's own care, thus contributing to women's historical excess burden of caregiving (Del Rio-Zolezzi et al., 2008; GENDES and other organizations, 2018). This has a paradoxical result: marriage is a protective factor for men, but not for women (Schraiber et al., 2005).

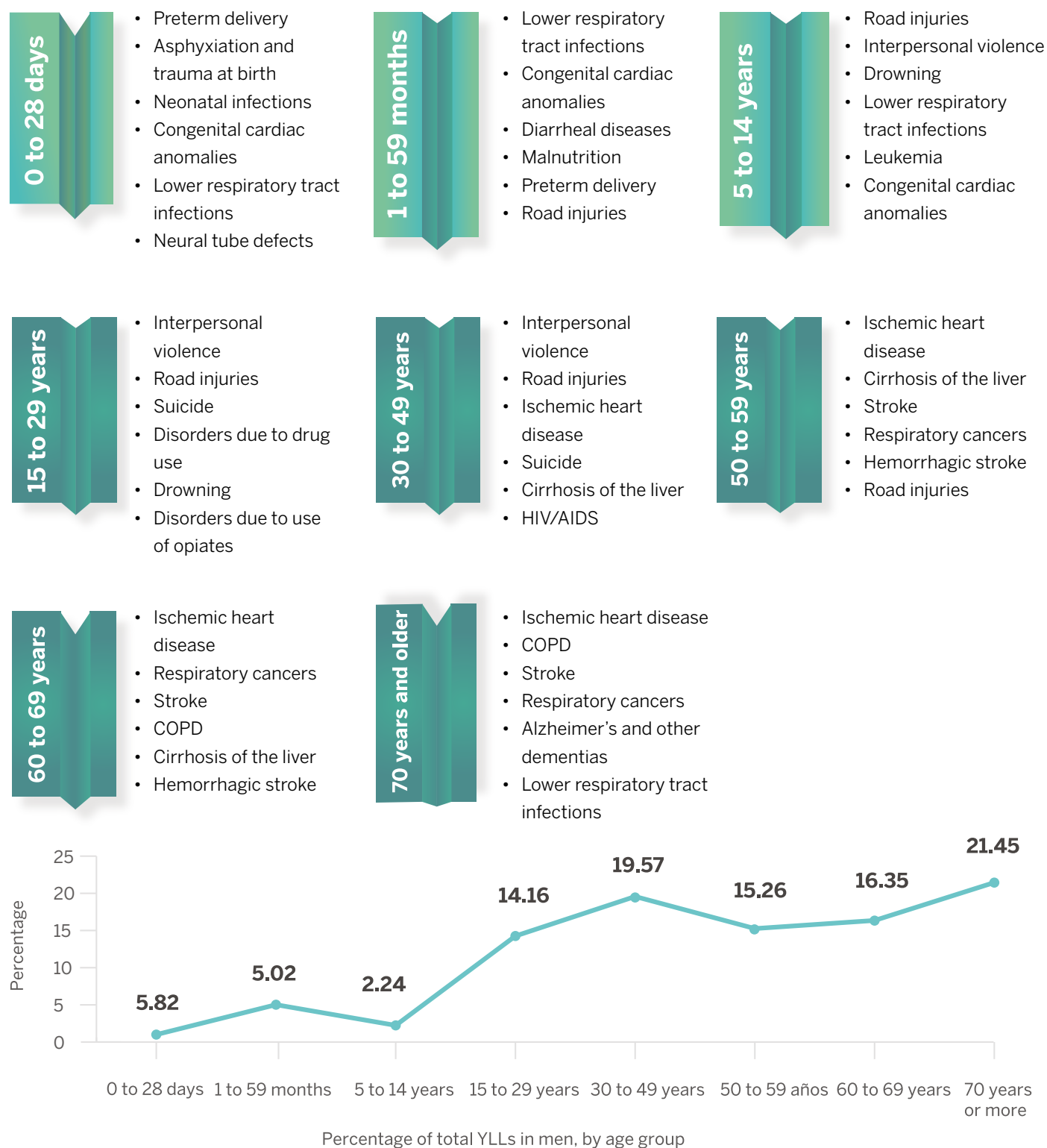
The disease burden in old age shows major gender-dependent differences, due to the accumulation of vulnerabilities associated with social roles throughout the life course. Health in old age, added to gender, income, and urban or rural residence, involves a dual epidemiological burden that includes infectious/contagious diseases and the results of inadequate nutrition (Salgado de Snyder and Wong, 2007). In the over-60 age group, women use preventive, medical, and hospital services more frequently than men do. At the same time, men's vulnerability increases in old age, due to differences in men's "needs" at this stage of life (e.g., having a partner and contributing in some way to the family in order to earn the right to live at

home) and the relative lack of emotional support men receive from the family (Pelcastre-Villafuerte et al., 2011). Economic insecurity tends to be a problem at this stage, primarily for those whose work life was in the informal sector and who, having not contributed to a retirement scheme, are not eligible for a pension in old age. In Mexico, for example, it is estimated that only 45% of men in urban areas and 16% in rural areas receive retirement income. For women, the figure is much lower (Salgado de Snyder and Wong, 2007).

Intersectionality can be seen in the links between gender, age, and family situation when analyzing diabetes, which affects both sexes similarly, although men tend not to seek timely medical care. Health workers play a determining role in how diabetic patients assimilate their diagnosis and treatment. Trujillo and Nazar (2011) state that health workers tend to blame patients for their clinical condition. This practice reproduces power relationships, legitimizes inequalities, and contributes to the reconstruction of hegemonic masculinity. In the case of young diabetic men, depression leads to abandonment of treatment in a proportion at least double that of women. In men, diabetes creates an identity conflict in terms of their sense of social expectations. This engenders a sharp drop in self-esteem, which can lead to depression and abandoning treatment (Nazar-Beutelspacher and Salvatierra-Izaba, 2010).

Older men, for their part, confront a social/family dilemma when they lose their economic/productive capacity, since this is accompanied by a loss of power in the family unit. This can lead to depression and suicidal thoughts, which in turn can reduce life expectancy. Accepting the reality of being sick means changing habitual forms of family interaction. If a man's main point of reference is his role as provider, he feels weakened since his authority in the group is ceded to his partner, whom he sees as a competitor in providing for the family (Montesinos 2002, cited in Trujillo and Nazar, 2011).

Figure 9. Leading causes of years of life lost (YLLs) in men throughout the life course, Region of the Americas, 2015



Source: Based on World Health Organization data (2016a).

Having considered the life course, we will now examine two other SDHs: ethnicity and work as markers of income and class.

3.2 Ethnicity

Historically, the Region of the Americas is marked by the early migrations of aboriginal peoples and the subsequent ruptures caused by the European conquest and then by slavery. The latter two processes reflect European hegemonic masculinity and, more recently, new and varied migrations. Pre-Colombian masculinity was stratified and hierarchical, with its own sexual division of labor and subjection of “the other” through war (Tovar-Hernández and Tena, 2015). The conquest and colonial period violently disrupted the existing order, though the original peoples were somewhat able to continue to protect their geographic territories, thus providing a territorial and political base. This helped them maintain a certain “institutionalized identity” (Safa, 2008). In the construction of today’s indigenous masculinity, the provider mandate prevails. In a context of precariousness work, this leads to many difficulties, including a need to migrate. Another key mandate is manliness/virility and its tangible result in the number of children a man has (Ramos, 2004).

In contrast to the first indigenous nations, the Afro-descendant population was brought to America by force, wreaking havoc on its territories, languages, and identities, which were completely subordinated to European norms (Safa, 2008). Over time, a collective self-image has been created (Meneses, 2014), in which masculine identity is intimately connected with the body as the sole territory of a hyper-virile being who is sexually superior to the white man. As a result, erotic exercise became a fundamental pillar that also involved domination over and objectification of women (Viveros, 1998). The masculinity of the Afro-descendant “macho man” is perceived as

being under permanent threat, even among his peers (Meneses, 2014), as if being a man consisted of constantly demonstrating and reconfirming a masculinity threatened by other forms of masculinity (Cogolo et al., 2004).

In both indigenous and Afro-descendant masculinities, virility plays a key role, though it takes different forms. For the Afro-descendant man, it is important to compete in sexual prowess and to ensure that others recognize this prowess. The indigenous man, on the other hand, is more reserved and conservative, and seeks recognition by having numerous children, who provide him support and preserve his identity (surname). In these two manifestations, the idea of male supremacy coincides with a constriction of women’s rights.

Place of residence influences the ethnic dimension of indigenous men, 45% of whom live in rural settings, some as refugees or in places where they have been forced to migrate. They also have less access to education, work, and income. In 2007, 45-50 million indigenous people belonging to more than 600 original peoples lived in the Americas, representing nearly 10% of the total population (and 40% of the rural population of LAC). According to the Economic Commission for Latin America and the Caribbean (ECLAC), there were 45 million indigenous population in Latin America in 2015, constituting 8.3% of the population and representing 822 indigenous peoples.¹¹

The indigenous population is also subject to a high degree of vulnerability, due to inequitable conditions and constant violations of human, social, political, and

¹¹ Estimates of the proportional representation of the indigenous population in selected countries of the Region of the Americas are as follows: over 40% in Bolivia (Plurinational State of), Ecuador, Guatemala, and Peru; and between 5% and 40% in Belize, Chile, El Salvador, Guyana, Honduras, Mexico, Nicaragua, Panama, and Suriname (Montenegro and Stephens, 2006).

economic rights. This translates into poverty and precariousness in living conditions, health status, and access to health services (Pan American Health Organization, 2017b). Poverty in this population is associated with high rates of unemployment and illiteracy, lack of adequate educational services, loss of bilingualism, absence of (or difficulty accessing) social services, displacement due to armed conflicts, over-exploitation of local natural resources, and degradation of the environment. In the wake of indigenous migration to the cities, these migrants experience severe inequality of economic and social conditions, with less access to basic, quality services than the general population (Pan American Health Organization, 2017b).

The Inter-American Development Bank (Deruyttere, 2017) believes that up to a quarter of the difference in income levels is attributable to belonging to an indigenous ethnic group or being Afro-descendant. A World Bank report (2015) shows that being born to indigenous parents increases the probability of growing up in a poor household, independent of other conditions such as educational level of the parents, household size, or place of residence. This creates a vicious circle that impedes the full development of indigenous children and shows that economic growth alone is not sufficient to reduce poverty.

The Pan American Health Organization (2017b) reports that indigenous and Afro-descendant populations and groups with sexual orientations that differ from the norm have the greatest health vulnerability. The lack of sufficient statistical data on ethnicity is further evidence of exclusion, limiting the analysis of specific information on men's health in these populations. Even without sex-disaggregated data, problems such as the excess prevalence of tuberculosis in the indigenous population can be seen. In Mexico, this figure is two times higher in the indigenous population than in the non-indigenous population; in Canada, it is 8 to 10 times higher than in the overall population.

Indigenous people are among the populations most affected by HIV/AIDS, along with men who have sex with other men, sex workers, transgender women, and users of injectable drugs (Pan American Health Organization, 2017b).

Another factor affecting indigenous people in the Region is alcohol-related health problems associated with increasing violence, both in rural settings and among migrants to cities (Pan American Health Organization, 2007). Suicide among young indigenous men has also been identified as a significant phenomenon in Canada and the United States of America (with rates five times higher than in the non-indigenous population) as a consequence of intense social stress, generationally transmitted historical trauma, histories of sexual abuse in boarding schools, and unresolved mourning (Economic Commission for Latin America and the Caribbean, 2011). There are similar data for northern Colombia, where indigenous peoples are losing their "will to live" due to the impact of the country's armed conflict in their communities (Pan American Health Organization, 2007). In Chile, mortality is 150% higher among indigenous adolescents than among their peers in the general population (Economic Commission for Latin America and the Caribbean, 2011).

Social stress has major repercussions on the lives of people who belong to minority or subordinated populations, or who live in settings of exclusion and stigmatization. This involves two variables: belonging to a minority, and the subjective characteristics of each person (Meyer, 2003). According to the American Psychological Association (2018), stigmatized communities suffer from four variables involving health disparities: trauma (sexual, physical, historical, racism, and post-traumatic stress), psychoactive substance abuse, depression, and violence.

Compared with non-indigenous populations, there is much less health coverage for members of indig-

enous populations, for whom geographic dispersion and the lack of an intercultural approach hinder access to health services. Also, men are less inclined to seek care and are resistant to lengthy treatment, such as is required for tuberculosis. In the wake of indigenous migration to cities, these migrants experience great inequality with respect to economic and social conditions, and they have less access to basic, quality services than the general population (Pan American Health Organization, 2017a).

The Afro-descendant population faces a situation similar to that of the indigenous population. An estimated 250 million Afro-descendants live in the Americas, accounting for over 50% of the population in Brazil, 45% in the English-speaking Caribbean, 12.9% in the United States of America, and 23% in Colombia (Pan American Health Organization, 2007). In Latin America, the conditions of intense vulnerability in which this population lives are similar to those of the indigenous population. In both Brazil and Ecuador, where the Afro-descendant population constitutes 52% of the total population, Afro-descendant men have less formal education than Afro-descendant women, and less than the overall population (López, 2011).

In Brazil in the year 2000, life expectancy at birth for white men was 71 years, in contrast to 64 years for Afro-descendant men (Pan American Health Organization, 2007). There is substantial evidence that this population has worse outcomes in a variety of areas, and that these communities have higher indices of poor health (American Psychological Association, 2018). This is true from the *barrios* of the United States of America to the *favelas* of Brazil, where health policies are inadequate to provide the necessary care, where skin color and social class are a stigmatizing and socially excluding factor in the health system, and where the rates of imprisonment of Afro-descendant men are high—all of this compounded by constant anxiety about satisfying life's basic

needs (American Psychological Association, 2018). Higher levels of violence (social, symbolic, economic, and even physical) are perpetrated against these populations than against the population as a whole, whether by the health system, armed groups, or the police. As Barker remarks in the M+H survey, the ethnic/cultural factor has a considerable effect on small and marginalized groups, as occurs in the indigenous communities throughout the continent, which experience discrimination.

3.3 The work dimension

As mentioned earlier, work is a central focus in men's lives and identities. For many, this begins with the experience of working as children. Starting in adolescence and young adulthood, work is a key differentiating factor in the diseases afflicting women and men. The sexual division of labor permeates numerous occupational fields in the Region and plays a role in shaping differential patterns of sickness and death (Garduño, 2011). In Latin America, men work mainly in the primary sector (63% in agriculture) and in the secondary sector (58% in manufacturing) (Merino-Salazar et al., 2017; Santos et al., 2012). Employment rates for men in many countries of the Region have been declining, while the rates for women have been rising, though they remain far lower than for men (World Bank, 2017b; International Labour Organization, 2016b). In Latin America, the informal economy has become a permanent structural pillar of the labor market. Over 60% of non-agricultural workers—for example, in the construction sector—are informal employees working in conditions that pose serious health risks (López-Ruiz et al., 2015).

Employed women generally have a double workload, since they also perform (unnoticed, repetitive, and undervalued, yet multiskilled) household work, while men generally perform physically heavier tasks, particularly those that pose increased risks to health

and life. The centrality of the provider role in the masculine identity is clashing with growing labor instability, leading men to put their health at risk in order to preserve their role as providers (Valenzuela, 2008; Olavarría, 2013, 2017). Thus, while work creates identity, and often confers a position of power and authority to the men of the family, it can also constitute a health risk (Jiménez and Tena, 2015). When social and material conditions make it difficult to overcome the obstacles to fulfilling this mandate, men (especially primary providers) experience a sense of crisis that leads to emotional exhaustion (Cruz Sierra, 2015), in turn affecting everyone around them, especially their families. According to Barker, in the M+H survey, being unemployed causes stress and social shame, and is a factor in social and familial detachment.

According to Del Río, in the M+H Survey, the social determinants magnify the effects of masculinity on men's health. For example, the risk of violence and substance abuse increases in men who lose their jobs. Poor and indigenous men face even greater barriers in terms of access to, and demand for, preventive health services, because the time required for care competes with paid productive activities, and because they lack the social security coverage needed to compensate for lost time.

Boso and Salvia (2015) have noted that unemployment—compounded by increased vulnerability or precariousness in housing conditions, and by belonging to an impoverished middle class—increases problems in interpersonal relations and family life. This affects men as well as women, although it produces greater distress in men, and it particularly 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” (Seidler, 2006), nor can they expect to have access to social security and the right to a pension. This has various consequences in the sphere of occupational health:

- Rates of fatal work-related injuries are eight times higher in men than in women (International Labour Organization, 2016a), representing a cost equivalent to 10% of gross domestic product (GDP) on a global level in the year 2000 (Fontes, 2002).
- Pesticide poisoning causes 14% of occupational injuries among agricultural workers, and accounts for 10% of work-related deaths in the developing countries (García, 1998). Other examples include cancer on banana plantations (Fontes, 2002) and male infertility due to occupational exposure to lead and to organic phosphate-based pesticides used in the agricultural industry.
- In mining, in microenterprises, and in the informal sector, problems such as musculoskeletal pain are constantly increasing, accompanied by greater exposure to other psychosocial and work-related factors (Gimeno et al., 2017).

Migration to the United States of America and to cities in Latin America (such as the migration of undocumented workers) brings with it enormous vulnerability for men and is a factor in excess male mortality. These migrations increasingly include children, young men, and more recently, women. The attendant vulnerability is associated with the serious dangers entailed in migration itself, the strain of manual labor (often under conditions that offer little or no health protection or services), crowded living conditions, access to new addictive substances, and unprotected sexual relations.

From a gender perspective, some studies have identified ways in which successful migration can increase

men's symbolic capital, since it is interpreted as a new form of heroism in the struggle to provide. In some rural communities, migration is a new rite of passage for many young men (Rosas, 2007).

Having discussed ethnicity/race and work as determinants, in the following section we will focus on sexual and reproductive health. Although not closely related to high mortality, this is a key part of human life that calls for broader and more effective participation by men.

3.4 Men and sexual and reproductive health

Sexual and reproductive health is an emerging theme in which there is a relative absence of male participation, but also great potential for men to become more fully involved. Gender affects the various ways in which men approach sexuality, reproduction, intimate relationships, and fatherhood. Sexuality, in turn, 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). Although this model is

changing quite rapidly, it continues to influence the practices of rural and urban young people of both sexes. There is, for example, the value placed on feminine virginity (Amuchástegui and Szasz, 2007). Gender inequities also continue in persistent problems such as unplanned pregnancies and sexually transmitted infections (STIs), and in family planning that focuses on women. The lack of male presence in these issues became clear at the conferences in Cairo (1994) and Beijing (1995), where men were urged to take a role in the sexual and reproductive rights of women, and in HIV prevention (Aguayo and Nascimento, 2016).

The problems that young people face today in this area are varied and complex. They must struggle with cultural barriers deriving from discriminatory policies and laws that limit the exercise of their sexuality, and with a lack of safe and healthy environments in which to receive care. Gender norms and attitudes shaped during childhood and adolescence become rooted over time and are reproduced in various ways in different regions and socioeconomic settings (Blum et al., 2017). Young men and women commonly begin sexual life with insufficient



knowledge about sexuality, how to prevent undesired pregnancies, and the risk of contracting STIs. Comprehensive sex education programs that promote respectful and pleasurable relations, and that address the emotional aspects of sexuality, remain limited in LAC.

It has been established that adolescent men are less motivated to question the unequal norms that favor them than are adolescent women, who recognize how these norms put them at a disadvantage (Chandra-Mouli et al., 2017). Young men tend to be uncomfortable talking about sex because they cannot or do not wish to contradict the stereotypes and hegemonic gender behaviors to which they feel pressure to conform. They need to prove, both to women and other men, their experience and their ability to conquer (Schuster and Krahé, 2017). Many of these young men have experienced problems that go unacknowledged due to a sense of shame or because they do not know how to ask questions and express feelings about sexuality. The beliefs, customs, and attitudes acquired in the process of constructing “how to be a man” affect the exercise of sexual and reproductive rights (IPAS-Bolivia, 2016).

Sexual orientation and sexual identity, often defined from an early age, constitute another challenge. This has important implications for health when there is emotional or physical abuse, or when it is difficult to obtain health services. Homophobia causes a great deal of suffering, inflicting violence on sexual minorities, and can even provoke hate crimes. It also limits expressions of tenderness and intimacy between men. Individual men’s realities differ according to whether they are heterosexual, homosexual, or transgender, something that is particularly evident when analyzing risk behaviors and barriers to accessing health services (institutionalized homophobia) (UNAIDS, 2016).

According to Luna, in the M+H survey, LGBTTI people commonly encounter more barriers to accessing health services; moreover, their mental health needs are different from those of other men. The barriers are even greater when sexual orientation is combined with factors such as age, ethnicity, poverty, or low level of schooling, factors that contribute to the likelihood of contracting HIV (Aguayo and Sadler, 2011). This population has a higher prevalence of psychological problems and higher suicide rates, and more sexual health problems due to exposure to HIV/AIDS and other communicable diseases. All of these factors are present in a context of harassment, exclusion, and stigmatization, which creates stressful social conditions for a minority population (Meyer, 2003; APA, 2018). Furthermore, LGBTTI people living with HIV who experience high levels of stigmatization are 2.4 times more likely than other people to delay seeking medical care, tending to wait they become very ill (UNAIDS, 2017).

The M+H survey shows that, despite these difficulties, members of connected and organized LGBTTI communities generally have greater awareness about managing their health than do heterosexuals, in part because messages to increase risk awareness have been targeted to this group, whereas the sexual health messages directed at heterosexual men focus primarily on preventing prostate and testicular cancer, and omit mention of other aspects of male health.

Men’s participation is fundamental to their sexual, emotional, and reproductive life. This includes decisions on whether to have children, when to do so, how many children to have, and at what intervals. Historically, however, the promotion of contraception and family planning in LAC has been directed at women. In 2015, 65% of women between the ages of 15 and 49 who were married or had a partner used contraception, with an unmet demand of 10.7%. In 2014, the contraceptive methods most commonly

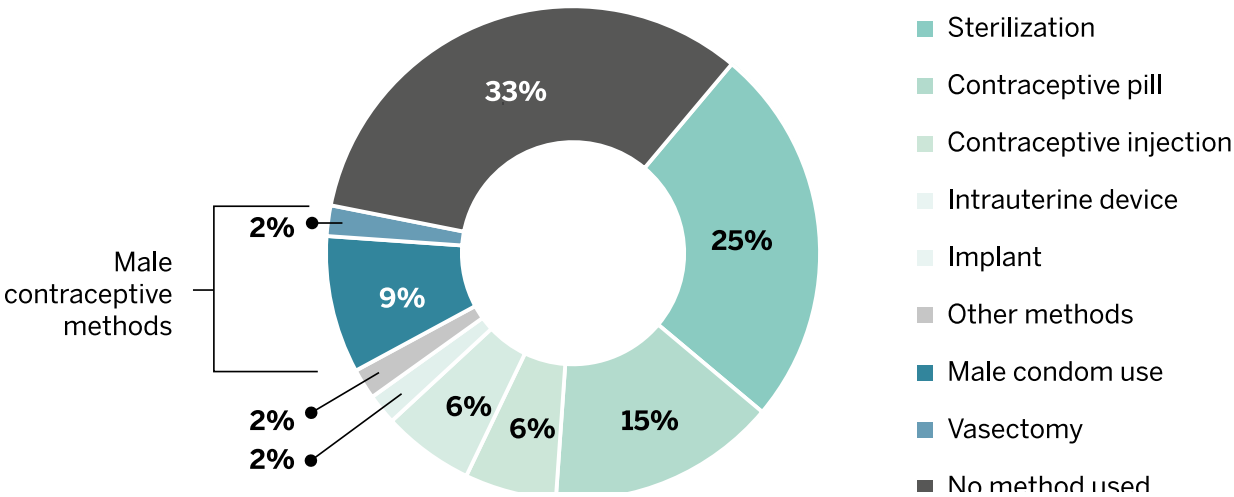
used in LAC were female sterilization (25%), intrauterine devices (15%), and contraceptive injections (6%), in contrast with the use of condoms (9%) and vasectomy (2%), totaling a mere 11% (United Nations Population Fund, 2016) (Figure 10). There continues to be a lack of sensitive public policies that promote shared responsibility for contraception in couples. Although vasectomy is safe, simple, and more effective than female sterilization, its prevalence remains low. Globally, female sterilization is eight times more common than male sterilization (19.2% versus 2.4%) (United Nations, 2015). This ratio is even more disproportionate in LAC (10 women for each man). Health policies in the Region continue to reflect traditional gender norms. The challenge consists of making men equal participants in sexual and reproductive decision making (Promundo and International Planned Parenthood Federation/Western Hemisphere Region, 2017).

Although vasectomy is safe, simple, and more effective than female sterilization, its prevalence remains low.

The issue of adolescent pregnancy, and men’s role in it, is related to contraception. The fertility rate in LAC between 1991 and 2014 was 76 per 1,000 adolescent women. It is projected that, between 2020 and 2030, women between the ages of

15 and 19 will give birth to 2 million live infants per year (United Nations Population Fund, 2016). This is associated with the increasingly acute poverty in the Region. Thirty-eight percent of girls and adolescent women become pregnant before the age of 20: the second highest rate in the world, after sub-Saharan Africa (International Planned Parenthood Federation/Western Hemisphere Region, 2015). Girls and women who give birth under the age of 20 are at greater risk of maternal mortality and birth-related complications, in addition to reduced opportunities for education and employment. The children of adolescent mothers are at increased risk of mortality, malnutrition, and dropping out of school. The men involved in these pregnancies and contraceptive strategies have

Figure 10. Contraceptive methods used by men and women between the ages of 15 and 49, 15 countries of Latin America and the Caribbean, according to available information (%), 2006-2013



Source: Based on data from the United Nations Population Fund (2016a).

not been part of the conversation, and the role they play has received almost no attention.

Male adolescents are commonly criticized for their lack of involvement in their partners' pregnancies. However, the prevailing norms in LAC do not expect them to; this responsibility is simply not a part of their upbringing. Consciously or unconsciously, families, schools, and the health system perpetuate or aggravate this view, at times punishing girls but not their partners for early pregnancies (Lundgren, 2000). This view reinforces men's lack of shared responsibility in childcare and household tasks. Despite institutional and social recognition that a young man is associated with each adolescent mother, there is no systematic record of the ages of the men involved. Based on information from the civil registry records in Mexico, Welti (2014) notes that of the 7,000 births by mothers under the age of 15, 60% of the fathers were over 20 years of age. 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 in the family. This means that the underlying issue represents a multisectoral challenge that must involve men's participation.

Another fundamental issue is men's participation in the process of pregnancy, birth, and child rearing, since 8 out of 10 men will be fathers at some time during their lives. Some surveys indicate increasing interest, both on the part of men and women, in fathers playing an accompanying role, and in their active participation, during pregnancy and childbirth. Data from the International Men and Gender Equality Survey (IMAGES) in cities in three Latin American countries confirm this trend, though in some countries men encounter obstacles to being present (Promundo et al., 2017). 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. There are still cultural and normative taboos that oppose the presence of men at childbirth, as well as regulations and constraints created by health care facilities, which are often crowded and lack the infrastructure needed to ensure privacy. Another reason for the absence of men at childbirth may be that some women prefer to be accompanied by a person other than their partner (Carter, 2002).

Various studies in high-income countries show that the presence and support of the father during childbirth can be a positive experience for both mother and newborn. The father's participation before, during, and after birth can play an important role in achieving humane and safe births, provided that pregnancy and birth are viewed as a setting in which the man's participation responds to the mother's needs (Cook et al., 2005). In addition, the father's presence, which provides an important emotional experience for both mother and father, facilitates bonding between father and child and promotes greater involvement in child-rearing (Promundo et al., 2017). In LAC, paternity leaves are practically nonexistent, or cover only very few days (fewer than 10 in most countries) (Lupida, 2016). This provides a clear opportunity for progress in public policy. Annex C includes a table showing the duration of paternity leave in the Region's countries. In order to bring about a major shift in sharing the responsibility for caring for their children, men will need to participate more actively, legislation will need to be changed, and greater openness in the work environment will be required (GENDES and other organizations, 2018).

Another problem showing limited progress in LAC is maternal mortality. This is associated with poverty, geographic isolation, lack of services, and importantly, women's extremely limited decision-making power, particularly in rural and indigenous communities. At the same time, insufficient attention has been paid to

men's role in decision making, specifically in the allocation of resources for seeking medical help. Delays in care for pregnant women can be attributed partly to a lack of will on the part of men, but also to the ways men are socialized and their lack of knowledge about the danger signs in pregnancy, and about the real possibility of preventing complications and death during this period.

The four issues addressed above (contraception and family planning, adolescent pregnancy, paternity leave, and maternal mortality) clearly exemplify gender disparities that reflect the lack of expectations on men to share full responsibility. This is an example of the gender culture that views reproduction as the sole domain of the female body. Unless men, particularly young men, are educated and made full participants in sexual matters, they are unlikely to be full participants in reproductive health. Opportunities can be created to construct and strengthen a positive masculinity based on a free and responsible expression of sexuality. This will result in the exercise of sexual and reproductive rights through the use of contraceptive methods, care for sexual and reproductive health, and shared participation in contraception and pregnancy planning, all with a view to creating a more just and equitable society (IPAS-Bolivia, 2016).

3.5 Masculinities in a diverse, globalized, and changing world

A final consideration of questions concerning the social determinants of health, masculinities, and health is presented in this section, underlining the complexity¹² of this issue in a diverse and changing world. Men's health, and the preventive and curative care

that can occur with their participation, can be seen in the context of multiple changes in gender relations, in turn reflected in economic, educational, social, and cultural changes. Major transitions are underway in the Region of the Americas, both causing and sometimes caused by changes in gender relations. These changes, outlined below, do not affect all countries or all sectors equally. They include:

- rapid urbanization that began in the 1970s;
- changes in the economic organization of society, with the mass incorporation of women in the paid work force;
- global warming, and its effect on the increase in natural disasters of all types;
- growing precariousness of labor, and consequent unemployment; deteriorating purchasing power; economic polarization; and persistent poverty—factors that require more family members (often women) to engage in paid work;
- increasing life expectancy at birth and population aging;
- growing internal migration to cities, and migration to other countries;
- earlier initiation of sexual relations, and a tendency to delay first marriage and birth of first child;
- a clear increase in the educational level of women;
- changes in the organization of the family, with reconstituted families, an increasing number of households headed by women, and a growing number of families formed by same-sex couples;
- demands and advances of movements centered

¹² Complex thinking aspires to multidimensional knowledge, conscious that causes in turn have causes, and that they are linked with one another, and seeks to become aware of the connections among isolated disciplines whose objects of study are, in fact, related (Morin, 1990).

on women, LGBTTI persons, indigenous populations, and Afro-descendant communities;

- increasingly polarized debate, along with growing acceptance of sexual diversity;
- the appearance and consolidation of gender equality policies and programs directed at women (some of which include actions directed at men), including those promoted by the health sector, contributing to more equitable gender relations in increasingly diverse spheres, such as education and politics;
- strong resistance to gender equality and to a recognition of sexual diversity by conservative forces;
- the implications of technological changes, with the emergence of new risks, such as cyber violence;
- internal military-political conflicts, and conflicts involving drug cartels and criminal gangs; and


- human trafficking, especially in women, girls, and boys.

These processes are taking place amid a clear deterioration in a number of the Region's countries, owing to the effects of more than 10 years of economic and political crisis. Some of the most abject manifestations of masculinity are re-emerging, such as drug trafficking, in addition to violent practices and the often bellicose responses of some States. Such actions are permeated with a masculinity that has contempt for life and prides itself on power based on weapons, money, and access to all manner of goods, including women, whom it views as just another possession. As many societies in the Region advanced slowly toward development and democracy (more political than economic), they came up against these realities, which persist as the second decade of the twenty-first century comes to a close. This deterioration impedes a full transition to gender equality and poses new and urgent challenges in working with men throughout the life course.



Men in public policy and health programs

4



There is an abundant body of theory and research on masculinities, to which the epidemiological evidence in the present study adds further substance. However, they have yet to shape, in any concrete way, public policies, programs, and projects. As a result of the hard work of feminist and women's organizations to promote inclusion in public policy, efforts have been focused on overcoming the gender gaps that continue to exist and to affect women. There have, nevertheless, been some specific, if limited, interventions involving men, designed to eradicate gender-based violence, improve sexual health, and build awareness, through campaigns on reproductive issues and efforts to promote more involved, active, and emotionally connected fatherhood.

Public policy and gender have been through a number of stages together:

- Policies indifferent to gender, directed “equally” at women and men, but with components that exclude women.
- Sexist public policies based on traditional gender roles that tend to reproduce such roles, excluding women from the resources and benefits available to men.
- Woman-focused policies to reduce gender gaps.
- Transformative or redistributive gender policies that consider the needs of women and men, promoting a redistribution of responsibilities, resources, productive and reproductive roles, and decision-making (INMUJERES, 2007).

The last two of these are the approaches that the present document considers to be “relational gender policies” attentive to gender specificities and sensitive to not creating new gaps and inequalities. PAHO's Plan of Action for Implementing the Gender Equality Policy defines, as a priority, more expansive gender-related concepts that assess the scope of gender equality and of current work on masculinities, in addition to other topics. These concepts are taken up in the current Strategic Plan of the Pan American Health Organization: 2014-2019 (Pan American Health Organization, 2014a), in which gender continues to be a central focus, putting forward strategies to remedy gaps in information, reduce health inequities, and promote health in all policies. One of the Plan's main specific targets is to reduce premature mortality due to violence and trauma among people ages 15 to 24.

In most countries in the Region, the health sector devotes major efforts to addressing the various health consequences of hegemonic masculine socialization. It does so, however, in a compartmentalized way, and generally without applying a gender perspective. Different agencies and specialists deal with matters such as HIV/AIDS, accidents, addiction, violent behaviors, and chronic diseases, while all of these are interlinked in men's lives in the overarching context of the SDHs.

Government policies and programs, as well as civil society, have slowly been adopting the masculinities perspective. In nearly all of the countries, government initiatives have been informed by the experience and proposals of civil society organizations. Some of these civil society initiatives, including some from the Region, have acquired an international presence:

- The White Ribbon campaign was one of the first actions by a men's organization designed to question and prevent male violence against women. Started by Michael Kaufman, along with other men in Canada, after the so-called Montreal Massacre, it currently has a presence in over 50 countries (<https://www.whiteribbon.ca>).
- Program H is being implemented by Brazilian and Mexican civil organizations in a number of countries, as an alternative way to create awareness in young men about gender issues, HIV prevention, violence, mental health, and fatherhood. The work conducted on fatherhood by MenCare and Program P has shown positive results. Finally, Program D, which focuses on masculinities, sexual diversity, and homophobia, deserves mention (<https://men-care.org>).
- The MenEngage alliance is a driving force in unifying labor around positive masculinities, with representatives in nearly all of the Region's countries, and with networks in North America, Mexico, Central America, Brazil, Colombia, Peru, and Uruguay, among other countries (menengage.org and menengage.org/regions/latin-america).
- Promotion of the agenda of SUMA por la Igualdad (GENDES and other organizations, 2018) has recently begun in Mexico, proposing public policies that involve men in cultural change, violence pre-

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vention, shared childcare responsibilities, and attention to men's own health.

Programs dealing with the issue of masculinities tend to be limited in scope, of short duration, and detached from public policy agendas. While these programs can be effective at the group or community

level, they do little to support sustained long-term initiatives to achieve significant change (Barker et al., 2012; United Nations, 2008). To promote gender equity and health, it is imperative to mobilize the necessary political will and economic resources to expand the scale and impact of work with men and boys (Hernández, 2014).

According to Barker et al. (2012), men often are seen not as allies, but as obstacles to gender policy. This may be true if the gender perspective is viewed as equivalent to policies on women, or if these interventions are considered too slow or as producing only minimal change. All of this has meant that initiatives for men's health tend to be marginal, insufficient, and late.

According to Barker, in the M+H survey, women's health tends to be seen in opposition to men's health, one detracting from the other, ignoring a relational and constructive view. Those involved in addressing men's health are seen in certain cases as being anti-feminist or in competition for scarce resources, when what is needed is research and action on men's and women's health in a relational approach.

Another criticism is directed at heteronormativity and the binary vision of the health system. According to Rivera Duarte, in the M+H survey, "there is no perspective that reflects the health realities of trans

men or others who have a masculine gender identity, nor does this exist for trans women.” Thus, society’s heteronormativity, and that of its health workers in particular, adds barriers for persons with a gender identity different from the established binary options, as Vargas Urías indicates in the M+H survey.

Annex C summarizes some of the initiatives and programs conducted in a number of the Region’s countries.¹³ The case of Brazil is of particular note. Along with Australia and Ireland, it is one of the only countries with national programs that comprehensively include men’s health. The National Policy for Comprehensive Health Care for Men, created in 2009, is cited as an integrated, intersectoral model capable of inspiring progress (Spindler, 2015). It is directed at men between the ages of 20 and 59, and has five thematic linchpins: (1) access and sense of welcome, with health services seen as also male-friendly spaces; (2) sexual and reproductive health, with men recognized as having sexual and reproductive rights; (3) fatherhood and child care, highlighting the benefits of involving men in caring for their children throughout life; (4) diseases prevalent in men, facilitating and guaranteeing access to care for these diseases; and (5) accident and violence prevention, focusing on risky and violent behaviors and their costs (Ministry of Health of Brazil, 2013-2018). The model has not been perfected, but it is a positive step forward in thinking about men’s health as part of the health system, rather than isolating it from the SDHs. Even so, the country’s budget for men’s health has suffered cuts due to the economic and political crisis that began in 2016. Brazil’s earlier policies on women’s health and for the LGBTTI population are also noteworthy.

In the M+H survey, Moreira da Silva, the program’s coordinator, remarks that:

13 This is an incomplete summary, since this was not the main objective of the report.

Care is still seen as an expression of fragility, not strength. All of which leads to the health sphere being perceived as non-masculine territory, and to a sense of not belonging, while care continues to be viewed as a feminine attribute. That view must be relinquished, and men must be taught to be protagonists in their own care.

The SDH perspective reminds us that it is important to promote the gender perspective not only in health policies, but to advance healthy policies in general, i.e., health in all policies.

Health-related behaviors, referred to incorrectly as “lifestyles,” do not reflect strictly personal and free choices. Three quarters of humanity (some 4.5 billion people) lack the option of freely choosing what is fundamental for health, such as adequate nourishment, a healthy living environment, and a gratifying job not harmful to their health. In other words, health is a choice only for those who can choose it, not merely for those who want to (Benach et al., 2010, p. 35).

The foregoing highlights the need to promote changes in the SDHs, encourage self-care by men, and provide adequate services.

The approaches adopted by the governments of Latin America to address the gender dimensions of health reform are not always taken into account, since they occur outside the health sector. Thus, application of the so-called gender perspective...requires a vision that goes beyond the health sector and includes in its analysis the diversity of social reforms that affect health outcomes (Bachelet, 2015, p. 19).

A healthy-policies approach, with a perspective based on the SDHs, should include areas such as education, work, and living conditions, and should address discrimination based on gender, ethnicity, and sexual orientation.

The United Nations (2008, p. 19) has analyzed various areas for intervention with men and emphasizes some of the barriers to men's participation in health issues. In relation to HIV/AIDS, it recalls that:

Many of our past efforts and, unfortunately, some of our current efforts, have fostered a predatory, violent, irresponsible image of male sexuality and portrayed women as powerless victims or as repositories of infection.

Indeed, interventions should not be based on negative sexual and gender stereotypes.

While the focus of many health policies and services tends to reproduce or reaffirm gender stereotypes, there are documented barriers that derive from the construction of masculinity, associated risks, and lack of personal resources for self-care, as well as logistical barriers to services (e.g., limited hours of service, absence of services in remote areas, etc.). These barriers hinder the success of policies and services. It is therefore urgent to stress the importance of a comprehensive approach to men's needs.

According to Ramos, in the M+H survey, lack of self-care makes under-utilization of health services by men prevalent, especially at the primary care level (prevention), since men tend to seek health care late, when they are already very sick. There are certain beliefs associated with machismo that inculcate feelings of shame and fear in men who may have to have their sexual organs examined or undergo a rectal examina-

tion for prostate problems, since they feel this humiliates them by putting them in a "homosexual" role.

There is a negative dialectic between the lack of clarity about men on the part of health services and men's own lack of interest—or their fear or shame—leading them to neither care for themselves nor seek care. Analysis of available services shows that there is insufficient universal health coverage in most of the countries in the Region of the Americas. Some of this is due to a shortage of personnel to provide comprehensive care for men, beyond what urologists can provide. In the M+H survey, Barker and Shand point to the need for health institutions to find a new way to approach men's health. The risk factors that lead to the emergence of noncommunicable diseases (unhealthy diet, drinking, etc.) are greater in men than in women, and their share in the overall disease burden is disproportionate (Ragonese et al., 2018). This situation becomes even more problematic when considering health coverage and education for indigenous and Afro-descendant persons, which is much more limited than for the rest of the population.

Failure to see men in terms of gender creates a void in policies, programs, services, and in university education for the various health professions. This blindness also limits the health sector's opportunities for taking responsibility for existing problems, such as various forms of obstetric violence (Castro, 2004) and the unacknowledged issue of sexual harassment within the sector (Pando et al., 2016). These challenging issues offer an opportunity for men to think, question, and exercise alternative forms of power and influence.

One of the most promising areas in work with men relates to fatherhood. The *State of the World's Fathers: Latin America and the Caribbean* enumerates various initiatives to improve men's participation through par-

enting policies, involving group education programs and home visits (Promundo et al., 2017). These include:

1. Designing parenting programs that take account of fathers, and of the various cultural and other barriers (such as scheduling) that exist.
2. Thinking critically about machismo and questioning it by analyzing its costs and impact on families and on men themselves.
3. Early prevention, before men become adults and fathers (e.g., Program H), through group education and activism by young people to change gender norms.


4. Creating opportunities for reflection and for learning the skills involved in childcare and parenting.

These approaches underline the value of programs that involve fathers in raising children and help reduce corporal punishment and child abuse. The challenge facing such activities and programs is how to implement them on a large scale in order to include stakeholders from all programs (including both health and education) and to develop strategies that address prevention and promote gender equality.

Conclusions

5





This document analyzes the social and cultural construction of masculinities as a set of attributes, values, functions, and practices that are understood to be culturally essential to men and that are incorporated through processes of socialization in various contexts (family, school, neighborhood, work, government institutions, media, etc.). In most countries in the Region, men still hold more positions of greater power (political, economic, and educational), and they enjoy greater autonomy than women, thus ensuring them various privileges. The literature shows how male socialization, with national and regional variants, is associated with mandates that constitute risk factors for both sexes. Gender inequality based on privilege and masculine mandates have health impacts, making health an excellent and even dramatic vantage point from which to observe risk behaviors, vulnerability, and the costs of hegemonic masculinity. A review of the epidemiological literature clearly demonstrates the following costs:

- a. Average LEB is 5.8 years less for men than for women.
- b. Men are at higher risk of dying from various causes:
 - Seven times more likely than women to die from interpersonal violence.
 - Six times more likely than women to die as a result of alcohol use.
 - Four times more likely to die of drowning and occupational injuries.
 - Three times more likely to die from road injuries and suicide.
 - Up to twice as likely to die from cirrhosis of the liver, HIV/AIDS, and drug use.
- c. Excess male mortality spikes in adolescence, with violent causes of death predominating and tripling the mortality rates in this group.
- d. All these data are reflected in the overall disease burden and YLLs, which show that one out of five men die before the age of 50.

The health situation of men has been hiding in plain sight for too long, at both the national and global levels. In addition to premature mortality, the other consequences for men are obvious, and policy makers and health care professionals have devoted inadequate attention to the issue. Today, some signs of change can at least be seen, but are they enough to make a difference? (Baker, 2018)

Our analysis is consistent with the conclusions of the M+H survey, and it converges in many ways with some of the results, conclusions, and recommendations of the report on *The*

Health and Well-being of Men in the WHO European Region (World Health Organization, Regional Office for Europe, 2018b), as well as with the global report on *Masculine Norms and Men's Health* (Ragonese et al., 2018), in terms of the close relation between masculinities and health, in which men's identities and practices demand or reinforce lack of care for their health, sometimes including total neglect. This has created a culture of risk, with associated lifestyles and behaviors that have negative consequences in many areas. As demonstrated by the M+H survey, these include: the workplace, with injuries resulting from a failure to follow safety rules (workers competing in "manliness" and virility); sexual relations, due to unprotected sex, which carry risks of contracting and transmitting STIs and HIV; road injuries due to driving while intoxicated, resulting in accidents and violent confrontations; family roles, with domestic violence and suicides caused both by men's failure as economic providers; and discrimination based on ethnicity, color, stage of life, etc. All of this reveals a range of vulnerabilities related to gender that have negative consequences not only for men, but also for women and for the families and communities in which men live, thus, for society as a whole (Aguayo and Sadler, 2011).

Specific health needs that can be identified. Just as women experience constraints on their right to health care and suffer gender violence and institutional violence, among other things, men develop internal barriers that prevent them from caring for their health, and find that health services lack receptivity, information, proper scheduling, and infrastructure.

Recognizing the complexity of these issues, we have analyzed masculinities and health from the perspective of the SDHs present in the Region: life course, ethnicity/race, work, and sexuality. These intersect with other internal inequalities, especially in men of particular ethnic groups, adolescents, and men of the LGBTTI community. Men with subordinate masculinities

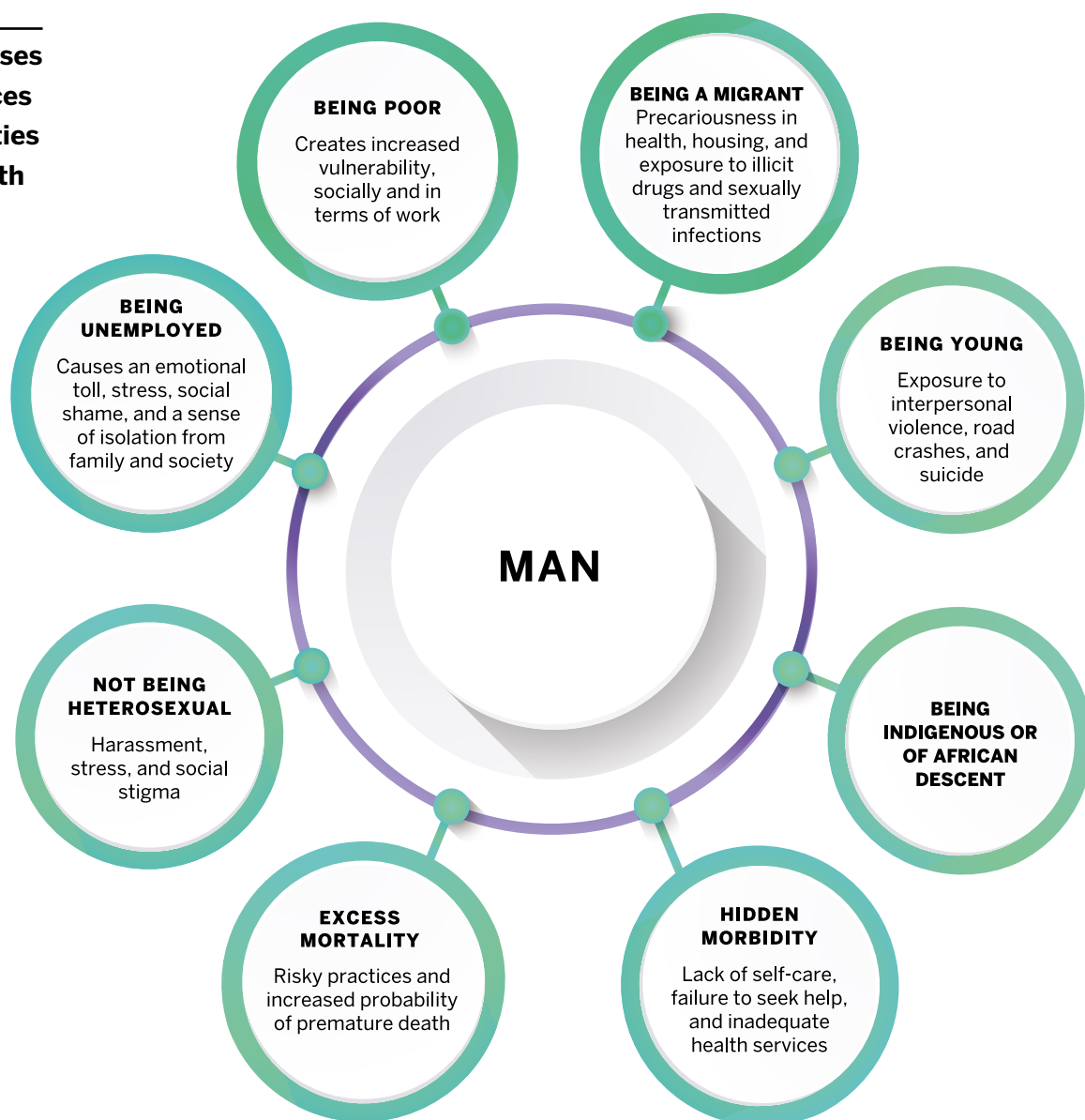
are more stigmatized, not only by the society, but also by the health system. In the M+H survey, Escobar emphasizes the additional training that health teams need in to provide care that is tailored to the needs of these groups. The health sector itself is not without internal manifestations of inequality and violence: it, too, is permeated with unequal gender relationships, both between health workers and toward the user population.

The LGBTTI population faces institutional stigmatization, unequal access to services, and health care personnel with insufficient training to meet their needs. This increases their vulnerability to critical problems such as HIV/AIDS and hate crimes, in addition to a lack of social opportunities for employment and education.

A number of studies indicate that both the Afro-descendant and indigenous populations experience health inequalities compared with the rest of the population. This includes their invisibility, in the sense that statistical databases do not disaggregate them in any systematic way. It has been shown that men in these communities have higher overall mortality, lower life expectancy, less access to all types of services, less benefit from HIV/AIDS treatment strategies, and less schooling, all of which point to the need for an intercultural approach to equity. It is clear that poorer people perform more dangerous work than others, and this affects their health both in and beyond the work setting. Figure 11 summarizes this intersectionality of vulnerabilities.

Sexuality and reproduction constitute an important area of unequal and power-based relationships shaped by gender. The exercise of sexuality based on masculine hegemony, lack of autonomy, and irresponsibility puts men and their partners, as well as the LGBTTI population, at risk (for STIs, violence, sexual dysfunctions, etc.). As Fernández Moreno points out

Figure 11. Causes and experiences of vulnerabilities associated with masculinities



in the M+H survey, men are generally asymptomatic carriers of STIs who do not know they have a disease, do not take the issue seriously, and do not take effective preventive action, being unfamiliar with basic hygiene and prevention measures. Men's participation in all aspects of sexuality and reproduction must be promoted, from the onset of their sexual maturation through conception, pregnancy, childbirth, nursing, and child rearing. This will also lead to closer, more affectionate, daily care of children, and will allow men to enjoy parenting as a shared responsibility.

There is clearly a need to impart comprehensive education about sexuality in schools and other settings, with a focus on rights and on the gender perspective. It is important to use content that fosters the development of skills, attitudes, social abilities, and values that give men permission to care for their bodies and protect their health and well-being (United Nations, 2014). Comprehensive education on sexuality should focus on both motherhood and fatherhood, and should use a gender approach, promoting men's participation, and openly questioning machismo and

sexism (International Planned Parenthood Federation/Western Hemisphere Region, 2015).

The lack of universal health coverage in most LAC countries is related to men's limited use of health services and to the fact that they tend to delay their use of these services. This is due both to their own inherent resistance and to the fact that they encounter access barriers such as: lack of consensus about men's involvement in equality policies; a gender emphasis that tends to relate only to policies designed to change the adverse realities of women and girls; and a view of men as being obstacles to achieving equality, while pigeonholing them in a traditional dominant, violent, and inequitable role, as if masculinity were inalterable. All of this makes it difficult to approach men's health problems in a preventive manner and to promote men's self-care and the health of others. Prenatal and infant medical checkups are not set up with fathers in mind, and men are not accorded even secondary status in child rearing, leaving them without the opportunity to develop co-responsibility (Barker et al., 2012; Aldana et al., 2015).

The result of this is clear and worrisome, both because of the enormous costs of the problem and its relative invisibility. Health policies and programs are advancing, though very slowly, toward a comprehensive life-course view of women's health. However, well into the twenty-first century, the absence of a comprehensive perspective on men's health is surprising. This void exists in policies, programs, and services, as well as in the university training provided for the various health professions in the Region. This is a historical blind spot that has been present since the origins of medicine and public health. It is rooted in biological knowledge, but in today's world, it can and must be overcome.

The health sector is making great efforts to deal with the multiple consequences of hegemonic masculine

socialization, but it does so in a compartmentalized way, and generally without a preventive and gender-equality approach. This disjointed approach to the different manifestations of masculinities, combined with the gender inequality experienced by women, exacts an enormous cost and affects the design and funding of health policies and programs.

Only by connecting the problems and constructing a relational gender approach that includes both women and men and their SDHs, can we achieve a perspective and response that can reasonably be termed "comprehensive." Proposals have emerged from civil society and academia to address this problem, with a focus on intervention through government programs and policies. However, initial responses have so far been marginal, insufficient, and late in coming. They must be expanded, and their continuity and systematic evaluation must be assured.

Epidemiological evidence makes it possible to assess the costs of hegemonic masculinity, including: the YLLs resulting from the main causes of mortality cited above; the DALYs; the costs of care and rehabilitation (including the unpaid care provided by women); the harm to other men and to women; the material damages and costs associated with isolating people in the prison system; and, not least, the impact on the lives of women and children.

It is essential that these costs be demonstrated, and this is a significant challenge for studies on disease burden. By preventing these costs in the first place, there will be no need for a debate on how to find the resources for working with men. As Shand says in the M+H survey, documenting the costs of toxic masculinity will help to define programmatic responses. The aim of creating awareness about these consequences is not to make men the victims of the twenty-first century, but rather to help them recognize, address, and prevent the factors that make them vulnerable.

Turning to the ideas of Barker et al. (2012, p. 63), we ask: Should the only reason for including men be to remedy the inequalities that women face? Or is it also possible to imagine that they have their own gender-related needs and vulnerabilities that should be included in designing public policies?

The answer to this last question is a full-throated yes.

Men's needs and vulnerabilities can be approached critically. Not only is this possible, it is essential: a process that should converge with efforts in favor of women on the path to equality.

In summary, these are our conclusions:

- There is a close relationship between masculinity and health, in which the roles, norms, and practices socially imposed on men reinforce their lack of self-care and encourage neglect of their own physical and mental health. This has created vulnerabilities, along with a culture of risk, accompanied by lifestyles and behaviors with adverse consequences in various areas (work, sexual relations, gender violence, accidents, and increasing drug and alcohol use), impacting the well-being of men and women.
- When analyzing masculinities and health in light of the SDHs (age, ethnicity/race, work, sexual diversity, etc.) and the life course approach, it becomes clear that the subordinated masculinities in the Region are seriously stigmatized by society and by the health system. In many cases, men face additional barriers due to a lack of specific training and sensitization of the health professionals who provide care for these groups.
- Considering the historical contexts and conditions of the colonial period and of slavery—which directly affect health—indigenous and Afro-descendant populations experience greater health inequities than the rest of the population. This is reflected in their invisibility in statistical databases that are not designed to provide disaggregated data. Men in these populations have higher mortality rates, shorter LEB, less access to various types of services, and less schooling, and they benefit less from strategies aimed at preventing and treating HIV/AIDS.
- Sexual practices based on hegemonic masculinity with little autonomy, scant information, and little access to care and sexual health resources endanger men and their partners, as well as the LBGTTI population, exposing them all to STIs, violence, sexual dysfunction, and other risks. There is a clear need for a comprehensive approach to gender rights and gender equality in sex education, both in and outside of school, with appropriate content for developing social skills, attitudes, and values that give men permission to care for their bodies and protect their health and well-being.
- The lack of universal health coverage in most LAC countries 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 because of the barriers they encounter in accessing care. What is needed in terms of policies, programs, and services for men's health is a comprehensive, life-course approach.
- The health sector deals disjointedly with the multiple consequences of hegemonic masculine socialization and generally lacks a preventive and gender-based approach. This failure to attend to the different manifestations of masculinities, combined with the gender inequalities faced by women, exacts an enormous cost and shapes the development and funding of health policies and programs.
- In most of the countries in the Region of the Americas, a large percentage of decision-making and

otherwise powerful positions are occupied by men, conferring on them various privileges. Studies on this topic show that male socialization is associated with roles, norms, and behaviors that, in turn, are risk factors for both men and women. The roles, privileges, and practices of hegemonic masculinity have health consequences, making health an excellent and timely lens through which to view the vulnerabilities and costs of hegemonic masculinity.

- Men run a greater risk of dying from various external causes, such as interpersonal violence (seven times higher than women), consumption of alcohol (six times higher), traffic injuries and suicide (three times higher), and work-related injuries (four times higher), as well as from HIV/AIDS and cirrhosis of the liver (two times higher). However, the overall health situation of women continues to be worse than that of men in terms of rights, circumstances involving violence, and access to power and resources.

Recommendations

6



Based on the available evidence, there needs to be greater awareness of how policies and programs can be adapted to the challenges of addressing men's health from a gender perspective. This perspective needs to recognize the diversity among men, along with the effects of the SDHs. Few countries in the Region have health programs for men, and few policies in the health sphere provide a gender perspective. In Brazil, the National Policy for Comprehensive Health Care for Men has led to significant advances in this area. Greater priority needs to be given to incentives to develop the capacity of health systems and health care providers, in order to improve prevention efforts and respond to men's needs. Consideration must also be given to determining how health services can reach men in settings such as work and sports, as Shand points out in the M+H survey, by adopting a salutogenic perspective not limited to hospitals and health centers (Antonovsky, 1996).

Available health services should ensure men's health in a comprehensive and multidimensional manner, offering schedules and settings that are accessible to men. There is a related need for political will and for greater knowledge within the health sector about how to address male problems, as highlighted by Esquivel Ventura in the M+H survey, and by GENDES and other organizations (2018). The challenges to achieving these goals include overcoming men's cultural and psychological barriers to seeking care, and addressing feelings such as fear, denial, embarrassment, and the sense that their masculinity is threatened. For men, a visit to the doctor can feel like a challenge to their pride, an accusation of inadequate self-care, or a violation of the masculine mandate to be strong. One way to change men's attitudes about using health services is to teach them about the risks to their health and to promote self-care practices from an early age (Lundgren, 2000), paving the way for men to use services earlier and to adopt practices that prevent illness and promote health.

The culture and perspective of the health system remains focused on mothers and children. Greater thought must be given to how primary care is structured, since it devotes too little attention both to men and women throughout the life course. Men must be viewed in relation to their family's health (sexual and reproductive health, parenting, etc.). In short, the primary care model must be rethought in order to give masculinities their proper place, as Barker says in the M+H survey, while the system's heteronormative vision must be challenged in order to appropriately address sexual diversity.

Escobar comments, in the M+H survey, that it is essential to view preventive action from the life course perspective, recognizing that attitudinal changes during childhood and adolescence can persist throughout life, and, conversely, that unhealthy behaviors in adult life generally are rooted in learnings incorporated during the early stages of life.

Important issues in this area include self-care, responsibility, and participation in the various areas of life (the body, sexuality, reproduction, work, family, and other important re-

lationships). As Campos Guadamuz indicates in the M+H survey, “all of the health problems that affect men are preventable but can be mitigated by promoting greater awareness and re-education in men.” Major risk behaviors in the male population (smoking, alcoholism, unhealthy diet, lack of physical exercise, etc.) should be a public health priority. The same is true for strengthening health assets and developing initiatives that discourage men from perpetrating violence against women, the LGBTTI community, and other men. These key conclusions were also reached by Ragonese et al. (2018).

Publications on this issue lack sufficient quantitative analysis and, more specifically, fail to provide qualitative analysis of these problems from a gender and masculinities perspective. We need to gain a better understanding of how the social construction of being a man leads to the elevated figures we have discussed, and how to promote changes in health practices. Further research is also needed on the multiple interrelationships between masculinities and the SDHs, especially those that give rise to specific disparities linked to ethnicity/race, work, sexual orientation, and life course. It is also necessary to consider how to systematize and communicate experiences in working with men in the health sector, in academia, in civil society organizations, and in international organizations, so that this information is communicated to public policy-makers at all levels.

Despite overwhelming evidence of the negative effects of hegemonic masculinity on the health of women and men, there is little evidence for the positive effects of men’s involvement in health, though some encouraging signs can already be seen in the area of sexual and reproductive health and parenting. A salutogenic perspective should help, for example, to identify socialization processes in men who are not violent, who are not addicted, who care for their own health, and are aging healthily, and to ex-

plain how this benefits quality of life throughout their life course. Efforts must also be made to identify the health assets present in the various contexts in which men live and develop. Rather than “new masculinities,” we are talking about creating and promoting positive masculinities.

Disease prevention and health promotion for men extends beyond the health sector. It is therefore important to understand the relational and transformational gender perspective and to incorporate it in a broad set of policies designed for and coordinated by other sectors, including labor, the environment, and safety. This should generate healthy policies and a focus on health in all policies, in which other sectors adopt policies that have positive impacts on health, with a particular emphasis on the SDHs that directly or indirectly affect men’s health. This demands broad participation by men themselves, something that is happening increasingly around the world through networks such as MenEngage.

The present document is a timely appeal for an integrated vision of men as not simply a risk factor but as part of the solution. This is a complex issue that deserves attention, participation, and resources from policies and programs aimed at building a new relational gender perspective. Such a perspective must be attentive to the old and new inequities between men and women throughout the life course, taking account of the SDHs. Examples of inequities include the increasing number of HIV/AIDS cases, addictions in women, and the failure to identify and address depression in men.

Nearly 30 years have passed since the first analyses of men’s health from a gender perspective were published in the North American and Ibero-American literature. Social security systems have treated wage-earning men simply as a labor force. Since the Cairo and Beijing conferences, men have been called

on to become active participants and to assume responsibility for sexual and reproductive health strategies, HIV/AIDS prevention, and the elimination of violence against women.

It is time to recognize men's various vulnerabilities and to view men as persons entitled to comprehensive policies and programs (while in no sense minimizing their importance for women) for care, prevention, and health promotion. These recommendations should not be perceived as threatening or competing with actions directed at women, but rather as an urgent response to problems that, directly and indirectly, also affect women.

The following recommendations emerge from a review of the literature, based on the contributions of experts and on the epidemiological evidence:

1. Improve, systematize, and disseminate quantitative and qualitative information about masculinities and health and about the many

related costs. Engage in deeper study of the diversities among men, the links between these diversities and the SDHs, and the resulting barriers, along with evidence about effective programs. Promote similar studies in the Region, as well as national assessments that can suggest more targeted approaches. This will require coordinated efforts by academia, the health sector, international organizations, and civil society.

2. Develop public policies and care programs (with adequate schedules and settings) for comprehensive prevention of the most important problems affecting men during the life course. Since men's health problems are inter-linked, comprehensive strategies must also be linked by adopting an SDH, intercultural, relational gender perspective. This requires ongoing dialogue with the women's movement, along with active promotion of participation by men.



3. Minimize the barriers to health-seeking and access for boys, young men, and adult men in situations of vulnerability, and step up efforts to provide equitable access to health services for men whose masculinities are subordinated due to ethnic/racial or sexual status.
4. Develop a broad intersectoral initiative that addresses the SDHs by creating healthy policies and incorporating health in all policies—with special emphasis on educational policies—and by promoting care and attention to gender inequalities and reducing barriers between programs. The enormous cost—and not only monetary cost—exacted by hegemonic masculinity on today's societies is unmistakably clear.
5. Examine in greater depth existing health assets and the positive practices in which men are already engaged, in order to strengthen knowledge and strategy from a salutogenic perspective.
6. Ensure the participation of all communities (men, women, LGBTTI, etc.) through promotion and communication, forming politically responsible communities that are involved in their own care and in the care of others.
7. Promote education that includes a gender, human rights, and intercultural perspective in the training of human resources who are responsible for education, treatment, and provision of services, in the health sector, related sectors, and universities (through information, awareness-building, and skills development on these issues).
8. Emphasize the development of programs for disease prevention, health promotion, and gender equality, directed at boys and young men, emphasizing non-violence, comprehensive sex education, parenting, and shared responsibility for childcare.
9. Address and prevent institutional expressions of hegemonic masculinity and its toll on women and men, including in international organizations, the health sector, universities, and civil society. Gender equality is not just words: it must be a daily practice for men and women.

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Glossary

Binarism: the tendency of most societies to classify nearly all elements in two differentiated and opposed groups, as in the case of “masculine” and “feminine.” Characteristics, attributes, functions, and values that can be seen in different ways in different cultures and periods are associated with these poles.

Collective violence: acts of social, political, and economic violence.

Diverse masculinities: masculinities that share elements with the dominant masculinity but also incorporate very different forms of being a man that contribute to variants in the course of the health/illness/care process.

Ecological model: a perspective proposed by Heise et al. that observes what occurs at various social levels, including the personal, interpersonal, institutional, and public policy levels.

Feminization of aging: the process by which the majority of older people in the world are women (190 women for every 100 men), despite the fact that more boys than girls are born in the world (105/100).

Gay studies: studies in which men for the first time question their identity and break away from the dominant masculinity, particularly in the area of sexuality.

Gender: form of social organization that consists of a set of historically and culturally constructed attributes and roles. Its objective is differentiation based on human biological differences, and alignment with a system of sex and gender that is internalized through socialization.

Gender perspective: a perspective that attempts to understand and denounce the subordinate condition of women, while opening the door to the possibility of understanding the condition of men.

Health/disease/care process: a complex process that individuals and groups go through—being healthy, suffering an illness of some kind, and adopting a particular care strategy—in the framework of specific historical, cultural, and social conditions.

Healthy policies (health in all policies): an approach in which public policies in all sectors systematically consider the health implications when making decisions, seek synergies, and avoid harmful effects on health, in order to improve the population's health and increase health equity.

Hegemonic or dominant masculinity: culturally constructed model based on the sexual division of labor in which men are dominant. Women and men who do not or cannot adapt to that model are discriminated against and subordinated.

Interpersonal violence: violence against persons with whom the perpetrator has no family ties, or against members of the perpetrator's family.

Intersectionality: a concept originating in feminist sociological theory that analyzes and discusses the ways in which oppression intersects with and creates unique and diverse experiences of discrimination.

Life course: from the epidemiological perspective, the long-range study of the health/disease effects of exposure to physical or social risks during gestation, childhood, adolescence, young adulthood, and adult life.



Masculinity: a complex set of attributes, values, functions, and behaviors that are understood to be essential to being a man in a given culture.

Masculinity as a risk factor: a central focus of work on masculinities that examines their social construction and the way they affect women's lives through socialization in the dominant masculinity, in which men represent a risk factor affecting women, children, other men, and themselves.

Men's health: from the gender perspective, this is the study of the differential trajectories in the health/disease/care process of women and men, incorporating a social and cultural view in which power relationships are present.

Micromachismos: non-obvious behaviors of violence and domination that men exert in daily life in their relations with women, which affect women's autonomy and psychological state.

Relational gender perspective: a perspective that examines the links between the experiences of women and men—in the present context, in the field of health.

Salutogenesis: in the context of the study of men's health, this includes the forms of being a man in which self-care and care of others predominate.

Self-care: a concept proposed by Foucault that makes it possible to analyze the relationship that men establish with their bodies and with their health, and that questions some of the mandates of masculinity that lead men to neglect self-care and medical care.

Self-inflicted violence: violence against oneself, including suicidal behaviors and self-inflicted injuries.

Sex/gender system: the set of ways in which a society transforms biological sexuality into products of human activity.

Socialization: cultural process through which ways of representing oneself, attributing value, and acting in the world are incorporated, and which takes place throughout an individual's life course.

Subordinated masculinities: men who suffer a high degree of stigmatization in society and in the health system because they belong to certain subgroups of men (for example, indigenous, Afro-descendant, and members of the LGBTTI community).

Violence: intentional use or threat of force or physical power against oneself, another person, or a group or community, that causes or is very likely to cause injury, death, psychological harm, developmental disorders, or deprivation. Violent acts may be physical, sexual, or psychological in nature, and include deprivation or neglect.

Vulnerability in men: the condition of men who have a minority presence or more limited power, originating in precarious environments and contexts, and associated with ethnicity, poverty, geographic dispersion, or rural setting, or with being a member of a sexual minority. These men may also exercise the privileges provided under the model of hegemonic masculinity.



- A. Methodology**
- B. Development and diversification of the masculinities field**
- C. National advances on work with masculinities and health**

Annex A. Methodology


The systematic review of the issues covered in this document included consulting the following sources: Google Académico/Google Scholar; the JAMA network; Latindex; ProQuest; Redalyc; SciELO; ScienceDirect; The Lancet; the World Bank; the Centers for Disease Control and Prevention; EME Masculinities; the United Nations Population Fund; the International Planned Parenthood Federation; the National Institutes of Health; the United Nations Educational, Scientific and Cultural Organization; the United Nations; the World Health Organization; the Pan American Health Organization; and the Joint United Nations Program on HIV/AIDS.

Technical feedback was obtained from various professionals at the Pan American Health Organization (PAHO), and a technical dialogue was coordinated with the following additional technical personnel in the Region: Adria Natalia Armbrister, PAHO health equity consultant; Anna Coates, who heads the Of-

fice for Equity, Gender, and Cultural Diversity; Carolina Hommes, PAHO life course consultant; Claudina Cayetano, PAHO mental health advisor; Denisse Wolfenzon, PAHO specialist in gender and health; Luis Alfonso, PAHO advisor on drugs; Maria Victoria Bertolino, PAHO gender consultant, Argentina; Rubén Mayorga, coordinator of the PAHO Subregional Program for South America; Sonja Caffé, PAHO adolescent health advisor; Amalia Ayala, PAHO family and gender advisor, Guatemala; Pierre Pratley, PAHO health services and gender advisor in Guyana; Lorraine Thompson, PAHO advisor on subregional cooperation in the Caribbean; Jonas Gonseth Garcia, PAHO advisor on quality health systems and services; Devora Kestel, PAHO unit chief for mental health and substance use; Lauren Vulcanovic, PAHO communications advisor; Ann Marie Williams, representative of the English-speaking Caribbean countries at CARICOM; Aurora del Río (National Center for Gender Equity and Reproductive Health, Secretariat of Health of Mexico); Eduardo Houellemont (Ministry of Health, Dominican Republic); Jane Kato (PROMUNDO, United States); Jerome Teelucksingh (University of the West Indies, Trinidad and Tobago); José Olavarría Aranguren (Universidad Academia de Humanismo Cristiano, Chile); and Juan Carlos Escobar (Adolescent Health Program, Argentina).

Methodology used for the Masculinities and Health (M+H) survey

In the framework of research on masculinities and health in the Region of the Americas, a survey was designed to gather the perspectives and contributions of key professional informants active in this field in a number of the Region's countries. In collaboration with PAHO's Office for Equity, Gender, and Cultural Diversity, a guide was created containing questions in the form of a dialogue (see below). The



five questions chosen are an attempt to encompass the main problems in the field of masculinities and men's health in the countries of the Americas. The present work attempts to give greater visibility to the most important social determinants of health and to learn about aspects of policies that exist or are needed to address men's health issues. The survey questions were:

1. What is the relationship, in your view, between masculinities and men's health?
2. What is your analysis of the interaction between the social determinants (ethnicity, sexual orientation, poverty, life course, class, work, education, etc.) and masculinities and men's health?
3. Based on your experience, what are the three main problems (in order of importance) in the broadly defined field of masculinities and health?
4. What policies and programs (government or civil society) are you familiar with that deal with masculinities and health in your country and in the Americas?
5. Please indicate the three main initiatives that would have to be implemented to address the most important voids in the area of masculinities and men's health.

The key informants were identified and selected by a non-probabilistic methodology that chose them for their suitability in terms of their academic experience and their involvement in public policy management. This first phase was followed by snowballing: using the suggestions of the initial key informants, masculinities networks, and the PAHO advisory team to identify further informants. Survey Monkey was used to send the questions and receive responses, though the alternative of a telephone interview was also offered.

The survey was sent to approximately 140 people, and 32 informants (21 men and 11 women) responded. In terms of the geographic areas covered, four of the informants were from North America (Canada and the United States), 22 from Latin America, and six from PAHO (one who covers Guatemala; four who cover the entire Region from PAHO headquarters in Washington; and one based in the Caribbean).

The 32 key informants who responded were: in North America, Guitté Hartog (University of Quebec, Canada/Mexico), Tim Shand (Promundo, United Kingdom/United States), Gary Barker (Promundo, United States/Brazil), and Ivy-Lim Carter (Movember Foundation, United States); in Mexico, Mauro Vargas and Ignacio Lozano (GENDES, A.C.), Hugo Rocha Pérez (Padres Cariñosos, A.C., Mohresvi A.C.), Aurora del Río (Secretariat of Health), Gerardo Ayala (Salud y Género, A.C.), Yuridia Rodríguez (independent gender consultant), Francisco Cervantes (Corazonar, A.C.), Nicholas T. Kaufmann (University of San Luis Potosí), Isabella Esquivel Ventura (FLACSO/UNAM), and Rosaura de la Torre (Centros de Integración Juvenil, A.C.); in Central America, Álvaro Campos Guadamuz (Instituto WEM, Costa Rica), José Roberto Luna (United Nations Population Fund, Guatemala), and Douglas Mendoza (Fundación Puntos de Encuentro, Nicaragua); in South America, Hugo Huberman (Argentina), Juan Carlos Escobar (Head of the Program for Argentine Adolescents, Argentina), Francisco Norberto Moreira da Silva (Men's Health Coordinator/Ministry of Health of Brazil), Andrés Rivera Duarte (Observatory of Men's Health and Diversity, Universidad Central, Chile), Marcos Nascimento (FioCruz, Brazil), Alexis Valenzuela (Universidad Central, Chile), Sara Yaneth Fernández Moreno (Universidad de Antioquia, Colombia), Miguel Ángel Ramos (Universidad Cayetano Heredia, Peru), and Darío Ibarra (Centro de Estudios sobre Masculinidades y Género, Uruguay).

The relevant information was extracted and compared using content analysis methodology. For questions 3 and 5 (dealing, respectively, with problems and initiatives), it was possible to weight the number of similar responses to establish an order of importance. Due to limited space, only the most important elements were included in the report.

Methodology used to group epidemiological data

The epidemiological data were investigated by consulting World Health Organization (WHO) databases at: http://www.who.int/healthinfo/global_burden_disease/en.

Four specific databases were analyzed:

- 1) Disease burden by age, sex, 2000-2015:
 - DALY estimates, 2000-2015.
 - YLL estimates, 2000-2015.
 - YLD estimates, 2000-2015.
- 2) Causes of death by age, sex, and region, 2000-2015.

Each of the cited databases groups world regions (tabulated and analyzed by WHO). For the Region of the Americas, the countries included are:

■ Antigua and Barbuda	■ Chile	■ Guyana	■ Saint Lucia
■ Argentina	■ Colombia	■ Haiti	■ Saint Vincent and the Grenadines
■ Bahamas	■ Costa Rica	■ Honduras	■ Suriname
■ Barbados	■ Cuba	■ Jamaica	■ Trinidad and Tobago
■ Belize	■ Dominican Republic	■ Mexico	■ United States of America
■ Bolivia (Plurinational State of)	■ Ecuador	■ Nicaragua	■ Uruguay
■ Brazil	■ El Salvador	■ Panama	■ Venezuela (Bolivarian Republic of)
■ Canada	■ Granada	■ Paraguay	
	■ Guatemala	■ Peru	

Secondary databases were also consulted, grouped by year according to the distribution of WHO and World Bank member countries.¹ Only 3 of the 33 countries in the Region of the Americas had data that were unreliable and therefore not useful: Bolivia (Plurinational State of), Haiti, and Honduras.

To analyze the cited databases and determine the overall disease burden in the Region and the existing gaps, the data were grouped in 5-year periods and disaggregated by sex. Charts and tabulations were constructed for the main problems, their trends, and percentages of the total for each sex. Data were also compared to determine the gender gap between the two sexes. For each indicator, a comparison was made based on the most prevalent causes for men versus the causes for women, making it possible to identify the most prevalent causes and the differential rates.

The life course analysis used data from three of the Region's databases (mortality, YLLs, and YLDs). The causes with the highest prevalence, rate, and percentage representation were filtered. These causes were analyzed using a global framework (leading causes)

¹ WHO Member States with populations of less than 90,000 in 2015 have not been included in the analysis.

and a specific cause to determine the central tendency among age groups.

Information from the database was used to create a simple regional grouping by country, and the Region of the Americas was divided into three large sub-regions (North America, the Caribbean, and Latin America) consisting of:

Latin America:

- | | | |
|---------------------------------------|---------------|---|
| ■ Argentina | ■ Ecuador | ■ Paraguay |
| ■ Belize | ■ El Salvador | ■ Peru |
| ■ Bolivia
(Plurinational State of) | ■ Guatemala | ■ Suriname |
| | ■ Guyana | ■ Uruguay |
| ■ Brazil | ■ Honduras | ■ Venezuela
(Bolivarian Republic of) |
| ■ Chile | ■ Mexico | |
| ■ Colombia | ■ Nicaragua | |
| ■ Costa Rica | ■ Panama | |
-

North America:

- Canada and United States of America
-

The Caribbean:


- | | |
|-----------------------|------------------------------------|
| ■ Antigua and Barbuda | ■ Haiti |
| | ■ Jamaica |
| ■ Bahamas | ■ Saint Vincent and the Grenadines |
| ■ Barbados | |
| ■ Cuba | ■ Saint Lucia |
| ■ Dominican Republic | ■ Trinidad and Tobago |
| ■ Granada | |
-

Once the countries were grouped, general population figures, age groups, and causes of mortality were summed. This exercise produced the following statistics: gross rate; percentage of total deaths, by sex; and determination of the leading causes of death, by prevalence and rate.

Annex B. Development and diversification of the masculinities field

It is important to explain how this field of knowledge has grown, along with our understanding of the issues that relate directly or indirectly to health and its social determinants. The issue of masculinities was influenced from the start by a number of classic feminist authors from Latin America, Europe, and the United States of America. The precursors of the initial analysis of masculinities are Kaufman (1989), Seidler (1991), Kimmel (1992), Badinter (1993), and Connell (1995).

The publication of studies and initiatives that analyze and question masculinities and men helps to foster a fuller conceptual understanding of the gender perspective as a truly relational perspective. In the English-language literature, Kimmel (1992) refers to the beginnings of masculinities as a field of study. Later, Brod and Kaufman (1994) addressed the need to theorize about masculinities, while Still (2003) edited a volume on men's bodies. In *Men's Lives* (2010), Kimmel and Messner considered the diversity of men's contexts and experiences in North America. In that same year, Deslauriers and other authors from Quebec published a volume that examined men in an attempt to "understand and intervene" from a social-work perspective. Important journals began opening their pages to authors addressing masculinities, examples of which include *Reproductive Health Matters* (London), *Gender & Society*, *Voice Mail*, and



later *The Journal of Men's Health and Gender*, a publication that also deals with the theme of masculinities and health.

Volumes written collaboratively by European, English-language, and Latin American authors gradually appeared. Ruxton (1994) articulated theoretical approaches based on field experiences; Breiner, Connell, and Eide (2000) attempted to bring the discussion of men's violence into the context of the peace culture; Pease and Prigle (2001) published a volume that considers men in relation to a globalized world; and Bannon and Correia (2006) proposed viewing masculinities as "the other half of gender" in discussions on development.

In Chile, Valdés and Olavarría (1997) compiled some of this initial work, along with early Latin American texts, for a publication in Spanish. Later, in 2003, Olavarría coordinated a volume on adolescent men, and remains active today. In Peru, Fuller (1997), Cáceres et al. (2002), and Ramos (2006) attempt to provide a broader view of the men of different sectors and ethnic groups in Peruvian society. In Colombia, the work of Viveros (1997) stands out, incorporating the Afro-mestizo ethnic dimension. Nolasco (1993) initiated what would later become a major Brazilian work led by Medrado, Lyra, and Nascimento. In Central America, Lancaster (1992) published an early study on machismo in Nicaragua, which was followed by the work of Montoya (1998), studying men who do not engage in violence. Salas and Campos (2006), of the Instituto Wem, in Costa Rica, set a precedent by addressing the issue of men in connection with sex tourism and human trafficking, a theme taken up later by Fernández and Vargas (2012), of GENDES, in Mexico.

At the same time, seminars were being held in various academic institutions in Latin America (Mexico's

Universidad Nacional Autónoma, Colegio de México, and Universidad Pontificia de Perú, Flacso-Chile) with support from the Ford and MacArthur foundations, setting the stage for the first exchanges that led to the emergence of the issue in national and international conferences. This eventually generated conferences focused specifically on masculinities (in Brazil, Chile, Colombia, Mexico, and other countries), as well as regional conferences such as the biennial colloquia on masculinities, most recently in Chile in 2015, Brazil in 2017, and Costa Rica in 2019.

An interesting development in men's studies is an anthropological perspective that considers diverse processes of socialization in very different contexts, along with the rites of passage present in almost every society. Guttman (1998) provides an excellent introduction to this approach. Many of these studies analyze rural and indigenous societies (Godelier, 1986; Mallart, 1993; Chirix, 1997; Rodríguez and De Keijzer, 2001; and De la Cruz, 2010), but there are also studies on men in urban environments (Brana-Shute, 1979; Fuller, 1997; and Guttman, 2000). One of the most ambitious studies is Gilmore's (1990), which examines different cultural contexts in an effort to identify the meaning of being a man in those settings. It is said that we have passed through a second stage in Latin America, a stage of ethnographic thinking that takes account of the diversity of masculinities, along with elements common to different cultures and contexts.

It is not only men who have contributed to this theoretical work. Notable work has been done by feminists examining masculinity. Examples are the work of Barbara Ehrenreich (United States, 1983), Elizabeth Badinter (France, 1993), Norma Fuller (Peru, 1997, 2000), Mara Viveros (Colombia, 1997), Mabel Burin (Argentina, 1997), Amuchástegui (Mexico, 2007) and Jiménez and Tena (Mexico, 2007). In addition to the



work of these authors, a significant number of masters' and doctoral theses address issues such as fatherhood, sexuality, and violence in men (Figueroa, Jiménez, and Tena, 2006).

Some of the subsequent work appears in compilations of authors from different countries. Examples are Careaga and Cruz (2006), Amuchástegui and Szass (2007), Ramírez and Uribe (2008), and Rocha and Lozano (2014), as well as journals in the gender field (*La ventana*, *GénEros*, *Debate feminista*, *La Manzana*).

Knowledge about masculinities has grown enormously, especially in the last 20 years, in the Region of the Americas and the rest of the world. This growth is evident in research, civil action, and to a lesser extent public programs and policies. Many thematic developments relate directly or indirectly to what is occurring in the health field. Some notable examples of this are:

- Violence toward women and between men: Liendro (1991), Bonino (1995), Castro (2004), Ramírez (2008), Garda and Huerta (2009), and De Keijzer (2010).
- Risk behaviors: Bonino (1989), De Keijzer (1998), and Barker (2005).
- Sexuality: Núñez (1994, 2007), Viveros (2002), Cáceres (2004), Gallego (2009), and Nascimento (2014).
- Reproductive health: Leñero (1994), Castro (1998), and Figueroa (1998).
- Fatherhoods: Fuller (2000), Olavarria (2001), Figueroa, Jiménez, and Tena (2006).

- Mental health: Herrera, De Keijzer, and Reyes (1995), and Burin (2000).

- Work: Garduño (2011), Olavarria (2015), and Jiménez and Tena (2015).

- Public policy: Aguayo and Sadler (2011), Ramírez (2017), and GENDES (2017).

Some of these thematic areas emerge from or are closely linked to actions in civil society. Organizations in Mexico (CORIAC, Salud y Género, A.C.), Brazil (Promundo, Nous, Papai, and Ecos), Central America (Puntos de Encuentro, Centro Bartolomé de las Casas, and Wem), and Chile (CulturaSalud) have initiated important explorations, training, and dissemination of the gender perspective with men (Núñez, 2017).

In a very recent assessment, Núñez (2017) points to 25 years of knowledge production in the field of gender studies on men and masculinities, and identifies the main fields, in order of frequency: sexuality/diversity/HIV/AIDS, identity/subjectivity/machismo, theory/methodology, fatherhood/couples/family, violence, reproduction/health/sexual and reproductive rights, historical/regional studies, culture/customs, and emotional health/risk/mortality/addictions.

Aguayo and Nascimento (2016) have provided a broader overview, in addition to identifying areas that call for more development. Similarly, Viveros (2017) has offered a wide-ranging review of Latin American work over 30 years, pointing to seven thematic areas of focus: (1) the subject of masculine identities (30% of the studies consulted); (2) studies on masculinities and violence (18%); (3) problems, dilemmas, and tensions around men's health (16%); (4) emotions and sexualities (14%); (5) epistemological reflections on

masculinities studies (14%); (6) cultural representations and work on masculinities (6%); and (7) settings of masculine homo-sociability (2%).

In this report, we have sought to shed light on the Caribbean region, where there is a dearth of data in this field. Machismo in the Caribbean is based on the premise of ensuring and strengthening the masculine “reputation”; thus, the pattern of a masculine ideal that emphasizes domination over women, competition between men, the exhibition of aggressiveness, and predatory sexuality (Nurse, 2004). This author also says that men rarely see themselves as a gender, since masculine characteristics tend to be spread through the society as the prototype of human behavior. Nurse also analyzes the differences between men who have what the author calls “multiple masculinities”, and also speaks of the hegemonic masculinity of the “white” man and the interaction of “othernesses” and “differences,” recognizing these as an important mechanism of governance, as occurs, for example, in the colonialist discourse (Nurse, 2004, p. 6).

De Moya (2004) analyzes Dominican masculinity as part of the “problem of legitimization” for men, and of the consensus on three general issues: (1) men as the “exact opposite” of women; (2) procreation as a necessary but insufficient condition to legitimize masculinity; and (3) competitive homosocial relations between men. In the Dominican Republic, the ideal female companion for most men seems to be, in their words, a type of merchandise: “lady in the street, nymph in bed, servant in the house.” Senior (2015)² studies Jamaican men, analyzing their roles, attitudes, reactions, influences, and perceptions in the

context of induced abortion. Finally, Sukhu (2013)³ explores male violence among the working class in Trinidad and Tobago, where mistreatment is taken to be “consistent” with the patterns of behavior and thinking of the men in the study.

Finally, in the course of this voyage through the Americas, we have also stressed certain thematic voids. These include men in relation to abortion and adolescent pregnancy, old age, the study of elites in the Region’s countries, and themes such as drug trafficking and militarization. Also notable is the scarcity of studies with a salutogenic perspective, in other words, a focus on men who do care for their health or are egalitarian in their gender relationships (De Keijzer, 2016).

Annex C. National advances on work with masculinities and health

Based on the review of the literature and the M+H survey conducted in 2017, this initial, non-exhaustive presentation serves as an introduction to current advances on masculinities and health in the Region. Leaving aside Brazil’s National Policy for Comprehensive Health Care for Men, what we see is a number of initiatives that are limited to addressing specific issues such as violence, HIV, reproductive health, fatherhood, and adolescence.

ARGENTINA. The National Program for Comprehensive Health in Adolescence, of Argentina’s Ministry of Health, has been working since 2015 to train health teams and build awareness about gender and masculinities, with the objective of analyzing the health problems of men and women from this point of view.

2 St. Patrick Senior K.T. *Untold stories of abortion: Masculinities and fatherhood*. Kingston: University of the West Indies; 2015.

3 Sukhu RLM. Masculinity and men’s violence against known women in Trinidad—Whose responsibility? *Men and Masculinities*. 2013;16(1):71-92. doi:10.1177/1097184x12468102



In civil society, the Network of Work Teams and Masculinities Studies (RETEM) works with men who engage in violent behaviors.

BRAZIL. See p. 47 of this document.

CANADA. This is the country that launched the White Ribbon Campaign to prevent violence against women, which now has a presence in over 50 nations around the world. It operates a unique health service with a high degree of comprehensiveness. The recent masculinities-focused campaign, “Don’t Change Much,” is conceived as a movement to inspire men and their families to live healthier lives. It uses reliable information and simple recommendations that call for small changes with major health impacts.


CHILE. Chile Crece Contigo [Chile Grows with You] is cited as a model program for men’s participation in pregnancy checkups, as companions during birthing, and on medical visits with their children during working hours. This program includes five-day post-natal paternity leave, which has been extended to six weeks that can be taken by either the man or the woman. The Centros de Hombres por una Vida sin Violencia [Men’s Centers for a Violence-free Life], of the Ministry of Women and Gender Equity, have a pilot project for specialized personnel that is in high demand, with few vacancies. For the LGBTTI population, two hospitals have a program to provide care for transsexual and transgender individuals, including hormone treatments and sex-change surgery.

COLOMBIA. The country has programs that work with violent men to reduce violence toward women. It is based on complaints and reports to the offices of the Commissioner for Families (comisarías de familia) and to government agencies. Various public

activities and programs in civil society encourage artistic and cultural activities aimed at avoiding the forced recruitment of children, the consumption of psychoactive substances, and the risk of living in the streets. There is also considerable activity in research and communication around sexual diversity.

COSTA RICA. The country has a Men’s Health Act, along with a recently implemented policy known as the National Positive Masculinities Policy (formulated by the Instituto WEM and adopted by the State). Instituto WEM has also done broad-based work organizing personal growth groups for men, in which they develop gender awareness and a readiness to engage in self-care.

MEXICO. In the last 30 years, groundbreaking work has been done by civil society groups such as CO-RIAC (on violence) and Health and Gender A.C. (on comprehensive health), leading to work by various other associations (GENDES, MHORESVI, Corazonar, and Hombres por la Equidad, among others). Currently, they are connected mainly through the Cómplices por la Igualdad network, whose focus is on fatherhood, non-violence, and prevention of homophobia—issues present on the Suma por la Igualdad agenda. Through the National Gender and Reproductive Health Center, the Secretariat of Health presents programs on Family and Gender Violence Prevention and Care to reeducate individuals who have engaged in violence, as well as strategies for fatherhood. The civil society model of working with men who have been violent has been adopted by governmental organizations, providing increasing coverage. However, there are numerous challenges, such as high demand for results from facilitators, who have little in the way of resources. In February of each year, the Institute of Safety and Social Services for State Workers urges men



to engage in self-care, with the paradoxical slogan “Superheroes also take care of themselves” [“Los Superhéroes También se Cuidan”]. Finally, the National Polytechnic Institute is active in violence prevention work, as well as in the areas of fatherhood, and has been promoting an increase in the number of days of paternity leave.

NICARAGUA. Organizations such as Puntos de Encuentro and Red de Masculinidades have been pioneers in Central America and have worked effectively on awareness-building and communication with adult and younger men, on issues such as violence and fatherhood. The Ministry of Health implemented a specific program to address the links between men’s health and women’s health, but it was then cancelled, and only family care models remain.

PERU. As a part of civil society, INPPARES implemented a pioneering program with its Men’s Clinic and Proyecto Macho, working in education and communication, with a broader population, on the relation between masculinities and health. Currently, this project is suspended, and the Men’s Clinic is functioning only as a service provider. In 1999, the Ministry of Health, with support from the United Nations Population Fund, sought to implement specialized sexual and reproductive health services for men, but the initiative failed to gain a foothold in the following years. Much of today’s work on issues of violence and fatherhood is done by Red Peruana de Masculinidades.

UNITED STATES OF AMERICA. The Health and Human Services Administration (a government agency) has carried out campaigns to promote men’s health. There are programs on certain types of cancer, such as prostate and testicular cancer, and non-scalpel vasectomy. The Centers for Disease Control and Prevention (CDC) have conducted preventive interventions

on sexual health. Some universities also conduct lines of research on men’s health and violence. Civil society has initiatives in various parts of the country, such as the work of the Movember Foundation, California’s Prevention Institute, and the model case of the specialized Young Men’s Clinic in Harlem, run by Columbia University, which works with the Latino and Afro-descendant population. Also of note is the NAMEN network, which creates links between civil society efforts in Canada and in the United States of America.

THE CARIBBEAN. This region has a long history in reproductive health, with a variety of initiatives directed at men, including work on the dimension of fatherhood. While civil society organizations initially provided care for family planning on a small scale, including services for men, their initiatives have been adopted by governments. In particular, Barbados and Guyana are making concerted efforts to establish men’s health programs.

In many countries in the Region of the Americas, legislation on paternity leave is increasingly common, but with a very limited number of days offered (see Table C1). In Argentina, there is 2 days of leave, though some provinces allow 5 to 20 days. Brazil provides 5 to 20 days for fathers who attend programs that offer orientation on fatherhood. Chilean legislation entitles fathers to 5 working days to care for their child. Cuba provides up to 3 months; Venezuela (Bolivarian Republic of), 14 days; Ecuador, 10 days; Colombia, between 4 and 8 days; Mexico and Nicaragua, 5 days; Panama, 3 days; Peru, 4 days; Uruguay, between 3 and 10 days; Guatemala, Paraguay, and the Dominican Republic, 2 days (Pro-mundo, IPPF/ WHR, 2017); Canada, 35 days (OECD, 2016); and the United States of America provides for 84 unpaid days of leave (International Labour Organization, 2017).

Table C1. Maternity and paternity leaves in Latin America and the Caribbean

Country	MATERNITY LEAVE			PATERNITY LEAVE		
	Duration (days)	Pay (%)	Source of pay	Duration (days)	Pay (%)	Source of pay
Antigua and Barbuda	91	100	Mixed	Non-existent		
Argentina	91	100	Social Security	15	100	Employer
Bahamas	84	100	Mixed	49	Unpaid	
Barbados	84	100	Social Security	None		
Belize	98	100	Social Security			
Bolivia (Plurinational State of)	91	95	Social Security			
Brazil	119	100	Social Security	35	100	Employer
British Virgin Islands	91	66.7	Social Security		**	
Chile	126	100	Social Security	5	100	Social Security
Colombia	98	100	Social Security	4-8	100	Social Security
Costa Rica	119	100	Mixed	None		
Cuba	126	100	Social Security	90		
Dominica	84	60	Social Security	None		
Dominican Republic	84	100	Mixed	15	100	Employer
Ecuador	84	100	Mixed	10	100	Employer
El Salvador	84	75	Social Security	21	100	Employer
Granada	91	100	Mixed			
Guatemala	84	100	Mixed	2	100	Employer

Country	MATERNITY LEAVE			PATERNITY LEAVE		
	Duration (days)	Pay (%)	Source of pay	Duration (days)	Pay (%)	Source of pay
Guyana	91	70	Social Security	Non-existent		
Haiti	84	100	Employer			
Honduras	84	100	Mixed			
Jamaica	84	100	Employer			
Mexico	84	100	Social Security	5	100	Employer
Nicaragua	84	100	Mixed	5		
Panama	98	100	Social Security	3		
Paraguay	84	50	Social Security		100	Employer
Peru	91	100	Social Security	4		
Puerto Rico	56	100	Employer	Non-existent		
Saint Kitts and Nevis	91	65	Social Security	Non-existent		
Saint Lucia	91	65	Social Security			
Saint Vincent and the Grenadines	91	65	Social Security	**		
Trinidad and Tobago	91	100	Mixed	Non-existent		
Uruguay	84	100	Social Security	3-10	100	Employer
Venezuela (Bolivarian Republic of)	182	100	Social Security	14	100	Social Security

Data reproduced from Lupica C, Paternity and parental leave in Latin America and the Caribbean. Essential tools to promote greater participation of fathers in the care of children. Masculinities and Social Change. 2016;5(3):295-320. doi: 10.17583/MCS.2016.2083

**Data unavailable.

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 negative behaviors associated with 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 in a multisectoral strategy of coordinated policies to improve the health of men and boys.

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