Need to close the men’s health gap for health equity

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weak aspects, especially the assumption that universality will automatically result in equity. To achieve equity and equality and therefore to be consistent in achieving girls’ and women’s sexual and reproductive health, it is necessary that girls’ and women’s needs and concerns are centrally included in the systemic changes that universal health care promotes. These include: ensuring that financing and other mechanisms incentivise health providers to focus on persons rather than particular diseases or health conditions; regulating mixed public-private systems that use criteria of equality, quality, scientific rigour and human rights compliance; providing a comprehensive and integrated set of sexual and reproductive health services over the life course of all girls and women that reaches those who cannot easily access health services; and ensuring that institutions that monitor, evaluate and set benchmarks toward universal health care coverage include benchmarking, standard-setting and monitoring and evaluation of sexual and reproductive health services. There must be both vertical and horizontal accountability through effective voice and participation by women’s and young people’s organisations in planning, monitoring and reviewing all health services.¹

http://dx.doi.org/10.1080/17441692.2014.986161.

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This commentary identifies policy targets and interventions that could address the largely ignored gender-based disparity in health, in which men tend to have worse health and lower life expectancy. In general, men’s multiple advantages do not translate into better health outcomes, in part because of notions of masculinity and the highly gendered nature of employment. These gender disparities are not properly addressed in the health policies and programmes of the major global health institutions. Only three countries – Australia, Brazil and Ireland – have adopted national, male-centred strategies. Three key targets of public and policy action should be schools, where stereotypes about masculinity can be challenged, the workplace and provision of health services and health promotion for marginalised men, men from minority populations, men in prison populations and men who have sex with men. WHO’s Regional Office for Europe has made a bold commitment to address gendered health inequalities but it is unclear what actions the office has taken to date or is planning for the future. The European Commission published a comprehensive report on men’s health in Europe in 2011 but no action plan based on its findings has been produced.¹

http://dx.doi.org/10.2471/BLT.13.132795.

**Addressing gender and power in sexuality and HIV education**

This review of evaluation studies found that including gender and power content in sexuality and HIV education curricula increases the likelihood that they will be effective. Electronic and hand searches identified rigorous sexuality and HIV education evaluations from developed and developing countries published between 1990 and 2012. Of the 22 interventions that met the inclusion criteria, 10 addressed gender or power and 12 did not. Sixteen of the 22 studies were from high-income countries (14 of them from the US) and six from low- or middle-income countries. Seven of the studies were girl or women only and 15 were mixed. Ten were school-based, five clinic-based, four community-based, two in multiple settings and one in a military recruit training base. Ten of the programmes demonstrated significant decreases in pregnancy, childbearing, STIs, or STIs and pregnancy combined. Twelve failed to show a significant, independent effect on any of these outcomes. Of the ten effective programmes, five enrolled both females and males and one of these found positive effects for both males and females, others found differential effects by sex, generally better outcomes for girls and women. The programmes that addressed gender or power were five times as likely to be effective as those that did not. Of the ten programmes that addressed gender or power, eight (80%) were associated with a significantly lower rate of STIs or unintended pregnancy. In contrast, of the 12 programmes