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Men's Health 1

Men's health: an intersectional and multilevel framework for understanding syndemic patterns of health

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See **Series** pages 1881 and 1899

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This is the first in a **Series** of three papers about men's health

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Men occupy a privileged position within gender power relations: the male body has been the default reference point for biomedical research and therapeutic development (with the historical exclusion of women from medical trials), and men dominate health services leadership and exercise well documented medical misogyny. Yet despite their privileged position, many aspects of men's health outcomes are neglected and undertheorised because they are not examined through an intersectional gender lens. Although consideration of gender and masculinity is important for understanding men's health, research thus far has focused predominantly on men's harmful health behaviours, overemphasising individual determinants of health, and a deficit-based approach. Little attention has been paid to the influence of structural determinants of men's health risks and vulnerabilities, or the gender-specific health outcomes of worsening social and economic inequalities. In this first paper of a *Lancet* Series on men's health, we present a conceptual framework for understanding men's health from an intersectional perspective, highlighting how structural, social, and commercial determinants of health, intersectionality, and syndemic theory can be combined to analyse men's health at different socioecological levels. We illustrate the framework using four selected case studies that show how the health outcomes of marginalised men are influenced by complex interactions. We provide a working definition of men's health that reflects existing literature and builds on the conceptual framework and case studies. Promotion of gender justice and health equity requires moving beyond one-dimensional approaches that construct men as problematic individuals, and towards better understanding and action on the broader set of power systems and structural determinants underpinning men's health.

Introduction

Men's health is characterised by paradox. Men occupy a privileged position within gender power relations and the (able, White) male body has been the default reference point for biomedical research and therapeutic development, which are associated with the historical exclusion of women from clinical trials,[1] domination of health services leadership by men, and well documented medical misogyny.[2] Simultaneously, modern, colonial, and postcolonial health programming has tended to focus on women's reproductive health and been oriented towards women as the assumed primary carers of children.[3] This focus has led to multiple exclusions from health systems, such as of men and women minoritised by race, ethnicity, gender expression, sexuality, class, or disability, and of women's health needs beyond reproduction. Despite the structural advantages men have relative to women, and with some heterogeneity across contexts and age ranges, analysis of Global Burden of Disease data from 1990 to 2023 shows that male life expectancy and disability-adjusted life-years have generally been worse than those of female individuals across most contexts,[4] particularly for disadvantaged and minoritised male patients (see the second paper in this Series[5]).

Explorations of men's health have thus far prioritised the discussion of gender, masculinities, and men's harmful behaviours, often treating men as a homogenised group and taking a deficit-based approach that overemphasises individual determinants of health.[6,7] The influence of structural and systemic determinants of

Key messages

- The paradox of men's health—that men are privileged in gendered power relations, but their life expectancy and disability-adjusted life-year outcomes are generally poor compared with those of women—remains underexplored, and gender mainstreaming efforts have rarely explicitly included men's health.
- Much of the existing research on men's health has focused on hegemonic masculinities in isolation and paid insufficient attention to the influence of other intersecting systems of power and structural, social, and commercial determinants on men's health outcomes (explored in more detail in the second paper of this Series).
- We present a conceptual framework for understanding men's health that integrates structural, social, and commercial determinants of health with intersectionality and syndemic theory to show how the health experiences of marginalised men are shaped by complex interactions at different socioecological levels. We illustrate key aspects of the framework with four case studies, selected on the basis of their representation of different geographical locations, health conditions, and manifestations of men's marginality.
- Across different global contexts, historical and ongoing social and economic marginalisation and precarity interact with hegemonic masculinities to create clusters of poor health and wellbeing outcomes for groups of men disadvantaged by class, race, nationality, disability, and gender expression, sexuality, or both.
- Coordinated action at multiple levels on multiple systems of power is needed to address the determinants of men's health and ultimately achieve gender justice and health equity for all (explored in more detail in the third paper of this Series).

men's life chances, health risks, and vulnerabilities (including racism, colonialism, poverty, and climate change) have been largely overlooked; although this dynamic is also present for women, approaches that consider how gender and structural determinants interact for men have been particularly absent. In addition to overlooking the heterogeneity among men, there has also been a failure by policy makers to discuss positive aspects of masculinity or manhood and the role that men can play in improving everyone's health.[8–10]

Furthermore, little attention in terms of research, policy, and programming has been paid to men's health despite available evidence of poor outcomes.[10–12] Although national governments and policy makers are slowly beginning to recognise men's health as an important issue,[13] only a few regional or global bodies have included men's health in their agendas (see the third paper in this Series[14]). This recognition comes at a time when the well established notion of gender as a key driver of health is under attack, and much of the progress and infrastructure supporting the health of women and girls is being dismantled.[15,16] This recognition also coincides with a societal rise in the presence and acceptance of harmful ideals of masculinity that are associated with men's poor health, gender-based violence, and gender inequities and injustice, including social mobility.[17–19]

Building on the *Lancet* Commission on gender and global health, we frame men's health (inclusive of trans men; panel 1) within a gender justice approach, which encompasses "universal rights in relation to health equity and gender equality", "recognises the diversity of needs and experiences, [and] calls for the inclusion of all people".[20] Gender justice is not a zero-sum game, whereby efforts to improve men's health must be at the expense of tackling women's oppression. To this framing, we add the WHO definition of health equity, which emphasises that health is a fundamental human right that is achieved only when everyone can attain their full potential for health and wellbeing.[25] Using Rowlands' model of power,[26] we acknowledge the need to end men's power over women and we argue that men also stand to benefit from gender justice, because patriarchy intersects with other structural forces to harm everyone's health, including men's. We use the concept of hegemonic masculinity: the form of masculinity that is culturally dominant in a given setting and characterised by patriarchal dominance of men over women and other less powerful men who do not live up to idealised notions of masculinity.[27–29] Since the publication of Connell's work popularising this term more than 30 years ago,[28] an important and expanding body of research has critiqued hegemonic masculinities and men's approaches to embodying these ideals, including recognition of the multiple or mosaic expressions of masculinities, in part shaped by other intersecting aspects of identity in any given context.[30–34]

Gender mainstreaming efforts, which have sought to systematically include a consideration of gender in policy and practice over the past 25 years, have rarely included men's health explicitly.[35–37] No agreed-upon definition of men's health exists,[38] in global, regional, non-governmental organisation, and national policy reports that focus on the health of men or elsewhere.[39–41] Many gender and health frameworks have included men and

Panel 1: Gender, sex, and diversity of intersecting male identities

In line with the 2025 *Lancet* Commission on gender justice and global health,[20] in this Series, we use the term gender to refer to the structure of social relations and practices that are organised in relation to reproductive bodies, which creates hierarchies of power and influences the distribution of resources within societies. We use the term men to refer to all adults who self-identify as such, recognising that the field of men's health should encompass a diversity of masculinities and male gender expression, including trans men. We use the term sex to refer to biological characteristics associated with sexual reproduction, chromosomal genotypes, hormones, and physical characteristics. The term is also used to classify bodies in a binary manner as either male or female. We therefore use the term male when classification has been done on the basis of biological sex, as has often been the case in data collection (including government administrative systems and the Global Burden of Diseases, Injuries, and Risk Factors Study). We recognise the complexities and challenges of attributing observed differences between individuals or populations to gender, sex, or both, and use the original terminology of published studies, which might lead to variation in usage across the Series. Sexuality should be seen as distinct from gender and we use the term sexuality to refer to an individual's sexual orientation, expression, and identity. Using an intersectional framework enables investigation of the complex expressions of power, privilege, and penalty associated with different masculine identities,[21] with cisgenderism being an important oppressive process for analysis in relation to men's health, alongside racism, classism, ableism, heterosexism, and other systems of power.[22] Intersectional theory highlights that expressions and experiences of masculinity and manhood are uniquely constructed at the intersection of multiple identities, including class, race, gender, sexuality, and ability in specific cultural contexts; however, as highlighted in *The Lancet*'s 2016 Series on transgender health, population-level data with which to monitor the health of transgender men and women are scarce.[23] Routine health surveillance in most countries does not assess gender identity as an equity stratifier and in many countries, stigma, punitive laws, and misunderstanding discourage many people from making their transgender status known or accessing health care.[24] Efforts must be made by the global health community to address this gap and fully engage the heterogeneity of men's identities in the journey towards gender justice and health equity.

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masculinities, but often as the dominant reference group; most were not designed to help monitor, understand, or address men's health. Furthermore, although structural determinants are inadequately attended to in both men's and women's health, the nuances of gender in relation to men's health are particularly overlooked and the idea that gender might not operate the same way in men's health as it does in women's health is rarely considered. Few of these frameworks are equipped to look beyond hegemonic masculinities alone to consider how men's social, political, and economic power does not necessarily translate to better health.

Men's health remains undertheorised, neglected, and inadequately funded,[42] with many health researchers, professionals, and policy makers unaware of existing work.[43] This situation has implications for men's health and wellbeing, as well as for families, caregivers (who are usually women), communities, and economies.[1] Although intersectionality is acknowledged in existing frameworks, the frameworks do not sufficiently focus on how hegemonic masculinities intersect with other social stratifiers to affect uniquely vulnerable subgroups of men, or the fact that hegemonic masculinities are not exhaustive of the ideals men draw from or seek to embody.[8,9,44] Continuing to emphasise the role that gender plays in everyone's health outcomes is important at a time of anti-gender push-back,[45] as is highlighting the gendered negative outcomes of worsening social and economic inequalities, including contributions to conflict.[39]

This Series aims to explore the paradox of men's health with an intersectional lens, to unpack the concomitant privilege and penalty that shape men's health outcomes through social and structural determinants. In this first paper in the Series, we present a conceptual framework for understanding men's health from an intersectional perspective that builds on existing theories, using selected case studies to illustrate how the health of different groups of men is shaped by intersecting systems of power, and propose a definition of men's health. In the second paper in this Series,[5] we review the patterns of health outcomes of men in comparison with those of women, as well as between different groups of men, and present evidence on social and structural drivers that lead to outcomes unevenly patterned by age, demographic characteristics, and global location across different groups of men.

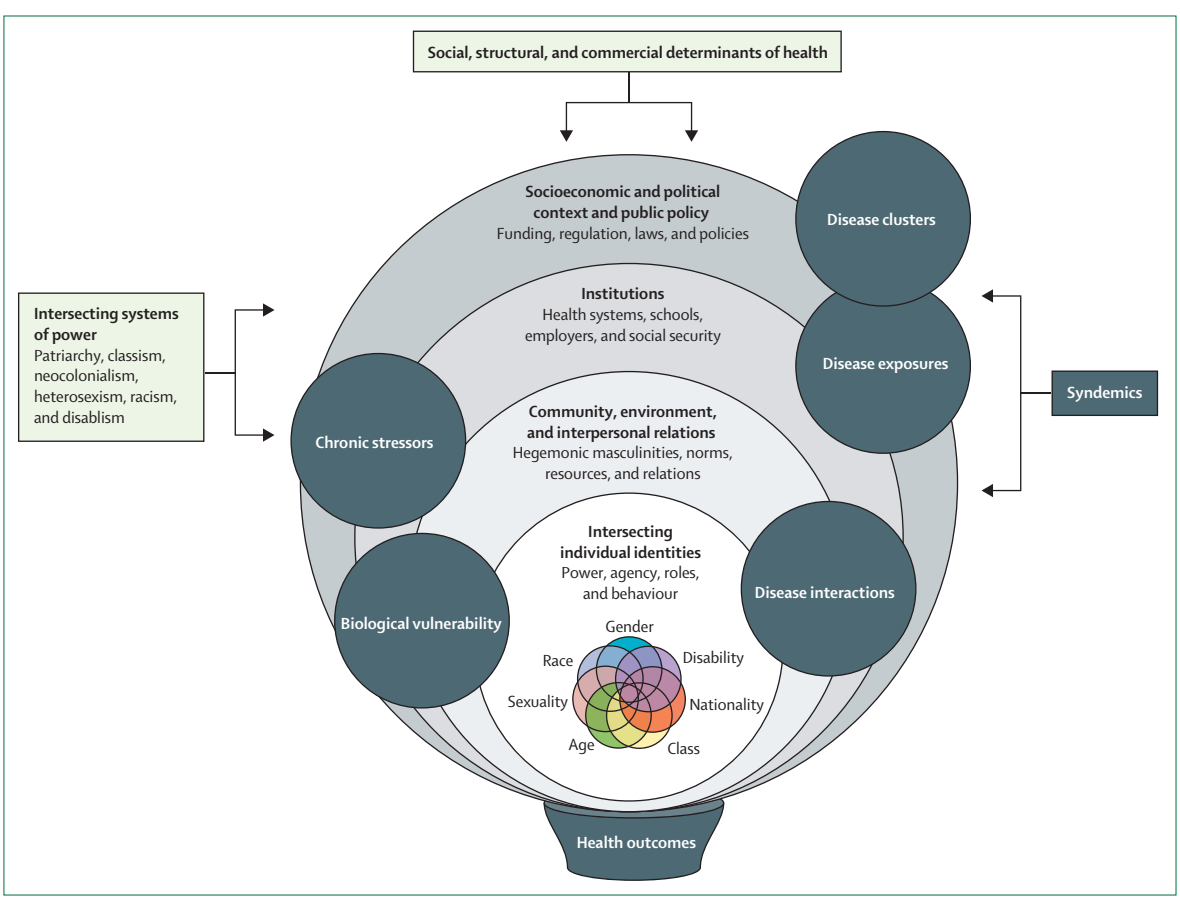


Figure: **A conceptual framework for men's health**
This framework draws on social, structural, and commercial determinants of health, intersectionality theory, and syndemic theory.

Finally, in the third paper in this Series,[14] we offer a theoretically informed analysis of the inattention to men's health and propose evidence-informed recommendations for promoting action to improve men's health.

A conceptual framework for men's health

Drawing on the discussions and critiques presented thus far and a narrative review of the literature (appendix p 1), we outline a conceptual framework that brings together social, structural, and commercial determinants of health,[46] intersecting systems of power,[47,48] and syndemic theory[49] to analyse men's health at different socioecological levels (figure).[50]

Socioecological models highlight how individuals are embedded in and influenced by systems at multiple levels.[50] Our framework identifies social, structural, and commercial determinants that shape health outcomes for men at four levels, all of which include the operation of power through intersecting systems: socioeconomic and political context (including public policy); institutions; community, environment, and interpersonal relations; and the individual level, which includes individual identity, agency, roles, and behaviour.

Intersectional theory recognises that multiple (ie, class, gender, political, religious, and sociocultural) systems of power intersect with hegemonic masculinity to create simultaneous disadvantages and privileges for groups of men on the basis of their positions within axes of social inequality.[51–53] This theory shapes our framework by showing how determinants of men's health are pervaded by interacting systems of power at all levels. For example, at the level of socioeconomic and political context, the forces of racism, capitalism, neoliberalism, neocolonialism, and patriarchy, among others, influence economies through flows of capital.[54] These forces also shape public policy on immigration and migrant entitlements,[55] and patriarchy simultaneously shapes political discourse, including political violence, which is often a key influence shaping the lived realities of marginalised men.

At the institutional level, health systems in many contexts are shaped by patriarchy, class, casteism, and racism and designed around women's reproductive biology and socially ascribed roles as carers. For example, primary health care, particularly in systems stripped back to essential health-care packages, is focused particularly on pregnancy and child health,

See Online for appendix

	Social, structural, and commercial determinants of health	Intersectionality	Syndemic theory
Men's vulnerability to pulmonary tuberculosis in the context of economic precarity in Africa	Poverty, precarious employment, and fragile health systems, shaped by neocolonialism and neoliberalism, underpin men's occupational exposure and susceptibility to tuberculosis.	Urban men in low-income, informal employment are faced with high occupational exposure to tuberculosis and the uncertainty of a daily wage creates systemic barriers to health care. Hegemonic masculinities emphasising men's income-earning responsibilities encourage prioritisation of work over health care.	Exposure to air pollution, alcohol and tobacco use, malnutrition, and chronic stress exacerbate biological susceptibility to tuberculosis and other respiratory diseases, which negatively interact with comorbidities such as HIV and silicosis, worsening health outcomes.
Cancer and heart disease risk among racially minoritised men with low income in North America	Legacies of slavery and colonisation, including residential segregation policies, generate stressful community and environmental conditions, resulting in Black and Indigenous men living in communities with reduced access to health-promoting resources or affordable, high-quality health-care options. These men face greater exposure to toxic and other health-harming factors (eg, toxic waste, fast food restaurants, liquor stores, etc) compared with their White counterparts.	Hegemonic masculinities intersect with commercial determinants (eg, racially and gender-targeted tobacco and alcohol marketing) to drive harmful health behaviours that increase cancer risk.	Cancer and heart disease are the most common causes of death, which cluster with chronic liver disease due to high tobacco and alcohol use, high access to carcinogenic, unhealthy food, and poor access to nutritious food.
Men's mental health in the context of conflict and forced displacement in the Middle East and north African region	Structural forces, including global economic pressures, neoliberal policies, patriarchal norms, and sectarian divides, create social fragility and conflict. Family-centric aid structures, perceptions of women's vulnerability, and institutional discrimination exclude men and exacerbate chronic stress.	Displaced men can have high mental health burdens. Single men receive little social support, and those who are unable to work and support their families suffer gender role strain. Racism and xenophobia in host countries impede social integration and contribute to health services under-use.	Multiple mental health conditions, including depression, post-traumatic stress disorder, and substance abuse disorders, interact negatively. Aggression and self-harm emerge as harmful coping behaviours, as does smoking, which increases non-communicable disease risk. Poor health-care access worsens previous health conditions.
Men's health and wellbeing during the COVID-19 pandemic in urban informal settlements in Bangladesh	Discriminatory global and national policies, weak governance and legal structures, and persistent wealth inequality undermine social protection and service delivery in informal settlements. Hegemonic masculinities and economic precarity interact to create chronic stressors and men resort to harmful coping strategies (eg, gambling, violence, or addiction).	Men with low income living in informal settlements faced pressure to provide for their families in the context of increasing constraints on livelihoods and violent enforcement of COVID-19 lockdowns by local authorities.	Poor environmental conditions, substandard housing, limited employment, gendered expectations and harmful coping strategies negatively interact to impact men's mental health. Low-paid, intensive, and informal manual labour also put men at risk of worsening existing mental health and other health conditions, including COVID-19.

Table: **Case studies illustrating the conceptual framework**

staffed primarily by women, and culturally oriented towards women as the primary carers of children, the sick, and older people.[3,56] Primary health care thus functions to socially exclude some women (eg, postmenopausal and trans women) and most men, who often perceive health services as female spaces.[57,58] Broader institutional systems, such as education systems, tend to consolidate hegemonic masculinities[17,59] and class, racial, and ethnic discrimination.[60]

At the community level, context-specific gender norms, including hegemonic masculinities, are usually harmful to boys and men as well as women and girls, and are consolidated through social media exposures, interacting with the inequitable distribution of resources and a toxic physical and social environment for many.[17,61,62] Repeated exposure to patriarchal hegemonic ideals, through social media or across community and family spaces, worsens stress and other harms to mental health.[63]

All these determinants intersect to create disease exposures that, along with individual vulnerabilities arising from interactions between chronic stressors and male biology, produce poor health outcomes for men. The framework we present here draws on syndemic theory, which takes a biosocial approach and explores how social, environmental, and disease-related factors interact synergistically in various and consequential ways.[49,64] This theory helps to explain why groups of disadvantaged men in particular socioeconomic, political, and cultural contexts are vulnerable to specific disease exposures and adverse interactions, which leads to clustering of diseases. For example, men who have sex with men have an elevated risk of both HIV transmission and mental ill health in ways that reinforce each other, particularly in contexts of community sexual prejudice shaped by patriarchal heteronormativity, underpinned by legal and institutional discrimination, and exacerbated by racial, ethnic, and class inequalities.[65,66] Poor health outcomes for men in turn contribute to poor social and economic environments and communities, for example by reducing productivity in the workforce, creating caring burdens (predominantly for women and girls), and increasing the risk of intimate partner violence.[67]

Illustrating the conceptual framework

The framework emphasises the importance of understanding how intersections between gender and other systems of power determine health outcomes for men, particularly men who are minoritised because of classism, neocolonialism, racism, heterosexism, ableism, or other oppressive processes. Here, we present four case studies that synthesise existing research to illustrate key aspects of the framework, selected on the basis of their representation of different geographical locations, major health conditions contributing to the gender gap in health outcomes (as discussed in the second paper in this Series[5]), and manifestations of men's marginality. Intended to be illustrative of the range of intersecting determinants of men's health globally rather than an exhaustive review of the literature, case study contributors identified additional literature relevant to the topic from their own experience and expertise, reflecting diverse geographical locations, social positionalities, and disciplines.

The table summarises how the case studies illustrate different elements of the conceptual framework.

Men's vulnerability to pulmonary tuberculosis in the context of economic precarity in Africa

This case study illustrates how the interaction of global and national economic policies, institutional health system biases, and gendered norms creates precarity and environmental exposures that shape the vulnerability to tuberculosis of men with low income and limit their access to diagnosis and treatment, ultimately creating disproportionate risk of tuberculosis and poor outcomes.

Men bear the brunt of tuberculosis incidence in Africa[68,69] and face systemic barriers to tuberculosis prevention and care.[70] Of the 2·62 million people who developed tuberculosis in the WHO African region in 2024, more than 1·35 million were men (alongside approximately 926 000 women and 337 000 children), with more than one in four men missing tuberculosis diagnosis and treatment. Tuberculosis thrives where poverty, precarious employment, and fragile health systems intersect. Men with low income, who are disproportionately represented in unstable, high-exposure jobs such as mining, transportation, and manual urban work, often face cumulative disadvantages across structural, institutional, and community levels.[71]

Overcrowded urban informal settlements (which accommodate more than 50% of people living in cities across Africa)[72] and poorly ventilated social settings and workplaces amplify airborne transmission of tuberculosis, and indoor air pollution from biomass fuels compounds pulmonary damage.[73] Tuberculosis-associated occupational hazards are widespread in male-dominated employment sectors;[74,75] for example, in Kenya, drivers and touts working in enclosed and poorly ventilated *matatus* (buses) have high rates of tuberculosis exposure.[76] Normative gender expectations of men as providers and scarce employment opportunities push most men into informal employment.[77] Men who rely on daily contracts for physically demanding but unlucrative work must act fit, even when they are unwell,[60] and prioritise work over health care to avoid shortfalls in income and food for their families.[78] Where men's workplace tuberculosis care programmes exist, they rarely make use of worker led structures of self-organisation, whether formal or informal.[79,80]

In low-income urban and peri-urban settings, hegemonic masculine norms valorising toughness, self-reliance, and risk taking interact with economic stress to produce harmful coping behaviours.[81] Alcohol and

tobacco use are often seen as markers of manhood or strategies to manage psychosocial stress and chronic cough, yet they exacerbate vulnerability to tuberculosis infection and progression to disease.[82] Moreover, many men perceive sickness and care seeking as emasculating and resort to what are known as paracetamol masculinities[83]—ie, using over-the-counter medication to suppress tuberculosis symptoms, sustain themselves, and avoid ridicule.[84,85]

Health-care delivery systems in many low-income countries prioritise maternal and child health services, rendering men's health needs invisible. Fear of stigma, long waiting times, indirect costs of travel, and lost wages deter men from seeking care in formal health facilities.[86] User-fee regimes, stock-outs, and weak diagnostic referral systems widen gendered access gaps, contributing to diagnostic delays and sustained community transmission.[87,88]

These structural and behavioural factors cluster with malnutrition, chronic stress, and comorbidities, such as HIV and silicosis, to produce syndemic conditions that accelerate tuberculosis morbidity and mortality among men.[68] The vicious cycle of tuberculosis-related morbidity and premature mortality reduces household income and social participation, deepens economic precarity, and constrains national productivity.[89] At a societal level, the health costs of male vulnerability to tuberculosis are borne not only by families but by entire health systems struggling with preventable disease burdens.[90,91]

Cancer and heart disease risk among racially minoritised men with low income in North America

This case study shows how power systems of racism and classism intersect with hegemonic masculinities and commercial determinants of health to drive risky health behaviours and limit access to high-quality health services, leading to inequitable non-communicable disease outcomes for minoritised men.

In North America, coronary heart disease and cancer remain by far the leading causes of death for men.[92,93] These diseases are also the largest contributors to the gender gap between men and women in terms of causes of death: in the USA, the number of deaths from heart disease and cancer were 204·4 per 100 000 population and 165·3 per 100 000 population for men and 126·8 per 100 000 population and 124·1 per 100 000 population, respectively, for women.[92] These outcomes are not equally patterned among men, with higher cancer and cardiovascular mortality rates in Black men compared with their White counterparts.[94,95]

In the USA, the legacy of slavery and racism interacts with contemporary public policy to create stressful community-level social and environmental conditions for Black American men.[96,97] A key example is the impact of widespread racial residential segregation, stemming from historical discriminatory policies such as redlining, which devalued areas with large Black, low-income, or foreign-born populations by ranking them as unsuitable for mortgage lending.[98] This practice led to disinvestment in these neighbourhoods and deliberate constraints on where racially minoritised populations could live, resulting in stark racial inequities in home ownership, wealth, education, employment, transportation, and environmental pollution that are still observed today.[99] Combined with the influence of hegemonic masculinity, which idealises stoicism, strength, and risk taking, and gender norms of culturally appropriate coping behaviours, these conditions increase the likelihood that men will engage in harmful health behaviours that increase the risk of both cancer and heart disease, such as smoking, alcohol or drug use, and overeating, in an attempt to cope with the stressors of daily life.[100]

Shaped by race-based residential segregation and other aspects of structural racism, commercial determinants of health play a substantial role in the patterning of non-communicable disease outcomes in Black and Indigenous men. Smoking is a major contributor to lung cancer, the leading cause of cancer deaths among men in the USA.[92] For decades the tobacco industry has targeted Black American communities, and Black men in particular, by advertising more heavily in stores with customers who are mostly Black American and by using price promotions to increase sales.[101] Menthol cigarette use is highly concentrated among Black American smokers—approximately 85%, compared with around 39% among smokers overall—a pattern widely attributed to decades of aggressive marketing by tobacco companies and associated with higher nicotine dependence, lower cessation success, and disproportionate smoking-related health burdens compared with non-menthol cigarette use.[102–104]

The influences of structural racism and private-sector interests have also shaped health outcomes for American Indian and Alaska Native men, particularly regarding the crisis-level threats of chronic liver disease and cirrhosis.[93,105] The epidemic of alcohol-related problems among many Native North American communities can be traced back to colonial legacies of European arrival and the role of alcohol in frontier society,[106,107] maintained by targeted marketing of alcohol towards men in Indigenous communities and the loss of traditional support networks, which leads to disproportionate use of alcohol as a response to stress, psychological strain, and depressive symptoms.[108]

Black American and Indigenous men in North America face particularly limited access to timely, high-quality care.[109] The history of harm and anti-Black racism in health-care institutions, including misdiagnosis and subjection to unethical research masked as health care, has led to distrust and low health care-seeking rates in these populations.[110,111] Black American men have the highest incidence and mortality rates of colorectal cancer of any ethnic group in the USA,[112] but particularly low uptake of colorectal cancer

screening, due to the interplay between traditional masculine norms, racism, and medical mistrust.[113,114] Black American cancer survivors receive most of their outpatient care from informal family caregivers, the majority of whom are women.[115] As in many contexts around the world, this reliance on women's unpaid and domestic care work restricts women's economic empowerment, embeds traditional gender roles, and creates substantial physical and mental strain for women.[116] Despite coverage gains between 2019 and 2023, Black American men (as well as Hispanic, American Indian and Alaska Native, and Native Hawaiian or Pacific Islander men) are more likely to be uninsured compared with their White counterparts in the USA, reflecting more limited access to affordable health coverage options due to ongoing racial disparities in employment and income.[117]

Mental health of men displaced by conflict in the Middle East and north African region

This case study illustrates how the poor mental health of displaced men from the Middle East and north African (MENA) region is shaped by the interaction between the global political economy and regional conflict, hegemonic masculinities, and public policies on migration and entitlements of asylum seekers and refugees, all of which lead to institutional exclusion.

The health needs of displaced men are often overlooked, with the vast majority of refugee studies focusing on women;[118] however, displaced men face a range of gender-specific physical and psychological challenges. Many of these challenges stem from trauma, torture, forced conscription, and sexual violence, which might be more common than recognised,[119] especially against men who have sex with men and trans men.[120] Mental ill health is particularly pronounced: a 2024 meta-analysis in the MENA region estimated that 42% of displaced people have depression and 45% have post-traumatic stress disorder (PTSD).[121] For men in particular, psychological distress is exacerbated by economic insecurity, unstable housing, visa uncertainty, underemployment, and loss of social status, all of which can erode identity and self-worth.[122]

Multiple forces have driven conflict and mass displacement in the past decade across the MENA region, which hosted 3·2 million refugees and asylum seekers at the end of 2024.[123] Deeply entrenched patriarchal and neocolonial power structures have contributed to wars and repression in many countries in the MENA region, including Syria and Yemen, where national regimes and militias exploit patriarchal norms and sectarian divides to maintain power through violence.[124,125] Global geopolitics and neoliberal policies create economic pressures that exacerbate social fragility; for example, international financial institutions have promoted austerity measures that have impoverished large segments of society in Syria and Egypt.[126–128]

Single men are frequently excluded from institutional responses to displacement, such as emergency housing schemes and health and social services, due to restrictive laws and gendered assumptions.[128–130] Many men avoid clinics or non-governmental organisations due to stigma or fear of being viewed as security risks,[130] driven by gendered media narratives that portray lone men as suspicious or dangerous.[128] Access to health care for displaced populations is often limited by legal, financial, linguistic, and cultural barriers,[131] and displaced men are substantially less likely than displaced women to seek help, especially for mental health conditions, due to fears of retraumatisation, mistrust of clinicians and psychotropic medications,[132] cultural stigma, and concerns about jeopardising employment opportunities.[133]

Within communities, displacement can disrupt gender roles, which can leave men who formerly identified as providers and protectors feeling emasculated and frustrated.[134] In many host states, refugees are barred from formal work, a constraint that hits men especially hard, as seen among Syrian men in Jordan, Lebanon, and Egypt who face ongoing fear and humiliation tied to their diminished status.[135] Unresolved emasculation often drives harmful coping behaviours, such as substance use, aggression, or domestic violence, and fuels identity loss, mental health decline, and ongoing risky behaviours.[136,137]

Men—particularly young men—are more likely than women to sustain conflict-related injuries that lead to disability,[138] and men with disabilities face elevated risks of acute harm during armed conflicts.[139] Many veterans accumulate disability-related debts because of health expenses and loss of wage income, embedding poverty, debility, and precarity, which negatively impact all aspects of health.[140]

A study published in 2020 shows that approximately one-third of displaced men have overlapping mental health conditions that cluster and reinforce one another.[126] These issues form a feedback loop: untreated trauma and PTSD can lead to alcohol or drug use, which increases the risk of violence or self-harm and further isolates men and deepens their distress.[141] Young men are particularly vulnerable to this loop due to high trauma exposure, unemployment stress, and risk of addiction.[126] Displaced men are also at heightened risk of non-communicable and infectious diseases; a study in Greek refugee camps found that male Afghan refugees made up a disproportionate share of respiratory tract infection cases compared with female Afghan refugees.[142] Sex-based inequalities can be exacerbated by heightened tuberculosis risk in conditions of displacement and overcrowding,[143] and an increase in coping behaviours such as smoking leads to cardiovascular diseases and cancers. This syndemic burden underscores how the neglect of displaced men contributes to their poor health, social marginalisation, and economic exclusion, undermining both individual wellbeing and broader integration efforts.

Men's health and wellbeing during the COVID-19 pandemic in urban informal settlements in Bangladesh

This case study highlights how, for disadvantaged men in informal settlements in Dhaka, Bangladesh, vulnerabilities and health risks are shaped by the interaction between global and national economic strategies, trade policies, and hegemonic masculinities, all of which were exacerbated during the COVID-19 pandemic.

Neoliberal reforms, including privatisation, reduced state spending, and strict budgets, promoted by the World Trade Organisation, The World Bank, and the International Monetary Fund, have combined with global economic downturn to deepen poverty and economic precarity in Bangladesh, which is highly loan dependent. Human Rights Watch reports that austerity measures linked to the International Monetary Fund have harmed jobs and social services, with an estimated 36 million Bangladeshis living in poverty and highly vulnerable to inflation, job losses, illness, and climate shocks in 2025.[144] Discriminatory national policies, weak governance, insufficient accountability, persistent inequality, and tax evasion undermine social protection and health service delivery, with people with low income in urban areas most affected.

Rapid urbanisation and rising inequality have created an estimated 5000 informal settlements in Dhaka that house approximately 4 million people. Land is commodified, which drives up housing costs beyond the reach of people with low income in urban areas. This intense competition for urban space has led to frequent evictions and growing unhealthy physical and social environments due to overcrowding, open waste disposal, poor drainage, crime, and gang violence.[145,146]

At the beginning of the COVID-19 pandemic in early 2020, national lockdowns, following WHO guidelines, meant that all industries, businesses, and schools closed, which led to severe job and income losses, particularly in informal settlements.[147] More than 1900 global brands cancelled or delayed US$3·7 billion in orders from Bangladeshi factories, causing massive job and income losses with little global accountability,[148] with the unemployment rate for people older than 15 years rising from 3·35% in 2023 to 3·65% in 2024.[149]

Hegemonic masculinities put pressure on men living in informal settlements to provide economically for their families;[150] however, these men are often constrained by little to no education, few skills, and unstable, low-paid work, mainly in the informal sector (including transport, construction, street vending, domestic labour, and factories). These jobs are risky and largely unprotected. The unemployment rate in two informal settlements in Dhaka in 2021 was 36·34%.[151] Approximately 85% of people employed in Bangladesh work in the informal sector, where exclusion from national labour laws leaves them without legal protection or social security.[149] Boys from families with low income are disadvantaged in education compared with girls in the same situation, with 74% of boys aged 15–19 years having some secondary schooling compared with 83% of girls, due to having to work to support the family.[152]

Whereas analyses have found that the COVID-19 pandemic worsened women's positions in Bangladesh, men with low income particularly experienced negative effects.[153] Qualitative studies of young men's experiences show high rates of anxiety and depression in the context of pressure to provide for their families, lost jobs, daily wage work, police violence in enforcing lockdowns, and food insecurity, with many using smoking and drinking as coping strategies.[154] Once lockdowns were lifted, men faced particular pressure to resume livelihoods, effectively being forced to choose between risking COVID-19 infection and starvation for themselves and their families. Male individuals had a higher infection rate than female individuals, and more confirmed (67%) and fatal (65%) cases were among male individuals than female individuals in Bangladesh (33% *vs* 35%).[153]

At the onset of the COVID-19 pandemic, higher rates of negative effects on mental health were reported among men than women (although later in the pandemic, higher rates of depression and anxiety were reported among women compared with men).[153] In many cases, men's poor mental health is tied to their perception of failing to embody gendered roles.[155] Failing to provide and frustrated with their lives, men can turn to negative coping strategies, such as gambling, drinking, or joining gangs, that threaten their health, as well as the health and wellbeing of their families. Intimate partner violence against women increased during the COVID-19 pandemic,[153] exacerbated by commercial drivers such as the expanding sex work industry and the prevalence of pornography in a context of little sex education, which reinforce hegemonic masculinities that valorise male sexual violence and exacerbate male anxieties in relationships.[156] Masculine norms of showing what they might see as strength and suppressing emotions discourage men from seeking psychological support.[157] Furthermore, the urban primary health-care system predominantly focuses on maternal and child health and family planning and does not explicitly include men.[158]

Discussion

Existing approaches to understanding men's health tend to focus either on gender and masculinities or on other drivers of health inequalities between men, rather than looking at how these two concepts intersect. The framework proposed here brings together intersectional theory; social, structural, and commercial determinants of health; and syndemic theory across different socioecological levels. We have explained the relationship between these concepts with examples focused on important contributors to men's poor health outcomes across different global contexts, to show the need for continued engagement with men's health and to underscore several important cross-cutting themes.

First, harms to men's health are shaped by interactions between global, regional, and national policies that drive increasing economic precarity and class inequalities.[159] Trade and economic policies, including recent reductions in development assistance in the USA and parts of Europe, might exacerbate economic precarity in low-income and middle-income countries, particularly where aid reductions constrain public provision of health, social protection, or other essential services.[160,161]

Second, men with low income, racially minoritised men, and otherwise marginalised men have poor geographical and financial access to high-quality education, health care, and humanitarian aid due to discriminatory norms that influence institutional policy in areas such as health care, urban planning, and development.[162–164] This situation is often exacerbated by gendered assumptions that underpin policy and practice, which equate women with vulnerability and commonly exclude men.[39] Gender justice requires that vulnerabilities of both women and men are recognised, resources are allocated to meeting their needs, and service provision is inclusive and accessible to all.

Third, risks to men's health in physical and occupational environments are underpinned by insufficient environmental regulatory powers and labour protections. These risks are felt more acutely by people who are politically and socially marginalised, which highlights the role of environmental injustice[165] (ie, exposure to environmental hazards and the social, political, and economic processes that shape intersectional vulnerabilities) in contributing to many poor health outcomes for men.[166] Commercial promotion of tobacco, alcohol, and pornography to marginalised men, often drawing on hegemonic masculinity,[167] contributes to a harmful social environment, together with social discrimination and interpersonal and community-level violence. Furthermore, when structural forces disrupt patriarchal gender roles, men often develop anxiety and depression or engage in unhealthy coping mechanisms due to gender role strain, whereby men perceive they are failing to live up to gendered expectations, such as providing for their families.[168] It does not follow, however, that inequitable gender roles and harmful hegemonic masculinities should be maintained or protected. Redistribution of gendered power within households and the cultivation of positive, equitable masculinities are important to achieve gender justice, but they are less likely to be achieved without concomitant action to tackle men's oppression and marginalisation across other axes of power. For example, analyses in South Africa have linked men's resistance to gender-transformative initiatives—those programmes and policies that actively examine, challenge, and change the root causes of gender inequality—to the lack of attention to the class and race disadvantages faced by men within these initiatives.[169]

Fourth, risks and vulnerabilities are mediated by the unique social positions of men within power systems, including aspects of identity such as gender (beyond the male–female binary), age and life course stage, education, citizenship, race, ethnicity, ability or disability, and class, which shape opportunities for agency, including occupations and incomes.[31] The often harmful and restrictive masculine norms associated with hegemonic masculinities contribute to the continuation of patriarchal power structures, which, although reproducing privilege for some men, create multiple harms for many others marginalised through interconnected systems of oppression, as well as women and people of other genders. Heterosexism and ableism are particularly underexplored as drivers of men's poor health.

Building on insights from the conceptual framework and case examples, here we propose a working definition of men's health adapted from the literature,[170–172] which we utilise across this series (panel 2).

Our analysis and working definition shows that promoting men's health, health equity, and gender justice requires sustained action across all systems of power and at multiple levels—global, national, and community—including within institutions across different sectors and a wide range of societal stakeholders. Key to this action are strategic alliances between advocacy coalitions of men, women, and people of other genders to challenge economic, social, and political inequalities, including but not limited to hegemonic masculinities that are harmful to all genders, to improve health for all (see the third paper in this Series[14]). Our case studies illustrate how the clustering of men's poor health outcomes has negative consequences for the women and children in their families and communities, including through vicious cycles of poor mental health and harmful coping strategies, such as alcohol, tobacco, and drug use, which exacerbate violence, divert family resources, and contribute to community and wider conflicts.[39] Such cycles generate caring burdens within families,[67] communities, and health systems and inhibit economic and human development.

Gender-transformative approaches that challenge gender inequalities should not reflect a zero-sum concept

Panel 2: **Working definition of men's health**

Men's health refers to a field of research, policy, practice, and men's lived experiences of health and wellbeing that examines how biological factors, social positioning, and the distribution of power and resources shape patterns of health, illness, and mortality among men. Men's health focuses on how exposure to risk and capacities to mitigate and respond to risk are patterned and clustered, and on access to health services and the social, structural, political, and commercial determinants that produce unequal health outcomes across diverse groups of men, differentiated by biology, identity, experience, and context.

of gender justice; they should benefit men as well as women by creating more equitable relationships, in which men's power over women might be reduced, but their opportunities for power within, and for power with (from Rowlands' model of power[26]) women allies and those of other genders against oppressions might be increased.[173] Efforts to foster more positive masculinities need to engage with the multiple intersecting power systems that shape men's health in specific social, political, cultural, and historical contexts. This engagement is crucial for shifting the focus on men's health solely at the level of harmful individual behaviours to encompass the role of structural, social, and commercial determinants and systems of power in sustaining and producing multiple vulnerabilities (sometimes simultaneously with the exercise of privilege and power) that lead to poor health outcomes. Interventions need to move beyond deficit-based biomedical approaches that focus on masculinities as barriers or risks, and towards more holistic, strengths-based models that recognise and embrace people's (including men's) local cultures, resources, and skills as crucial assets in health-care provision.[174–176] This move includes supporting the many positive contributions men make to family and community health,[177] and the use of dialogue and equity-focused participatory approaches with the aim of developing more inclusive and equitable services.

The application of syndemic theory in our framework enables us to highlight how the clustering of health conditions in marginalised populations of men (eg, cancer and heart disease in Black American men, or PTSD and substance misuse in displaced men) is driven by the harmful social conditions in which these populations live.[49] Combining syndemics with intersectional approaches highlights the role of power systems in driving concentrated health disadvantage at the population level,[178] as well as how these systems produce chronic stressors that intersect with biological vulnerabilities to create health outcomes, as illustrated by men's vulnerability to tuberculosis in the context of economic precarity in Africa. Together, this conceptual view can help in guiding policy makers and practitioners to identify what types of interventions matter—those that enhance individual and community resilience, leverage the strengths of marginalised groups of men, and explicitly address the full range of social inequities and broader structural determinants that shape men's health.[66,179] Application of the framework will generate learnings about the complex interactions between systems of power at different socioecological levels and the implications for gender justice and health equity that are useful for informing strategic advocacy and tailored interventions to improve men's health.

Conclusion

The changing geopolitical order, ongoing and new conflicts, economic protectionism, and cuts to international aid mean that analysis and action for social justice—including gender justice and health equity—are urgent. This Series paper shows how the paradox of men's health stems from the way hegemonic masculinities, which privilege men in gender power relations but also create multiple harms for all genders, intersect with other social characteristics and systems of power in complex ways to affect men's health outcomes. By presenting the analysis from an intersectional perspective across different geographical locations, conditions, and groups of marginalised men, we emphasise the need to move beyond one-dimensional approaches that focus on individual men's behaviours to better understand, analyse, and act on the broader set of power structures and social determinants that underpin men's health.

Contributors

Conceptualisation: RTo , BRE, WM, and ST. Funding acquisition: RT, ST, and SFR. Identifying relevant literature: RTo, BRE, FF, DG-S, IJ, AAM, SFR, BR, RTh, RMT, CU, ST. Literature search and case study methodology: RTo, BRE, WM, ST. Project administration: RTo, BRE, WM, and ST. Writing of the original draft: RTo, BRE, FF, DG-S, DMG, IJ, AAM, SFR, BR, RTh, CU, and ST. Review and editing: RTo, BRE, WM, JWFC, FF, DMG, SJH, IJ, SVK, AAM, SFR, BR, RTh, RMT, CU, and ST.

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