

COVID-19, EQUITY AND MEN'S HEALTH: USING EVIDENCE TO INFORM FUTURE PUBLIC HEALTH POLICY, PRACTICE AND RESEARCH RESPONSES TO PANDEMICS

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ABSTRACT

In March 2020, the World Health Organization (WHO) announced that COVID-19 (novel coronavirus) reflected a global pandemic. Early epidemiological analyses demonstrated that boys and men have similar rates of COVID-19 infection to girls and women. However, boys and men appear to be disproportionately impacted with respect to severity and mortality, including those from marginalised or minority backgrounds. Yet, considerations of sex and gender, and their relationship to health and social inequities, have been absent from recent COVID-19 policy and practice pandemic responses. This evidence-based commentary discusses the nexus between COVID-19, equity, and boys and men's health from a broad public health perspective. Using scholarship about intersections between race and gender; and poverty, social determinants of health, and gender; we explain why a health equity lens is important to address the health and social inequities boys and men face during pandemics. This contribution provides guidance about future global public health pandemic responses for society's most vulnerable groups of boys and men.

Key words: *COVID-19; pandemic; men's health; equity; gender*

INTRODUCTION

On 11 March 2020, the World Health Organization (WHO) declared COVID-19 as a global pandemic.¹ COVID-19 is a novel coronavirus – it was a new strain of infectious disease that had not been previously identified in humans.² COVID-19 was first detected in the Wuhan province of China in December 2019, with a reasonably rapid spread to other countries.¹

Symptoms of COVID-19 were broadly consistent with the flu and other respiratory viruses, with easy spread through direct face-to-face contact and frequently much more serious outcomes. This has led WHO to advocate for a range of public health measures, including four critical areas for action – (a) prepare and be ready; (b) detect, protect and treat; (c) reduce transmission; and (d) innovate and learn.^{1,3}

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State and national governments responded to the advice of the WHO in diverse ways – with most committing to the delivery of public health responses and social distancing measures, and consistent public communication about the need to ‘flatten the curve’,⁴ which is a colloquial term used to promote the ideology of slowing the increase in the number of cases to reduce the burden on public health and hospital infrastructure to care for people with COVID-19-related conditions and illnesses. This is designed to mitigate the burden of hospitalisation thereby ultimately reducing mortality rates. Strategies adopted included: heightened public health messaging and health education efforts;⁴⁻⁶ school and university closures (accompanied by a quick shift to online education modalities);⁷⁻⁹ community lock-downs, stay-at-home orders and business closures (with the exception of essential services personnel);^{7,10-12} unprecedented travel restrictions and state/country border closures;¹⁰⁻¹² explicit quarantine and self-isolating practices for those directly impacted;^{6,11-12} and a suite of social policy investments at national levels – often equating to billions of dollars - focused on increasing access to welfare, supporting business continuity, and mitigating the economic impacts.¹³⁻¹⁵ Generally speaking, pandemic responses to COVID-19 reflected uncharted territory for many countries, with community-spread of COVID-19 often outpacing government decision-making processes, and subsequent public health policy and practice responses.^{11,14,16,17} These responses, unprecedented in their scope and scale, spanned local, state and national governments worldwide; occurred over the course of a few months; and were guided by consistent advice from the WHO and public health experts to take decisive and immediate action.^{14,15}

But what does all this have to do with sex, gender and the health of boys and men? The short answer is... lots. This commentary discusses the nexus between COVID-19, equity, and men's health from a public health perspective. It describes how existing men's health scholarship could be used more purposefully to inform decision-making, and to drive the development and implementation of evidence-based public health policy and practice strategies, during the

current COVID-19 pandemic. In doing so, it provides a roadmap for how future public health pandemic approaches could better respond to the needs of the most vulnerable and marginalised groups of boys and men in a timely way. While the COVID-19 impacts on children have been notably lower than those noted among adults, we have deliberately included a focus on boys in our commentary, as many of the health and social inequities we discuss emerge during childhood and are sustained throughout their life-course.

Women also face major problems caused by COVID-19. As the majority of healthcare workers and carers, they are exposed to a high risk of infection.¹⁸ Gender-based violence has increased during lockdowns.¹⁸ A recession will have a significant impact on women's employment and incomes.¹⁸ Women are also far less likely than men to be in senior decision-making roles concerning the pandemic and its social and economic impacts. This ultimately means women have less agency during COVID-19 to shape public policy responses to meet their health, social and economic needs. This paper's focus on men must not be read as a statement that the pandemic primarily affects men or that there is some sort of binary choice to be made by policymakers, clinicians and others between the needs of men and women. Women are clearly hugely affected by COVID -19 and their needs must be met, alongside men's, in a response that takes full account of sex and gender. Moreover, evidence has long shown that gender-relations approaches are important for enhancing both men's and women's health.^{19,20}

WHY CONSIDER THE HEALTH NEEDS OF MEN IN A PANDEMIC?

As of 16th June 2020, the WHO has reported 7,941,791 cases of COVID-19, and a respective 434,796 deaths, globally.²¹ Early epidemiological analyses demonstrated that boys and men have similar rates of COVID-19 infection to girls and women. However, boys and men appear to be disproportionately impacted with respect to severity and mortality.²²⁻²³ With the median proportion of deaths across the 40 countries with sex disaggregated data showing 58% of deaths were male, with double the number of male deaths as compared to female deaths in confirmed cases (calculated from <https://globalhealth5050.org/covid19/> 19 May 2020). Peter Baker from the Global

Action for Men's Health (GAMH), recently wrote a blog about men's health attitudes and behaviours for the UK Men's Health Forum, explaining that when compared to women men have higher rates of smoking and drinking, lower rates of hand-washing, and greater likelihood of delayed help-seeking.²⁴ There is also emerging evidence that men are less likely than women to wear a face-mask.²⁵ This provides a partial, albeit important, explanation as to why men's vulnerability and mortality associated with COVID-19 may be heightened. Other commentators have revealed the disproportionate impact of COVID-19 on boys and men is likely to have a combination of both sex-based immunological and gender differences. This has included a recent GAMH webinar delivered by Professor Alan White and blog he wrote for the UK Men's Health Forum;²⁶ a blog in *BMJ Global Health* by Purdie and colleagues from *Global Health 50/50*;²⁷ and an article published by McLachlan & Wittert on the Australian Healthy Male website.²⁸ Calls for improved sex-disaggregated data collection, reporting and fast-track publication processes at state and country levels; and the need for urgent investment in sex and gender focused COVID-19 research, and respective evidence-informed policy and practice responses, have been key messages delivered by these public health experts.

One useful example, is the work of *Global Health 50/50* in attempting to provide timely country-level sex-disaggregated data with the best information available to inform global COVID-19 public health planning processes (see <https://globalhealth5050.org/covid19/>). Another example, was the release of the GAMH *COVID-19 and Men: Call for Action* on 14 May 2020,²⁹ which has also advocated for:

- Gender-responsive actions at the global, national and local levels that take full account of the specific needs of men and boys, as well as women and girls, during the pandemic and its aftermath.
- Further disaggregation of data to show how outcomes by sex intersect with age, income, race and other key variables.
 - Research into the wider impact of COVID-19 on the mental and physical health of men and boys as well as on issues concerning their employment, education, personal relationships and family life.

Account should be taken of new opportunities to increase men's involvement in parenting and caring and to improve work/life balance through greater home-working.

- The development and deployment of gender-responsive health promotion interventions to reduce men's risk of infection. Evidence of good practice in this field should be rapidly and widely disseminated.
- Sustained support for organisations supporting men and boys, including for employment, education, mental health, alcohol and gambling issues. Organisations that work with male perpetrators and male victims of domestic violence also have an important role to play.
- A focus on addressing the underlying conditions that are linked to men's higher mortality from COVID-19 and which in their own right have a significant impact on men's health outcomes.

On the same day as the release of GAMH's call for action, the WHO, published an 'advocacy brief' on *Gender and COVID-19*.¹⁸ This calls on Member States and all global actors to guide investments in quality and gender-sensitive research on the adverse health, social and economic impacts of COVID-19. Countries are advised to incorporate a focus on gender into their COVID-19 responses in order to ensure that public health policies and measures take account of gender and how it interacts with other areas of inequality. The brief acknowledges that 58% of global deaths from COVID-19 have been male but does not address male-specific issues in any detail and is, in any case, not binding on members states.¹⁸ It does, however, indicate that we need to think about dimensions of gender in both Western and developing country contexts.

A take-away message from this commentary, is that sex and gender have remained largely absent in most COVID-19 public health policy and practice responses.^{23,30} This is concerning for a few different reasons. First, sex and gender differences have been ignored despite substantial evidence that these determinants of health are critically important. Indeed, WHO has been recommending that epidemic-prone infectious diseases should be sex and gender disaggregated

since 2007.³¹ Second, the lack of engagement with evidence about sex and gender differences means that policy-makers and practitioners are ill-equipped to address health and social inequities experienced by boys and men as a result of COVID-19, exposing the lack of progress made to date in mainstreaming sex and gender issues into health policy, especially where men are concerned. Finally, this means that health inequities already experienced by vulnerable and marginalised groups of boys and men are likely to be exacerbated during the COVID-19 pandemic; and will largely remain unaddressed. We briefly discuss each of these issues below, and then point towards current men's health evidence that can inform future pandemic responses of this nature.

UNDERSTANDING SEX AND GENDER DIFFERENCES

First, there are clear sex (i.e., biologically rooted) and gender (i.e., socially rooted) differentials (i.e., inequalities) that have been both implicitly and explicitly ignored or dismissed by decision-makers and public officials during the COVID-19 outbreak. This apparent disregard for epidemiological evidence should act as a red flag for those working to improve the health and wellbeing of boys and men. It insinuates that conceptualisations of sex and gender are unimportant, and that inequalities do not matter, within the context of global pandemics.^{23,31} We suggest otherwise, as do others.^{23,30-31} As, Wenham, Smith & Morgan convincingly argue in relation to COVID-19:

“Recognising the extent to which disease outbreaks affect women and men differently is a fundamental step to understanding the primary and secondary effects of a health emergency on different individuals and communities, and for creating effective, equitable policies and interventions.”²³

A lack of preparedness among senior bureaucrats, government advisors, and politicians, to engage with emerging public health evidence about sex- and gender-based inequalities, from both biomedical and social scientific standpoints, is worrying.²³ It limits the potential for adopting gender-sensitive and gender-transformative public health responses that are frequently advocated in academic scholarship.^{23,31-35}

It also clouds the ability to take a deeper dive into understanding why some, but not necessarily all, gender inequalities are unfair and unjust (i.e. considered to be inequities).

UNDERSTANDING HEALTH AND SOCIAL INEQUITIES IN THE CONTEXT OF MEN'S HEALTH

Evidence from the social sciences can help to unpack gender, health and social inequalities. Importantly, it can help us to understand whether these disparities are unfair and unjust. For decision-makers to acknowledge that gender, health, and social inequities exist – and therefore require respective equity focused policy and practice responses – there must first be an acknowledgment that disparities exist. This has seldom occurred in the context of COVID-19. While the need to address population vulnerability has been a prominent part of academic commentary relating to COVID-19;^{3,10,11,36-45} it has only been partially evident in national public health responses in the UK and Australia,^{3,7,11,46} and seldom addressed by other countries. The need to address underlying social determinants of health has been a prominent feature of scholarship emerging from Australia and the US.^{3,11,44,47} Indeed, the recent murder of a Black man, George Floyd, by police in the US has acted as a global catalyst for anti-racism advocacy through the Black Lives Matter movement. This has occurred at the same time as COVID-19 and resulted in public protests and demonstrations across the world. It has heightened public awareness of racial inequities and the associated need to acknowledge and challenge white privilege and supremacy. Racial inequities, among others, will be discussed further shortly.

The vulnerability of certain groups are rarely acknowledged in popular and social media in comparison to broader population-wide discussions about COVID-19; and seldom have these recognised the inequities faced by men. The cumulative impact of these observations is that practical solutions to address inequities have been relatively slow to come to fruition. When they have occurred, they have usually focused on the elderly (e.g. dedicated

opening hours at supermarkets; and the promotion of online social networking to reduce loneliness);⁴⁸ geography (e.g., border closures to rural and remote communities);^{4,10} or socio-economic considerations (e.g., access to food security programs, emergency welfare payments and loans, and homelessness).^{49–53} Importantly, these approaches have seldom addressed gendered inequities, or the congruence with other social inequities. Similarly, public health responses to address inequities during COVID-19 have rarely reflected cross-sectoral or integrated service delivery responses. This is contrary to existing public health evidence about what approaches are most likely to work to reduce health and social inequities.^{54,55} Given that recent responses to COVID-19 demonstrate that decision-makers have struggled to grapple with, and respond to, evidence about the disproportionate impacts of COVID-19 on men's risk of death compared with women, it is unlikely that a more nuanced gender lens will be adopted to address the needs of the most vulnerable and marginalised groups of men. This is a shame, as the field of men's health has much to offer in this regard. As such, advocacy efforts should ensue. These advocacy endeavours should be driven by peak men's health organisations such as GAMH and the International Society for Men's Health, and national equivalents such as the Men's Health Network in the US; and the Men's Health Forums in Australia, the UK and Ireland. Continuing public and professional education about COVID-19 and men's health through webinars and dedicated events (which has been evident during men's health week); acknowledging individuals leading by example through media articles and awards; continued engagement with politicians and senior government officials; and lobbying for additional funding to continue research about COVID-19 and the longitudinal impacts on boys and men, are a few practical examples.

UNDERSTANDING HEALTH INEQUITIES FACED BY VULNERABLE AND MARGINALISED GROUPS OF MEN

In addition to the higher mortality noted among men, there have also been disproportionate patterns of morbidity and mortality experienced by racial

minorities, including African-American, Indigenous and immigrant populations.^{38,41–45,56–59} For example, England and Wales Black males are 4.2 more likely to die of COVID-19 than White males.⁶⁰ Further evidence continues to emerge from the US and other countries. Scholars have argued that these risks are compounded by pre-existing racial and ethnic disparities within health and social welfare systems, and that urgent action is required to curb this imminent threat.^{38–45,59,61} However, it is important that we adopt an intersectional framing around the way we view health and social inequities. When discussing racial health disparities and COVID-19, Chowkwanyun & Reed suggest:

“To mitigate myths of racial biology, behavioural explanations predicated on racial stereotypes, and territorial stigmatization, COVID-19 disparities should be situated in the context of material resource deprivation caused by low SES, chronic stress brought on by racial discrimination, or place-based risk.”⁶²

Therefore, discussion about sex and gender, and its relationship with race and other risk characteristics such as disability, sexuality, geography and socio-economic status, is critical. Yet to date, it has remained at the margins of academic and public discourses relating to COVID-19. But why?

A distinct equity and men's health narrative has emerged over the past two decades, which has grown exponentially over the past few years.^{63–67} This has paralleled scholarship advocating for a social determinants approach to men's health.^{68–73} Commentary in this space has frequently examined links between gender, specifically masculinities, and men's health.^{33,64–67,71,74–84} This has typically focused on vulnerable, marginalised, and minority groups of boys and men.^{66–67,76,81–89} Importantly, this scholarship has frequently used intersectionality as a conceptual framework, whereby the nexus between age, gender, race, sexual orientation, disability, geography and/or socio-economic status has been explored.^{64,67,86,90} That is, we now have an emerging evidence-base that can be used by decision-makers to generate new and different health promotion and public health strategies.⁶⁷ Such evidence can still be used more purposefully during ongoing COVID-19 responses, and future pandemic

planning, to address issues of vulnerability associated with health and social inequities.

We now provide selected evidence to illustrate our position. The summaries provided are focused on (a) intersections between race and gender; and (b) poverty, social determinants of health, and gender. In both instances, discussion is primarily related to scholarship about boys, adolescent males and young men. These examples are intended to be illustrative only. Nonetheless, the information presented provides some guidance about how and why a men's health equity lens is important during pandemics; and directs readers to relevant literature that can inform future pandemic responses. We encourage those interested in men's health to also publish additional and more detailed evidence-based and equity-focused syntheses likely to promote positive public health responses for vulnerable groups of boys and men in future global health crises.

EVIDENCE ABOUT EQUITY AND MEN'S HEALTH THAT COULD BE USED FOR FUTURE PANDEMIC RESPONSES

Race and Gender

There is a growing body of evidence focused on the identities of boys and men of colour, and how these are shaped by conceptualisations of manhood and masculinities.^{81,82,91-93} This is particularly evident in relation to young men of colour.^{63,94} This includes scholarship about the health of African-American (Black); Indigenous; Latino, Hispanic and Asian boys and men, much of which has an explicit focus on masculinities. The health and social inequities experienced within and between these populations are diverse, but can include high rates of risky health practices all of which have been shown to be more important in the development of severe illness in this COVID-19 pandemic – including those relating to smoking;^{95,96} unsafe sex;⁹⁷⁻⁹⁹ alcohol and substance misuse;^{95,100} and violence.¹⁰⁰⁻¹⁰² Poor mental health and wellbeing^{103,104} and high rates of suicide ideation and suicide^{105,106} have also been noted, and with the economic impact of COVID-19 are likely to get worse. Barriers associated with health service access, which

impinge on help-seeking practices and health service use, are also common.^{76,91,107-111}

There are already multiple examples of the synthesis of evidence exploring race-gender relations.^{94,103,104,112-116} Such work has highlighted the importance of:

- settings- and place-based health promotion approaches, with a particular focus on engagement through faith-based settings,¹¹⁷⁻¹¹⁹ barber shops,^{120,121} sports clubs/organisations,⁸³ and colleges and universities;^{82,122-124}
- strategies that explicitly address healing, inter-generational trauma and racism,^{61,101,125-130}
- involving peers and family;^{84,131,132}
- strengths-based approaches that focus on achievement, success and building leadership capacity;^{133,134} and
- approaches that address specific health issues, such as mental health and wellbeing and respective mechanisms associated with coping and resilience.^{82,84,103,104,123}

Importantly, there are now multiple organisations, services and programs that exist to address health and social inequities experienced by boys and young men of colour. Selected examples from the US alone include: the Campaign for Black Male Achievement; My Brother's Keeper; the National Compadres Network; Forward Promise; National Black Men's Health Network; Executives' Alliance for Boys and Men of Color; Coalition of Schools Educating Boys of Color; Making Connections; and the Young Black Men, Masculinities and Mental Health (YBMen) project.

In the context of COVID-19, this means we have a strong evidence-base, and growing network of professionals, that can guide decision-making aimed at reducing the health inequities experienced by this population. Policy-makers and public officials need to be guided by such knowledge and expertise, particularly in relation to successful methods of engagement, communication, and strategies for improving health and wellbeing, in times of crisis. This means encouraging men's health champions to share contemporary and emerging evidence about men's health equity with policy-makers; lobbying government

and industry through clear 'calls to action' (such as that highlighted by GAMH earlier in this article); and that researchers need to focus their attention towards knowledge translation efforts, such as the development of policy briefs, which are more likely to resonate with, and be accessible to, policy-makers and government advisors. This will help support the development and implementation of more meaningful health and social policies.

Poverty, Gender and the Social Determinants of Men's Health

As mentioned earlier, there is considerable scholarship about poverty influencing the health and wellbeing trajectories of boys and men, and that of their families and the communities in which they live. There is strong evidence emerging that the COVID-19 virus has had its most damaging affects within crowded populations with low incomes and poor housing, and yet they have been the most underserved in pandemic responses.^{44,47,135} Evidence suggests that health promotion and prevention efforts in the early stages of life can help to mitigate poorer health and social outcomes later in life.¹³⁶⁻¹³⁹ This is particularly evident among boys and young men of colour. Action aimed at addressing social determinants of health is critical. This includes strategies directed towards boys and young men of colour that address poor educational outcomes; over-representation in the child welfare system; high rates of incarceration and exposure to the criminal justice system; and poor job attainment and retention, and high rates of unemployment.^{116,140-149} Arguably, action in these areas - across multiple countries - has been variable. While a focus on social determinants of health has been evident in the development of some national men's health policies in Australia and Ireland, implementation barriers have previously been noted.^{150,151}

In the context of COVID-19, we can learn from emerging research findings about the challenges and barriers boys and young men face when at school and at university.^{145,148,149,152} We need to acknowledge the multidisciplinary evidence sources being used, and novel approaches subsequently being adopted, through the development and implementation of initiatives

and projects that aim to decrease rates of suspension, and increase rates of participation, achievement, and completion, among vulnerable groups of boys and young men across all levels of the education system. For example, a greater focus on gender-based online learning pedagogies that resonate with boys and young men would be useful.¹⁵²⁻¹⁵⁸ Similarly, paying attention to emerging evidence associated with the use of gaming, information technology, smartphone Apps, and social media platforms as engagement tools with this population^{82,123,153,160,162} are also pertinent for guiding public health pandemic responses. Indeed, health promotion and prevention interventions relating to sexual health,^{31,163} and mental health^{82,123} have used these tools successfully to engage vulnerable and marginalised adolescent boys and young men. This emerging evidence has potential to inform current debates about the relationship between COVID-19 and these important community concerns.

While thinking about the intersections between poverty, gender, and the social determinants of health from a men's health perspective, it is equally useful to look at patterns of inequity that exist outside of the health sector, and what is being done to address them. We need to look at interventions being developed in the child welfare and juvenile justice systems to engage 'at-risk' youth at the earliest stages possible. This includes the adoption of gender-sensitive and culturally-responsive prevention and early intervention restorative justice practices,¹⁶⁴⁻¹⁶⁶ and justice reinvestment approaches.^{168,169} This also involves learning from appropriately tailored alcohol and drug treatment programs in prisons;¹⁷⁰ and respective through-care and aftercare approaches for men transitioning from prison or residential alcohol and treatment facilities back into community life.¹⁷¹⁻¹⁷⁴ This emerging evidence is particularly relevant for decision-making about how to deal with prison populations in pandemics, as has been needed during COVID-19.¹⁷⁵

Economic status, and economic security, are also both important determinants of health. Therefore, the economic impacts of COVID-19 in relation to industry shut-downs are vital to monitor. While it has been recognised that women are disproportionately impacted by COVID-19 through the shut-down of

female dominated sectors, so too are low-income and minority workers. In particular, men from minority groups are more likely to be affected by the shutdown,⁵⁹ indicating the importance of looking at inequities that exist between groups of boys and men. For example, a recent analysis of the economic impacts of COVID-19 on ethnically diverse populations in the UK, found that 'Bangladeshi men are four times as likely as white British men to have jobs in shut-down industries, due in large part to their concentration in the restaurant sector; and that Pakistani men are nearly three times as likely, partly due to their concentration in taxi driving' (p4).⁵⁹ However, scholars from the US have also argued that low-income and minority populations are also over-represented among essential service workers, making it more difficult for these workers to abide by shelter-in-place directives, exacerbating their exposure to risk.⁴⁴ Similar concerns also have been raised for those that are homeless,⁴⁷ where men are known to be over-represented. Responding to these economic risk factors, and the social and racial inequities that underpin them, is critical in times of pandemics. However, sustained and systemic investments are also required to ameliorate these risks over the longer-term. While there have been insufficient investments to adequately deal with the scale of issues relating to the men's health inequities that we have outlined in this paper, we must also consider fiscal constraints during periods of economic instability. One purposeful strategy could be to improve intersectoral and cross-departmental policy responses consistent with contemporary Health-in-All-Policies approaches.^{176,177} This is about working smarter; and has significant potential to save government expenditure over the longer-term.¹⁷⁸⁻¹⁸⁰

In addition, to required action on the social determinants of health already noted above, there is also a need to influence environments through improved urban planning processes that address gender-specific needs. For example, numerous countries have turned to temporary urban design measures to quickly create new forms of space for their citizens that enable safe physical activity and commuting within cities.¹⁸¹⁻¹⁸³ Cities such as Bogotá, Milan, New York, and Paris have incorporated interim solutions such as pop-up

bike lanes and widened footpaths and sidewalks, giving urban planners an opportunity to adopt more people-friendly and environmentally conscious designs.^{183,184} We encourage city planners, local and state government officials, and the public health community to work collaboratively to craft new urban designs, and accompanying physical activity and active transport interventions, to better cater for the needs of boys and men. This will be particularly important in designs that shift away from car travel in favour of cycling and walking. In a 2019 UK study, a higher percentage of men participated in risk cycling behaviour resulting in more crashes compared to women regardless of age.¹⁸⁵ So cities must also consider how designs can account for men's perceptions of risk while encouraging cycling and outdoor physical activity.

CONCLUSION

In this paper, we have raised concerns about the invisibility of sex- and gender-specific approaches to COVID-19 from a men's health equity perspective. In particular, we have described limitations in relation to the way governments and public officials, and subsequent public health responses, have addressed health and social inequities experienced by vulnerable and marginalised groups of boys and men. We have drawn on global scholarship to demonstrate how existing evidence about intersections between gender and race; and social determinants of health and gender; can be used to inform future pandemic responses. This evidence reinforces the importance of investing in contextually-relevant, culturally-responsive, age-appropriate and gender-sensitive health promotion interventions for boys and men when responding to vulnerabilities associated with pandemics.^{31,33,67,83} We acknowledge that this commentary only provides a partial snapshot of how men's health inequities could have been addressed during COVID-19. Yet, it provides a useful starting point for ensuring more assertive public health research, policy, and practice responses are directed towards the most vulnerable and marginalised populations of boys and men during future pandemics. A failure to learn from the COVID-19 experience, will mean that health inequities experienced by these men will remain unabated. This will have both

short- and long-term negative impacts on the health, social, cultural and economic dimensions on the lives of men, their families, and the communities in which they live. A more concerted commitment to addressing men's health equity in policy and practice spheres can change this narrative for the better. Adopting an intersectional lens, and working collectively across sectors, can make this change possible.

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