

Raising awareness about men's health equity and structurally based risks for COVID-19

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Reports of COVID-19 deaths do not often provide a full explanation of patterns, tending to focus on people's race or ethnicity, where they lived and with whom, whether they were affluent or poor, elderly or young, women or men—one factor at a time.

According to Derek Griffith, professor of medicine, health and society

and founding director of the Center for Research on Men's Health, such information may more accurately indicate risk for contracting and dying from COVID-19 than how people behave. But it is not enough to examine the impacts of the virus exclusively by race, place, age, sex or gender. Guided by CRMH's core tenets and the strategic mission of the Office of the Vice Provost for Research, Griffith takes an intersectional approach to researching the impacts of COVID-19, advocating for a more nuanced understanding of identity's role in determining risk to enhance policy reforms toward greater health equity.

"When we rely on intersectionality to study COVID-19 deaths around the world, we know that women bear greater social and economic burdens from the virus and that lower socioeconomic status and densely populated areas create an increased risk, but we also know that in almost every country, men are experiencing more severe cases and dying at considerably higher rates than women," Griffith said. "When factoring in marginalized and minority backgrounds, severity and mortality among men are even higher. People can be equally vigilant about protecting themselves, but, because of structural factors outside of their control, the impact on them may not be equal."

In a recent article published in the *International Journal of Men's Social and Community Health*, Griffith and his colleagues find that even though men and women contract COVID-19 at equal rates, men account for 58 percent of deaths from the virus and double the amount of female deaths in confirmed COVID-19 cases. The impact becomes even more severe among racially and ethnically marginalized groups of men. For instance, in England and Wales, Black men are 4.2 times more likely to die from COVID-19 than white men, and similar evidence in racial disparities continues to emerge in the U.S. and other countries. The authors caution that the severity of cases among marginalized men should not be viewed as evidence of biological or [behavioral differences](#), but that they should be considered through an intersectional framing that accounts for various

structural risk factors, such as socioeconomic status, geography, disability and sexuality, along with racism.

"Historically, academic and public discourses have lacked a comprehensive understanding of [men's health](#)," Griffith said. "But emerging evidence can and should be used by decision-makers to inform public health strategies and health promotion during the COVID-19 pandemic and to plan for future ones. Men are not a homogenous group, and policies that embrace this complexity and heterogeneity will better serve some of the world's most vulnerable populations."

In a similar article published in *Preventing Chronic Disease*, Griffith and his colleagues examine COVID-19 severity and mortality among men through a biopsychosocial lens. Since purely biological (i.e. sex) or social (i.e. gender) factors cannot on their own explain sex disparities in COVID-19 deaths, this commentary considers how these factors intersect to determine men's health outcomes and emphasizes the importance of viewing COVID-19 mortality risk through a men's health perspective, rather than focusing exclusively on how men and women differ.

"While the reasons for men facing greater health risks from COVID-19 are not entirely clear, most health patterns are the result of a combination of biological, behavioral and psychosocial factors," Griffith said.

Two examples of possible biological factors include a weakened immune response in men due to the role of immune-related genes along the X chromosome, which women have two of and men only have one, and higher levels of an enzyme called ACE2 in men's bodies that the virus uses to enter the host cell in the respiratory system. Behavioral and psychological examples include the way men are more likely to downplay the severity of the virus and engage in riskier behavior.

"Identifying these factors associated with [increased risk](#) for COVID-19 mortality is critical," Griffith said, "but determining how to reduce the risk and save lives is equally important."

Given the growing body of research that demonstrates men's heightened probability for severe and lethal cases of COVID-19, especially for men from marginalized backgrounds, Griffith and his colleagues provide a five-pronged intervention strategy to meet men's health needs and reduce the harmful impact of the virus. The strategy includes:

1. Health education, community engagement and public health outreach: Focus on how health behavior is gendered and attend to the values and priorities of men; address health education for men's partners and families; and increase access and eliminate barriers to community-wide testing to reduce testing stigmatization.
2. Health promotion and preventive care: Clinicians should focus on men with underlying comorbidities and encourage behavioral changes.
3. Sex-disaggregated data in clinical practice and policy: Clinical trials related to COVID-19 should consider biological and psychosocial factors.
4. Rehabilitation and health care delivery infrastructure: Train a new workforce of [community health](#) workers to assist patients rehabilitating from COVID-19, particularly difficult patients, including men, and expand telehealth services.
5. Health policy and legislative interventions: Policy makers need to explicitly address gender and advance legislation that promotes data disaggregation and dissemination by race, ethnicity and sex. Policies should consider the heterogeneity of men and strive for gender equity but not make men's health and women's health competing issues.

This guidance could help society see beyond the regularly reported counts of COVID-19 cases and deaths and begin to provide better care to those populations most represented within those counts. Griffith hopes to advance such a shift, because if the general public were acutely aware of who is most adversely impacted by COVID-19, that might catalyze nuanced national and global reforms to address this and future pandemics.

"In order to most effectively save lives, we have to reach a point where enough pockets of society feel we need intersectional [policy reforms](#)," Griffith said. "The way we get there is by revealing that we are not all equally impacted by the virus and so we cannot have a one-size-fits-all approach. We need to seize this moment to reimagine and redesign health care policies and systems to advance health equity."

More information: James Smith et al. COVID-19, Equity and Men's Health, *International Journal of Mens Social and Community Health* (2020). [DOI: 10.22374/ijmsch.v3i1.42](https://doi.org/10.22374/ijmsch.v3i1.42)

Derek M. Griffith et al. Men and COVID-19: A Biopsychosocial Approach to Understanding Sex Differences in Mortality and Recommendations for Practice and Policy Interventions, *Preventing Chronic Disease* (2020). [DOI: 10.5888/pcd17.200247](https://doi.org/10.5888/pcd17.200247)

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