MOVEMBER® CHANGING THE FACE OF MEN'S HEALTH

The Real Face of Men's Health

2025 UNITED STATES REPORT

MOVEMBER® INSTITUTE
OF MEN'S HEALTH
MUSTACHES LOVE RESEARCH

The Real Face of Men's Health

2025 UNITED STATES REPORT

MOVEMBER® INSTITUTE
OF MEN'S HEALTH
MUSTACHES LOVE RESEARCH

ABOUT MOVEMBER

A little over 20 years ago, a bristly idea was born in Melbourne, Australia, igniting a movement that would transcend borders and change the face of men's health forever. The movement, known as Movember, united people from all walks of life, sparked billions of important conversations, raised vital funds, and shattered the silence surrounding men's health issues.

Since 2003, we have challenged the status quo, supported men's health research, and transformed the way that health services reach, respond to, and retain men in healthcare. We have taken on prostate cancer, testicular cancer, mental health, and suicide prevention with unwavering determination.

We have raised over $1 billion for men's health, thanks to a passionate community of global Movember supporters. These critical funds have supported more than 1,300 men's health projects worldwide, including hundreds of advancements in biomedical research and the creation of some of the world's largest prostate cancer registries, built on the real-life experiences of hundreds of thousands of men.

Since taking on mental health and suicide prevention in 2006, Movember has emphasized the importance of better social connections, early recognition of men's mental health challenges, and improving clinician competencies in responding to men in distress. We want to ensure that more men know what to do when mental health challenges arise, and that their supporters are better prepared to step in when needed.

Movember will continue championing new research, cutting-edge treatments, and community programs to promote healthy behaviors in men. We advocate for inclusive healthcare systems that are tailored to the unique needs of men, women, and gender-diverse people from wide-ranging cultural backgrounds. In doing so, we hope to create a future where barriers to healthy living are overcome, stigmas are removed, and everyone has an equal opportunity to live a long, healthy life. By improving men's health, we can have a profoundly positive impact on women, families, and society. Healthier men mean a healthier world.

ABOUT THE MOVEMBER INSTITUTE OF MEN'S HEALTH

Building on a 20-year legacy of investment in men's physical and mental health, the Movember Institute of Men's Health has ambitious goals to improve the quality of life of millions of men worldwide. By uniting global experts in men's health, the Institute aims to accelerate research and translate it into tangible, real-world outcomes.

The Institute aims to raise the profile of men's health with policymakers, ensuring it is prioritized in proportion to its impact on public health. By focusing on critical areas that include men's mental health, suicide prevention, prostate and testicular cancers, and healthcare that is responsive to the needs of boys and men, the Institute seeks to address preventable risk factors that contribute to 77% of male deaths and 54% of healthy years of life lost. Through these efforts, the Institute aims to drive sustainable, global progress in men's health.

To learn more, please visit Movember.com/movember-institute.

ABOUT THE CO-AUTHORS

Derek M. Griffith is the Risa Lavizzo-Mourey Population Health and Health Equity University Professor, Fellow and Senior Advisor on Health Equity and Anti-Racism in The Leonard Davis Institute of Health Economics, and Director of the Program for Men's Health Equity at the University of Pennsylvania. Among other roles, Dr. Griffith is Chair of Global Action on Men's Health and serves on Movember's Global Men's Health Advisory Committee.

Brian P. Heilman is a Senior Research Fellow at the Movember Institute of Men's Health.

Jon N. Gilgoff is the Research Manager and Co-Chair of the Boys and Men's Health Collaborative at the University of Maryland, Baltimore. Dr. Gilgoff is also Policy Officer for the Men's Health Caucus of American Public Health Association and Advisory Council member for Healthy Men, Inc.

Emily C. Jaeger is the Research Project Director in the Program for Men's Health Equity at the University of Pennsylvania.

Josh A. Knight is the Director of Statistically Speaking.

Peter H. Fisher is a Research Fellow at the Movember Institute of Men's Health.

Zac E. Seidler is the Global Director of Research at the Movember Institute of Men's Health. Associate Professor Seidler is also a Principal Research Fellow at Orygen at the University of Melbourne.

A NOTE ON STANDING TOGETHER IN GENDERED HEALTH

This report focuses on the connections between gender and health. On average, globally, men die younger than women, while women spend a significantly greater proportion of their lives in poor health and with disabilities compared to men. Trans and nonbinary people have disproportionately worse health outcomes compared to the general population. None of these outcomes is acceptable.

Throughout this report, we highlight the health inequities faced by men and, through new research, examine the impact of men's poor health on others, including women. We also draw on men's and women's health data to paint a clearer picture of men's health and to highlight the economic costs of men's poor health. However, we do not address the economic costs related to the health of trans and nonbinary people, women's health, or the many areas where women's health is underserved, such as the underdiagnosis of coronary heart disease.[1] We acknowledge and support the work of leaders in these fields who have campaigned for decades to raise awareness of intersectionality, gender-based inequities in health, and health outcomes.

In the same way that the Movember campaign followed the trailblazing women raising funds for breast cancer care, we follow in the footsteps of – and owe a huge debt to – women and lesbian, gay, bisexual, transgender, queer, intersex, and other advocates who have shown the importance of an approach that takes full account of sex and gender. We hope to stand alongside other organizations, including women's health advocates, in advocating for the universal recognition of gender as a social driver of health and in prioritizing investment in healthcare that acknowledges and addresses the health inequities and diverse needs of women, men, and nonbinary people. There is no binary choice in gendered health.

Caitlin's Story

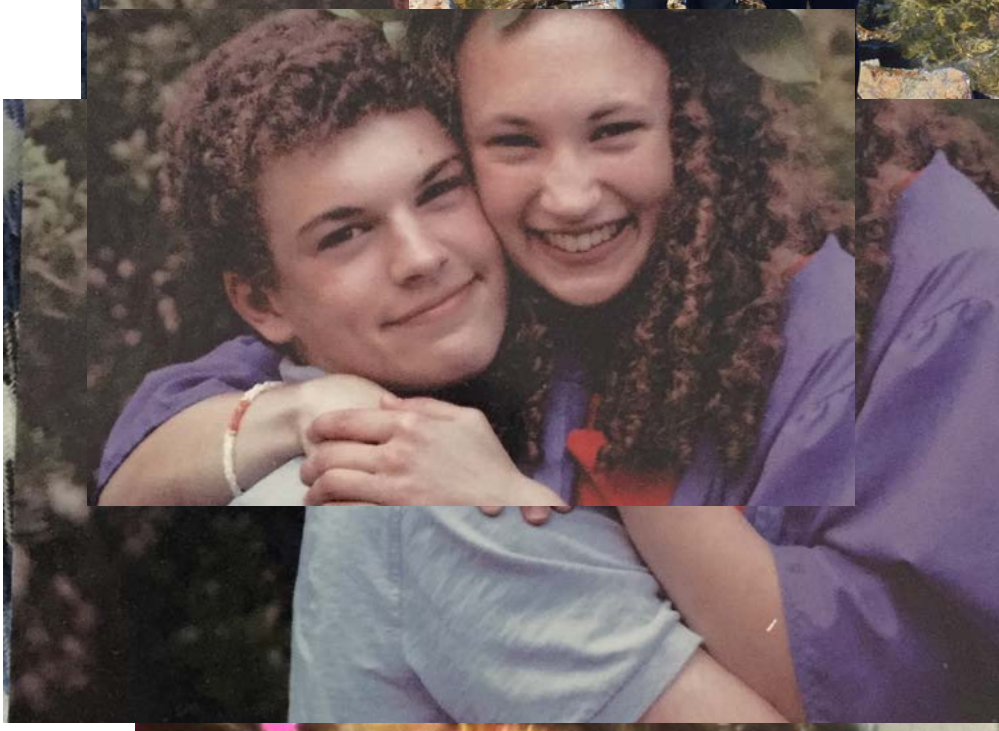
I'm Caitlin Towers, and everything I am today is wrapped up in the memory of my little brother, Joey. In the fall of 2016, at just twenty years old, Joey died by suicide, and with him went my best friend. He was kind and goofy, genuine and musical, endlessly curious about the world. Growing up, I proudly wrote "Joey's sister" on my name tag at every school event instead of "Caitlin." It annoyed him to no end, but no part of who I am was ever more important than being his big sister.

After Joey's passing, our family and his friends rallied around one another, sharing stories that made us laugh and cry in the same breath. It was through his fraternity's annual bikeathon in his honor that I first discovered Movember, an organization dedicated to men's mental health and suicide prevention. Seeing how a simple conversation or a shared mustache could break down walls of silence, I realized I wanted to be part of something bigger than my own grief. As a high school English teacher, I've carried that lesson into my classroom every day: young men shouldn't have to go it alone, and sometimes even a small act of openness, a friend reaching out or a teacher sharing her why, can change a life.

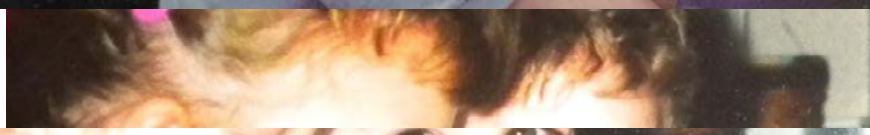
Out of that conviction, in 2019 JoeyFest was born. What started as a gathering at a local brewery has become an annual ritual of live music, heartfelt conversation, and community connection. Each year we carry forward Joey's passions, the songs he loved, his love of the outdoors, and the easy laughter he sparked in everyone around him, and we open the door for honest talks about mental health, loss, and hope. It's a night where the music is upbeat, the stories run deep, and no one is expected to hide their scars.

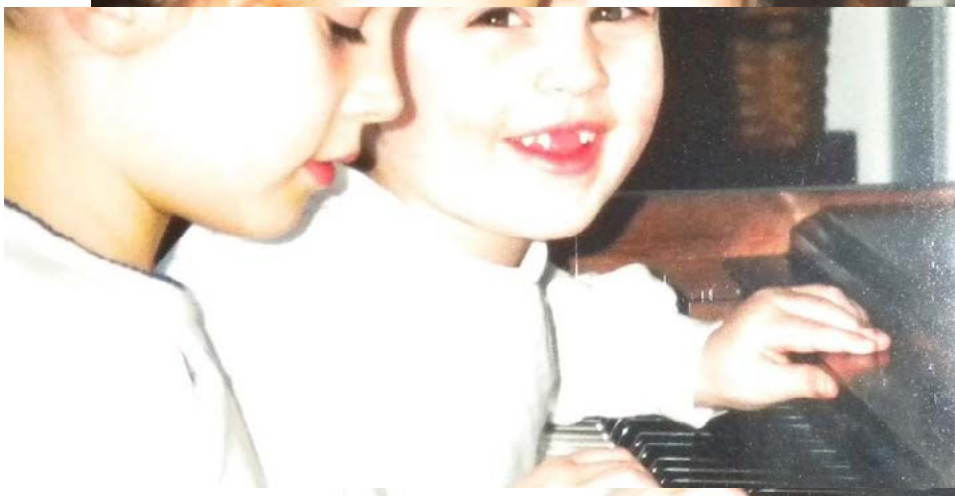
JoeyFest is my way of honoring my brother's spirit and reminding every brother, son, friend, and neighbor that they are not alone in their struggles. I see it in the faces of my students when I share my story: those young men who nod slowly, relieved to know that asking for help isn't weakness, it's strength. I've watched students open up at our school's Movember club

and friends and strangers alike share their voices at JoeyFest's open-mic segment or on the written word wall, voices and pens shaking as they name what they've carried in the dark. I've been humbled by the community of people who drive miles to stand shoulder to shoulder, to raise a toast to Joey and to the promise that together, we will keep fighting for every man's right to a tomorrow.



Today, I carry Joey with me in every classroom discussion, every hallway greeting, every late-night email from a student who just needs to know someone is listening. His absence has shaped my presence, for my students, my community, and myself. Through JoeyFest and my work with Movember, I've found purpose in turning heartbreak into hope, grief into gathering, and silence into song, and I'll keep showing up, because every young man deserves to know that he's seen, he's heard, and he's worth fighting for.





CONTENTS

CONTENTS

Chapter

01

Introduction

THE URGENCY OF THE MOMENT

Why this report? Why now?

Men's health touches everyone. When men are healthy, benefits radiate outward, strengthening families, deepening relationships, and energizing communities. When men's health falters, it strains the people and places they are part of, with much of the burden falling on women as informal caregivers. In this view, the "real face" of men's health is not only men's faces but also those of the loved ones, communities, and systems around them.

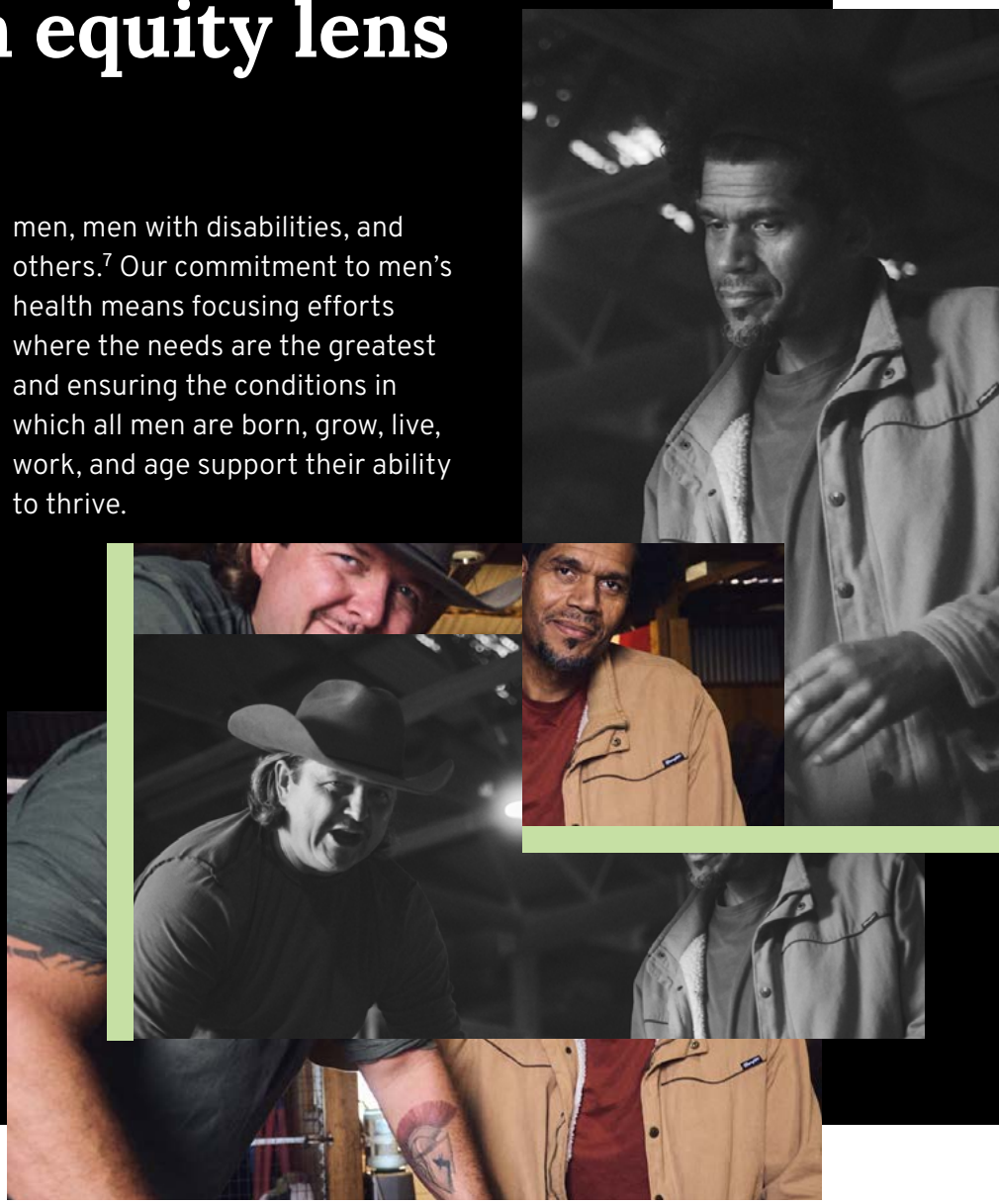
We are at a moment of increased public attention on men's health in the United States. Media coverage; high-profile deaths from cancer, heart disease, and suicide; COVID-19's toll on men; and rising awareness of "deaths of despair" and rural health challenges have brought the complexity of men's health into view.[2] Athletes and other public figures have spoken openly about depression and other conditions, humanizing these issues for millions. Despite spending more on healthcare than any nation in the world, the US has seen health outcomes fall behind those of peer countries for decades.[3] One of the most underused levers for improving the nation's health is a stronger focus on the health of men and boys. Yet without coordinated effort grounded in dedicated investments, nuanced research, meaningful and data-driven policy action,[4] and real-world solutions, we are missing critical opportunities to turn the tide.

The goal of *The Real Face of Men's Health* report is to amplify this conversation and drive change by taking a comprehensive view of the state of men's health. This means widening our view of what drives men's health and where change is possible. Biology and individual behavior matter, but so do the systems and structures that shape men's lives.[5] Social drivers (such as employment, education, racism, incarceration, loneliness, and social connection) and commercial drivers (such as alcohol and tobacco marketing, gambling, and pornography) play major roles in shaping outcomes.[6] Recognizing these drivers opens new avenues for action across policy, business, philanthropy, and community leadership, many far outside traditional healthcare.

These insights reveal that men's health is not a side concern but a cornerstone of the nation's social and economic vitality. Advancing men's well-being expands opportunities for healthier families, stronger communities, and a more resilient nation. For the first time, this report brings the evidence and insights together in one place, offering a clear path to move from awareness to action.

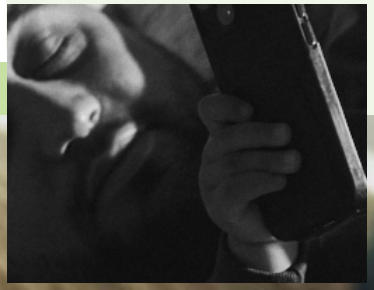
We cannot truly address men's health in the United States without a health equity lens

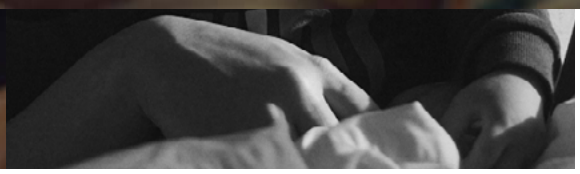
Men are not all the same. Race, class, sexual orientation, geography, immigration status, and disability all shape how well and how long men live. Unlike a one-size-fits-all approach, a health equity approach recognizes that differences in health are not inevitable – they are created and sustained by systems, policies, and environments that advantage some groups and disadvantage others. This lens ensures that strategies to improve men's health actively work to remove barriers, redress injustices, and direct resources toward men who experience the worst health, including men of color, low-income White men, GBTQ+ men, men with disabilities, and others.[7] Our commitment to men's health means focusing efforts where the needs are the greatest and ensuring the conditions in which all men are born, grow, live, work, and age support their ability to thrive.



Featured data in this report

This report breaks new ground by applying original analyses to national datasets and pairing them with two newly commissioned surveys, together offering a scope and depth of insight on men's health trends that has never before been assembled in one place.





NATIONAL DATA SOURCES – BRINGING A NEW LENS TO NATIONAL HEALTH DATA

First, we bring fresh analysis to existing national datasets, including those from the National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC) as well as other leading public health data repositories. Even as our data presentations draw from publicly accessible raw datasets, in many cases, they are the only examples known to the authors where mortality and health trends are clearly broken out by sex, race/ethnicity, and geography. As such, we are able to apply a gender-responsive lens to highlight trends, inequities, and insights that are otherwise missed when health patterns are not presented in a sex-disaggregated way or when men are treated as a monolithic group. This approach has allowed us to surface patterns with direct implications for targeted interventions and policy priorities.

"MEN'S EXPERIENCES OF CARE AND CONNECTION" SURVEY

In 2025, Movember fielded one of the most comprehensive surveys of its kind: a nationally representative study of 4,126 US men ages 18 to 69 who had seen a healthcare provider in the past year. The survey sample reflects the nation's demographic, geographic, socioeconomic, racial, ethnic, and sexual-orientation diversity. With unusually strong racial and ethnic representation, the sample provides insights that speak to communities often left out of research. Together, these data offer an unprecedented window into the realities of men's interactions with the healthcare system, evidence that can inform more tailored and effective interventions.

"HEALTHY MEN, HEALTHY WORLD" SURVEY

Also conducted by Movember in 2025, this nationwide, cross-sectional online survey examined the experiences of 2,109 informal caregivers supporting men's health and daily needs. Respondents – 61% women and 39% men – reported on the time, tasks, and emotional demands of unpaid caregiving, with primary relationships including spouses, partners, friends, and siblings. The average caregiver spent six to 10 hours per week on activities such as appointment scheduling, personal care, and emotional support, with many logging 24 hours or more. The survey combined closed-ended measures with open-text reflections, later thematically coded, offering both quantitative insight and rich qualitative detail. These data illuminate the hidden labor sustaining men's health, highlighting the personal investments made by caregivers across the country.

Note: Data in this report cover the 50 US states and the District of Columbia; US territories such as Puerto Rico are not included. National health data systems often have inconsistent coverage or limited in Puerto Rico and other US territories. And our capacity to conduct new data collection there was also constrained. This gap reflects the broader marginalization of territorial communities in US health research, underscoring the need for more inclusive data collection in the future.

Chapter

02

The Big Picture

THE STATE OF MEN'S HEALTH IN THE US

Behind every statistic in this chapter are real lives: fathers, brothers, friends, and colleagues whose health and well-being shape – and are shaped by – the fabric of families and communities. By bringing together the most comprehensive and up-to-date data available – national sources as well as newly commissioned surveys – we take stock of where men in the United States are thriving, where they are struggling, and what that means for the people around them. The patterns we uncover are complex, often sobering, and impossible to dismiss.

We begin with **life expectancy**, the clearest measure of how long men live. Next, we examine the leading **causes of death**, then turn to **premature mortality** to see how often lives end too soon, and finally measure the **years of life lost** to capture the full toll of dying young.

After addressing **geographic inequalities**, we dig into urgent public health priorities: **mental health and suicide, social connection**, and **social norms** that shape health behaviors. We also highlight the **economic costs** when men's needs go unmet and examine how men engage in terms of **help-seeking and healthcare**. A final section considers **the life course**, tracing how health risks and opportunities change as men age.

Throughout, we pair national trends with state-level and demographic breakdowns, draw occasional international comparisons, use maps and visuals to make disparities clear, and provide focused deep-dive sections to connect the numbers to their real-world stakes. The result is a panoramic view of men's health, one that is both evidence-driven and grounded in lived realities.

Life expectancy

LIVES ARE CUT TOO SHORT FOR TOO MANY MEN.

Life expectancy at birth is one of the clearest measures of a population's health. It shows not only how long people are living but also how social conditions, public policies, and health systems shape those lives over time. The story for men in the United States is troubling. For more than a century, men have died younger than women, and in recent decades, they have also fallen far behind men in other wealthy countries.[8]

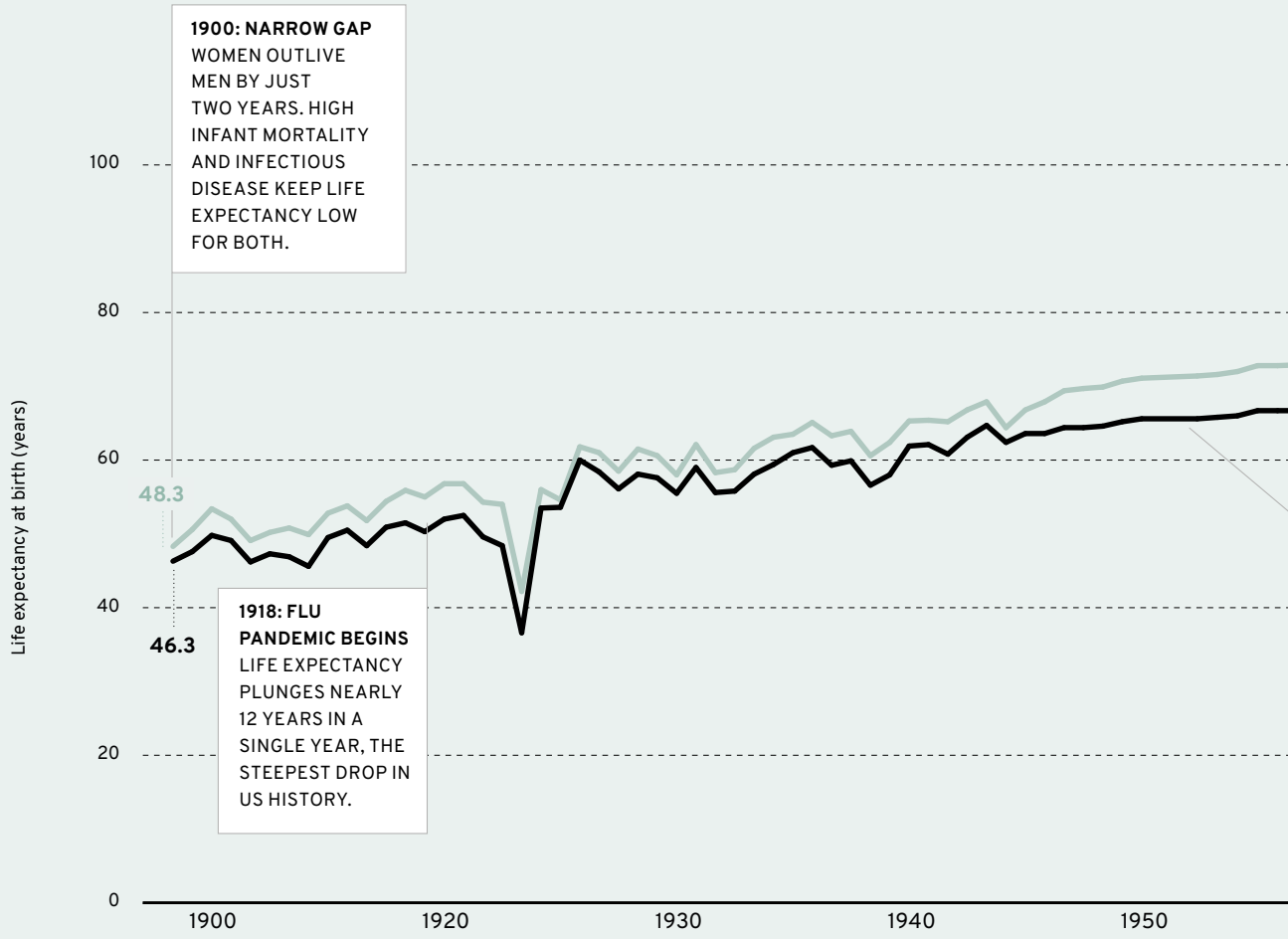
The patterns in our infographic (Figure 1) reveal both progress and warning signs: fluctuations in the size of the male–female gap, periods when gains stalled or reversed, and a growing divide between the US and its economic peers. While some biological differences in health risks exist, they do not fully explain these trends. Factors such as workplace exposures, violence, health behaviors, access to care, social norms, and chronic stress all contribute, and these are shaped by policy choices, economic conditions, systemic inequalities, and cultural expectations, not just genetics.

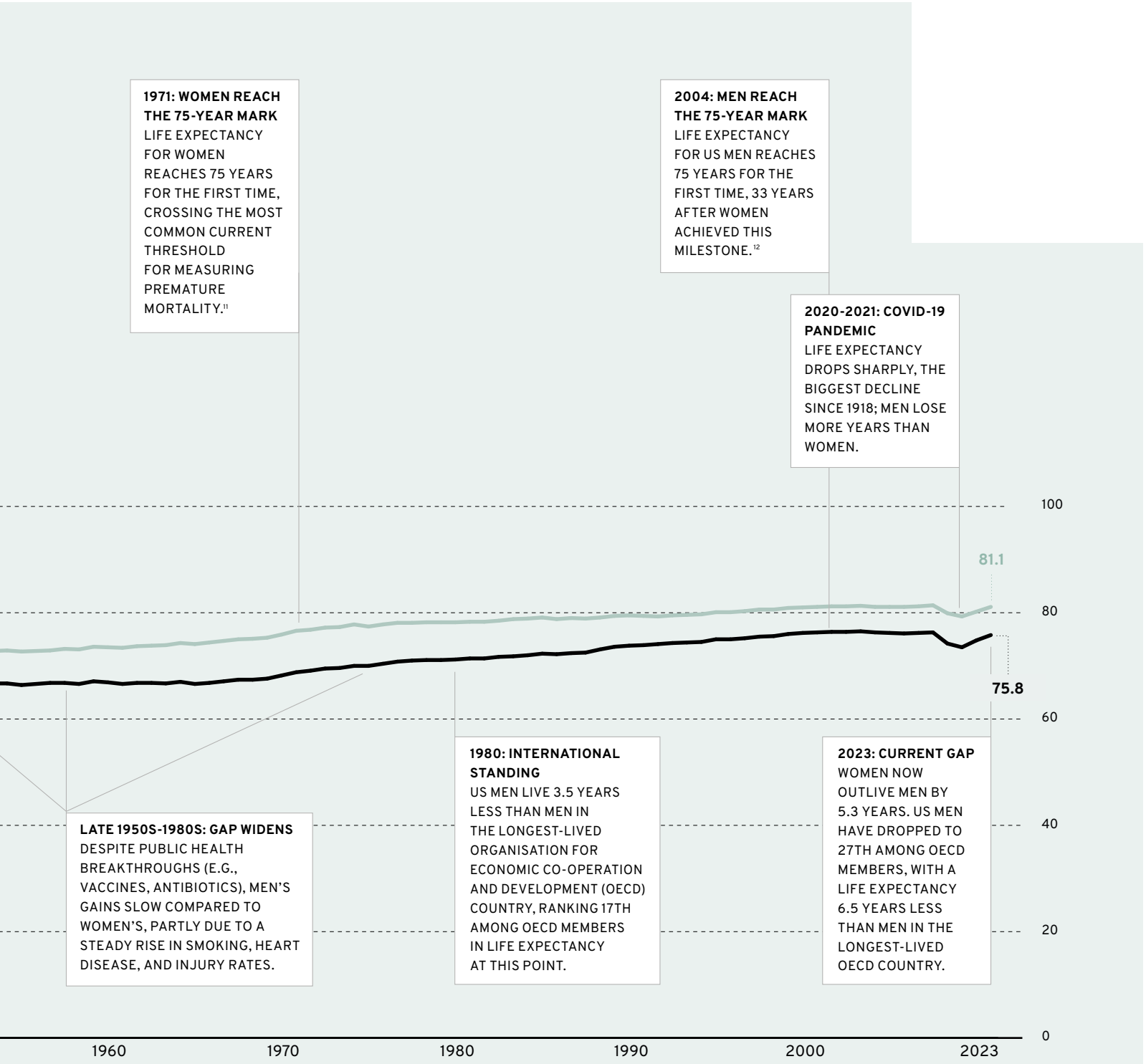
This is not only a men's issue. US women also live shorter lives than women in most other high-income countries, and they spend more of those years in poor health or with serious limitations.[9] Men die too soon; women often live longer but with a heavier burden of illness and disability.[10] Neither outcome is acceptable.

MEASURING LIFE EXPECTANCY

In this section, we present data on life expectancy at birth. Life expectancy at birth refers to how many years a person born in a certain year can expect to live on average. This approach is distinct from other measures of life expectancy that present the expected average number of years of life remaining at a given age.

Figure 1. **LIFE EXPECTANCY AT BIRTH FOR MEN AND WOMEN IN THE US, 1900-2023**





Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

IN EVERY RACIAL AND ETHNIC GROUP IN THE US, MEN LIVE FEWER YEARS THAN WOMEN; IN SOME COMMUNITIES, BOTH MEN AND WOMEN DIE FAR TOO YOUNG.

In every racial and ethnic group in the United States, men live fewer years than women in the same group. The size of that gap varies from 7.4 years among Black Americans to 4.0 years among Asian Americans, but the pattern is consistent.

Looking at men's life expectancy alone reveals stark inequities. In 2022, American Indian and Alaska Native men had the shortest life expectancy of any group, at 64.5 years. That is more than 10 years less than non-Hispanic White men (75.1 years) and more than 17 years less than Asian American men (82.3 years). Non-Hispanic Black men had the second shortest life expectancy at 69.1 years. Non-Hispanic White men in the US have a life expectancy of 75.1 years, which is still more than seven years shorter than Asian American men's and nearly two years shorter than Hispanic men's. These are staggering differences.

DIFFERENCES IN LIFE EXPECTANCY ARE NOT ONLY ABOUT GENDER OR BIOLOGY.

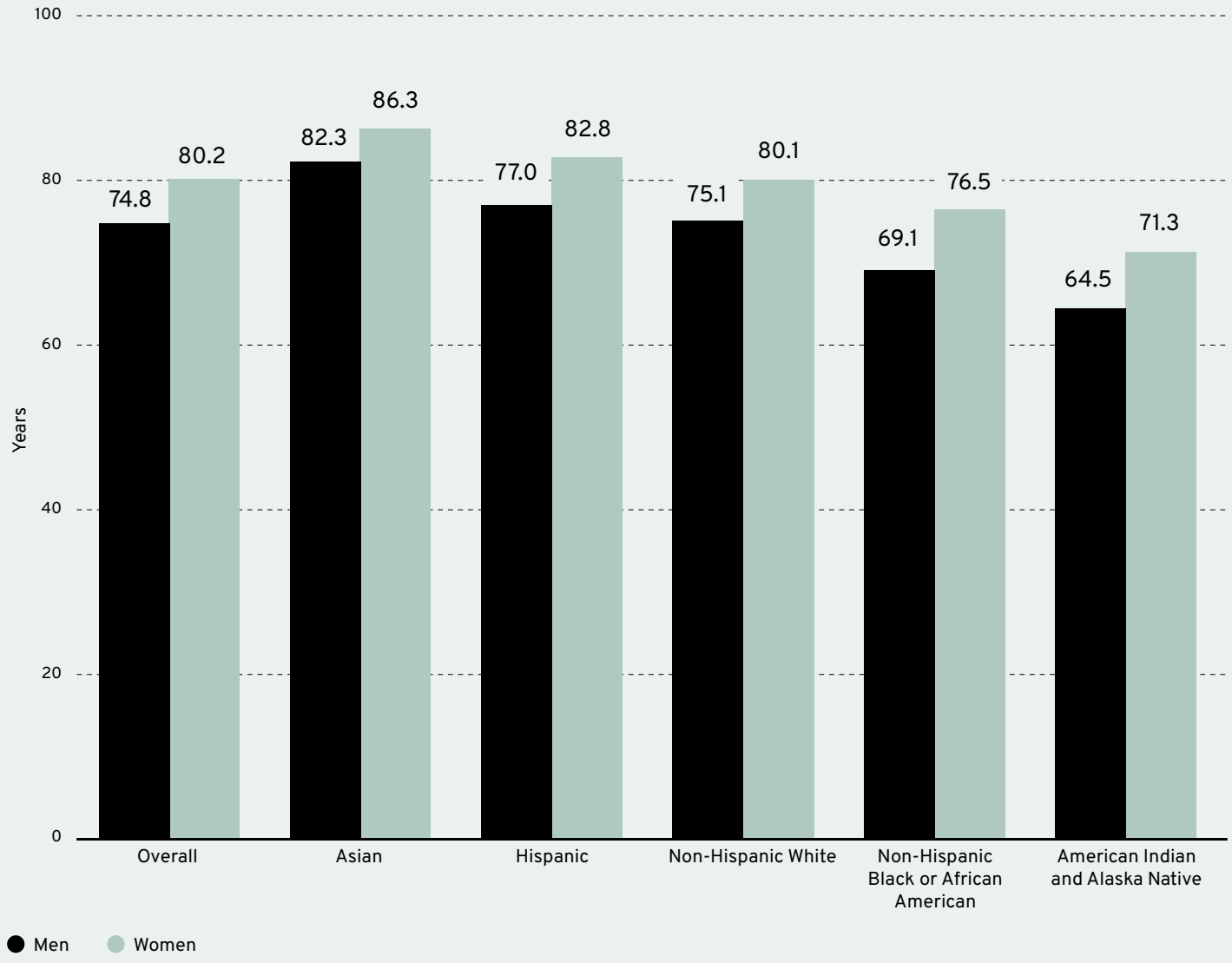
These data show that when communities face adverse social drivers of health – such as limited access to quality healthcare, healthy food, safe housing, good jobs, clean environments, and protection from discrimination – these systemic disadvantages shorten lives for everyone in that community.[13] In American Indian, Alaska Native, and Black communities, women's life expectancy is also far lower than the national female average. In other words, the same structural forces that cut men's lives short also weigh heavily on women in those communities, erasing much of the advantage that women typically have in longevity.

These patterns underscore that differences in life expectancy are a measure of how opportunity, resources, and protections are distributed in the United States. They show where the burden of poor health falls hardest and point to the kinds of inequities that must be addressed for both men and women to live longer, healthier lives.

64.5

In 2022, American Indian and Alaska Native men had the shortest life expectancy of any group, at 64.5 years.

Figure 2. **LIFE EXPECTANCY AT BIRTH BY HISPANIC ORIGIN, RACE, AND SEX IN THE US, 2022**



Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

Causes of death

HEART DISEASE AND CANCER TOP THE LIST, BUT ACCIDENTS, UNINTENTIONAL INJURIES, AND DRUG OVERDOSES STAND OUT.

Heart disease and cancer remain, by far, the leading causes of death for US men (see Figure 3). The four leading causes of death from cancer are, in order, lung cancer, prostate cancer, colorectal cancer, and pancreatic cancer.

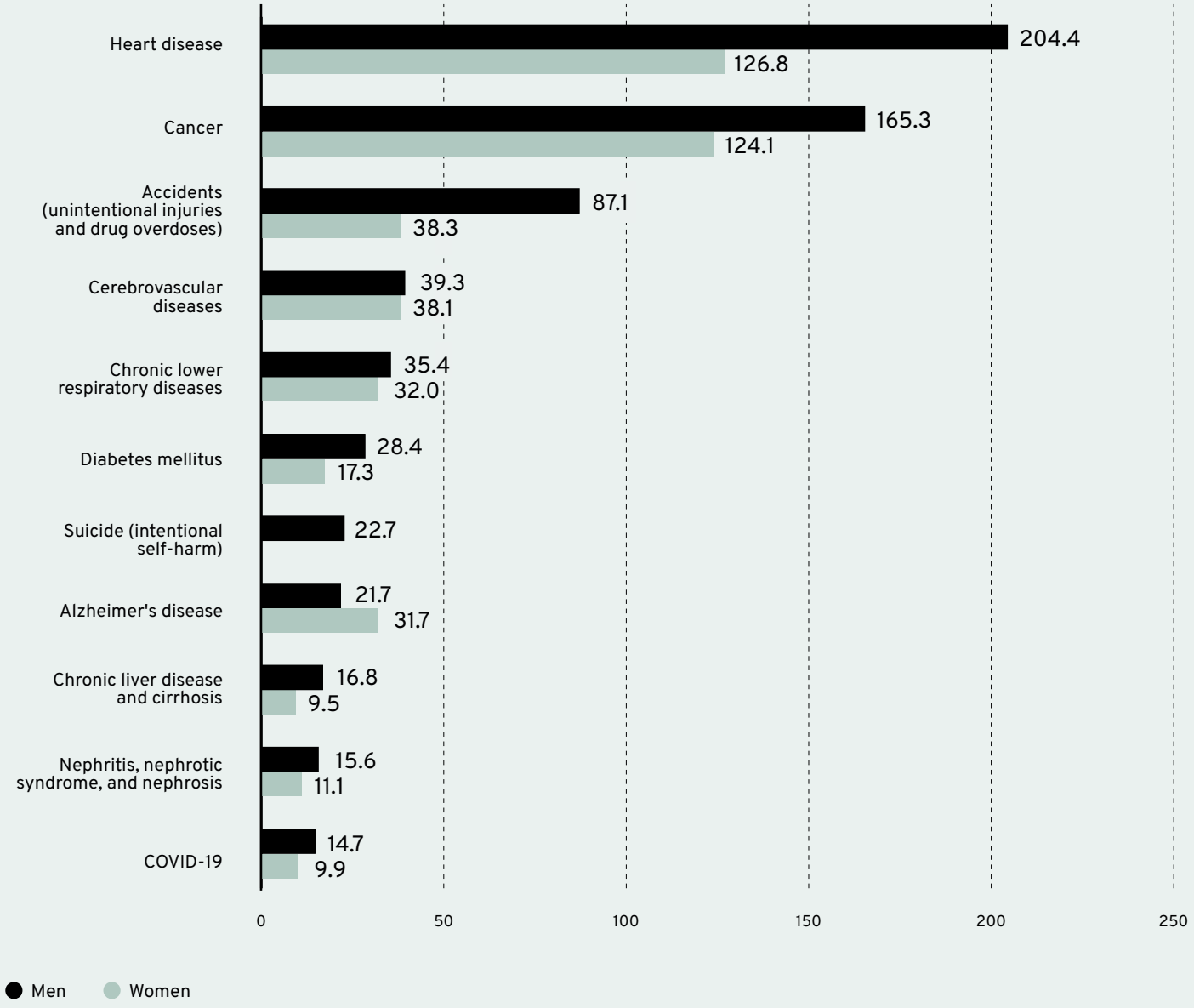
The category of "accidents, unintentional injuries, and drug overdoses" (which includes poisonings, drug overdoses, motor vehicle crashes, falls, drowning, and other accidental causes) ranks third overall for US men. This reflects the very high rate of these deaths among men in the United States compared to men in other OECD countries, underscoring the unusually heavy toll of preventable injuries and overdoses for US men.

Important differences between men and women in leading causes of death go a long way to explaining the persistent gender gap in life expectancy. Heart disease and cancer top the list of causes of death for both men and women, but men's rates are considerably higher in each.

MEASURING CAUSES OF DEATH

Leading causes of death are presented as the number of deaths from each cause per 100,000 people in the population. These rates, based on the latest available CDC data, show which medical conditions, injuries, or other events are responsible for the most deaths in a given population.

Figure 3. **LEADING CAUSES OF DEATH FOR MEN AND WOMEN IN THE US, 2023**



Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

A Closer Look

Prostate cancer risks

Prostate cancer is one of the most common cancers among men in the United States. About 1 in 8 US men will be diagnosed in their lifetime, with this rate rising to 1 in 6 among Black men.[14] Survival rates are very high when the disease is found early (almost 98% live at least five years).[15] However, these outcomes are not the same for everyone. Black men are more than twice as likely to die from prostate cancer as White men, making their death rate the highest of any racial or ethnic group in the US.[16] While aggressive prostate cancers may occur somewhat more often in Black men, research shows that the bigger reason for these higher death rates is unequal access to timely, high-quality care. Prostate cancer research, treatment innovation, and clinical trials have been a cornerstone of Movember's mission since its inception, representing one of the organization's most significant and sustained areas of investment.

1 IN 8

men will be diagnosed with prostate cancer in their lifetime, with this rate rising to 1 in 6 among Black men.

Premature mortality

TOO MANY DEATHS ARE HAPPENING TOO EARLY; ABOUT HALF OF ALL MALE DEATHS HAPPEN BEFORE AGE 75.

In 2023, more than 855,000 men in the United States died before their 75th birthday – 53% of all male deaths that year. The threshold of 75 years reflects an age that most people in high-income nations such as the US could expect to reach in the absence of major health risks – hence, the term premature (or alternatively, preventable[17] or avoidable[18]). While premature mortality rates plateaued from 2010 to 2019, they spiked sharply during the COVID-19 pandemic before returning more recently toward pre-pandemic levels (see Figure 4).

The leading causes of premature mortality mirror the leading causes of death overall: heart disease (85.9 per 100,000); cancer (84.2 per 100,000); and accidents, unintentional injuries, and drug overdoses (77.0 per 100,000). The gender gaps are striking. Men made up more than three out of five deaths before age 75 in the most recent year for which data are available.

Before age 75, men die 161% more often from accidents, unintentional injuries, and drug overdoses than women; 119% more often from heart disease; and 19% more often from cancer. As in the prior section, premature deaths from accidents, unintentional injuries, and drug overdoses stand out: they occur at more than 3.5 times the rate of the fourth-leading cause, suicide, underscoring the outsized toll of injuries and overdoses on men's lives.

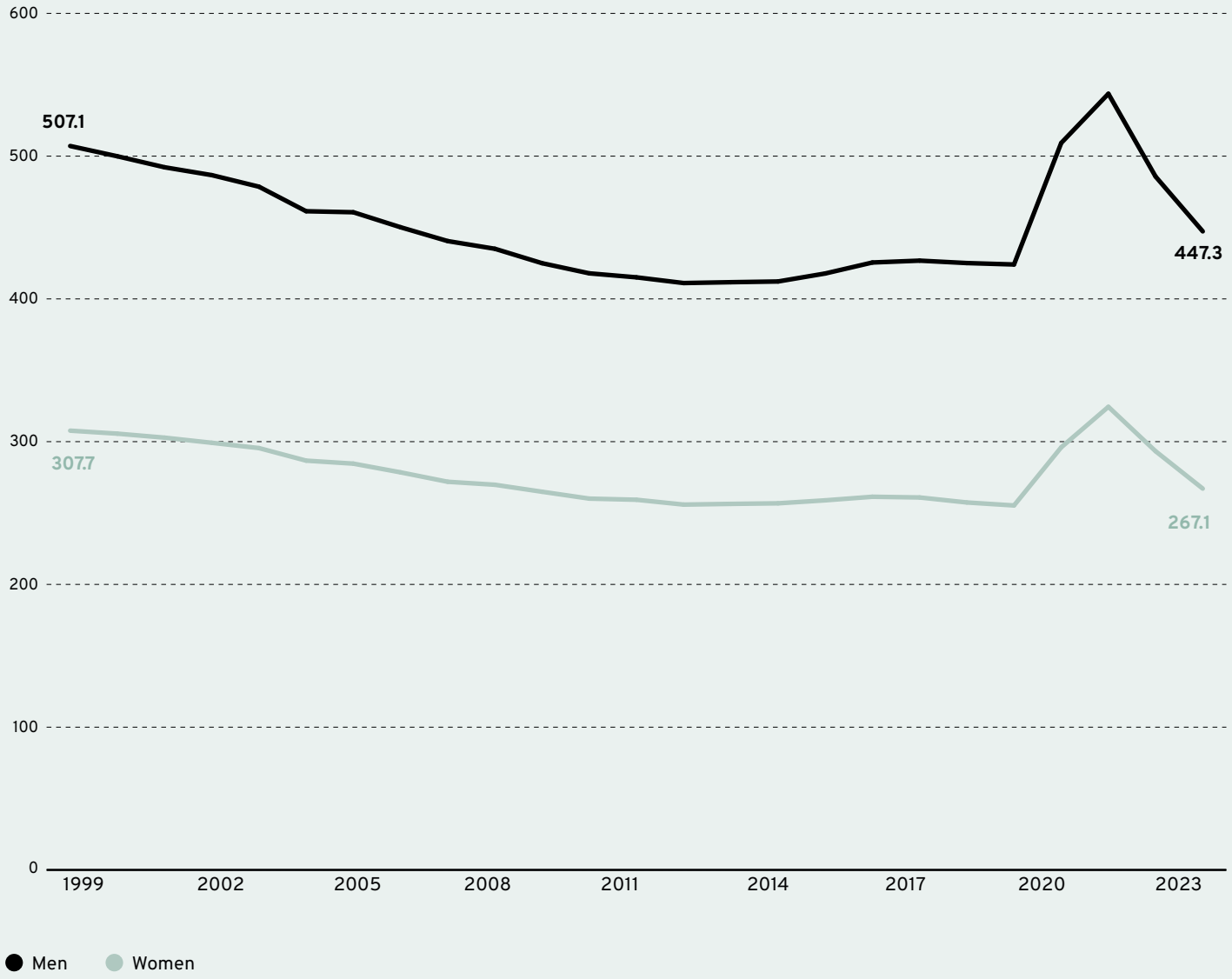
53%

of all male deaths in the United States in 2023 – more than 855,000 men – occurred prematurely.

MEASURING PREMATURE MORTALITY

Leading causes of premature mortality are presented as the number of deaths per 100,000 men under age 75 associated with each cause.[19]

Figure 4. **PREMATURE MORTALITY (<75 YEARS) TRENDS BY SEX (AGE-STANDARDIZED MORTALITY RATES PER 100,000 POPULATION) IN THE US, 1999-2023**



Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

RECKONING WITH THE REALITY WHERE ENTIRE COMMUNITIES DON'T REACH NATIONAL STANDARD.

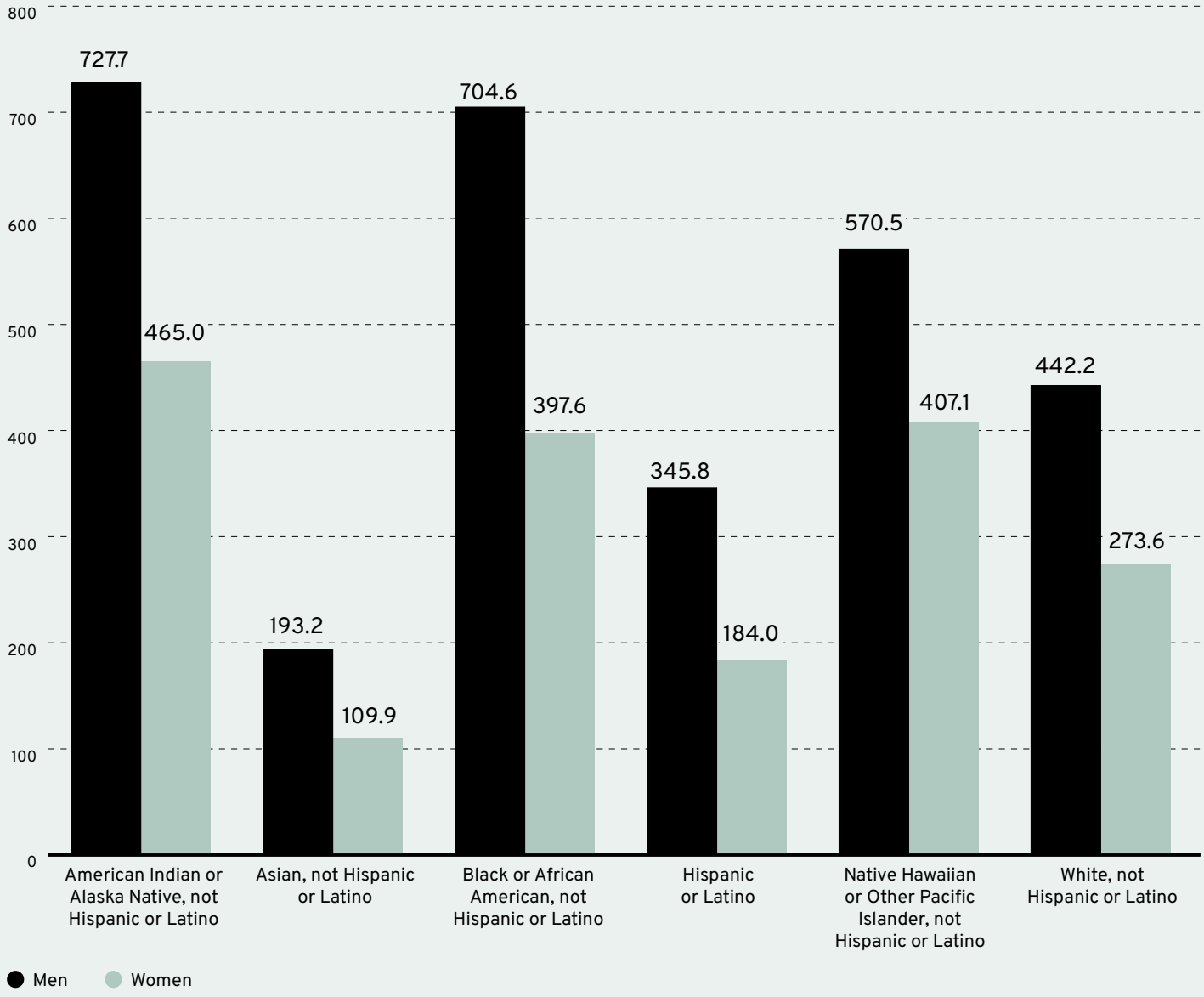
It is striking that some groups of men in the US have never reached a life expectancy of 75 years. Asian, Hispanic, and White men have all crossed that line at some point in history. But for Black men and American Indian and Alaska Native men, the *average* life expectancy has always been below this age[20] below 75 years. By the standard public health metric, this means by the standard public health metric, this means that the average death for men in these communities is premature. These are not just statistical gaps; they represent entire populations for whom dying early has been the norm, not the exception. In 2023, American Indian and Alaska Native men were 3.8 times as likely to die before age 75 as Asian men, the group with the lowest rate. Black men faced a nearly identical gap, dying 3.6 times as often before 75 as Asian men.

Within every racial and ethnic group, men are more likely than women to die before age 75, but the size of that gap differs sharply. Among Asian and Black Americans, men's likelihood of premature death is approximately 80% higher than that of women in the same group. Among those who are Native Hawaiian or other Pacific Islander, the gap is closer to 40% – large but meaningfully lower. These intersectional patterns point to the role of social and environmental factors that affect men and women differently, racial and ethnic groups differently, and men and women *within* each racial and ethnic group differently.

<75

For Black men and American Indian and Alaska Native men, the average life expectancy has always been below 75 years.

Figure 5. **AGE-STANDARDIZED PREMATURE MORTALITY RATE BY HISPANIC ORIGIN, RACE, AND SEX IN THE US, 2023**



Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

Years of life lost

THE US STANDS OUT FOR THE SHEER NUMBER OF YEARS OF LIFE LOST (YLL), AS WELL AS THE ENORMOUS TOLL OF MEN'S EARLY DEATHS FROM DRUG OVERDOSE AND SUICIDE.

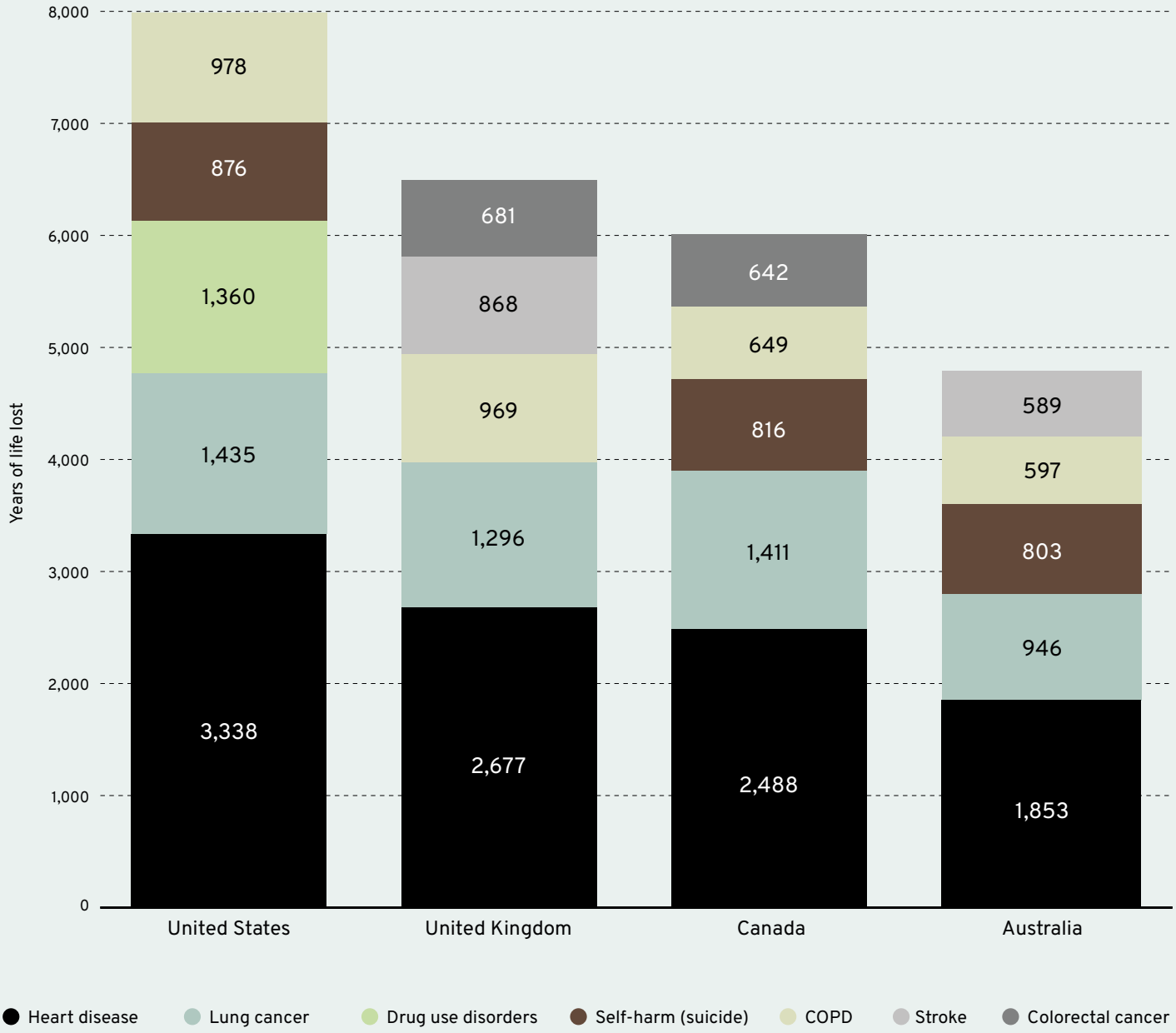
In 2019, heart disease was the leading cause of YLL among men in the United States, responsible for 5.38 million years lost. Lung cancer followed with 2.31 million years lost, and drug use disorders ranked third at 2.19 million. Chronic obstructive pulmonary disease (COPD) accounted for 1.58 million years lost, and suicide for 1.41 million. Importantly, all five of these top causes of YLL are at least partially preventable through public health interventions, clinical care, and social policy.

For context, comparing US YLL levels per 100,000 men with those of other high-income OECD countries shows how strikingly high the burden of men's health is in this country (see Figure 6). YLL rankings highlight that the prominence of drug use disorders in the US is especially significant for men's health. Men account for the majority of overdose deaths in the US, and compared with chronic diseases (which tend to occur later in life), these deaths often occur decades earlier than the average life expectancy. Despite suicide sitting lower in the US ranking, the YLL rate for suicide among men in the US exceeds the rate in these other countries.

MEASURING YEARS OF LIFE LOST

Leading causes of years of life lost (YLL) presented in Figure 6 are the number of years of life lost due to each cause per 100,000 people in the population. The source for these data is the Institute for Health Metrics and Evaluation (IHME). These figures clarify which causes take away the greatest total years of life from the population, giving more weight to deaths that happen at younger ages. IHME's methodology applies a standard global life expectancy target in measuring YLL, not one that varies due to sex or location. For example, if the standard life expectancy were 75, but a person dies of cancer at 65, this would be 10 years of life lost due to cancer. This simplified example is illustrative; in actual practice, the standard life expectancy is higher than 75, and life expectancy within YLL calculations is adjusted by age to reflect the expected average number of years of life remaining at each given age. We use 2019 data because it is the most recent year based on pre-pandemic real-world patterns, avoiding the short-term distortions brought by COVID-19.

Figure 6. **TOP FIVE CAUSES OF YEARS OF LIFE LOST (YLL) AMONG MEN IN FOUR COUNTRIES, 2019**



Source: Schieb LJ, Greer SA, Ritchey MD, George MG, Casper ML. Vital signs: avoidable deaths from heart disease, stroke, and hypertensive disease—United States, 2001–2010. MMWR Morb Mortal Wkly Rep. 2013;62(35):721-727; Institute for Health Metrics and Evaluation. Global burden of disease (GBD). Accessed August 22, 2025. https://www.healthdata.org/research-analysis/gbd; CCEMG – EPPI-Centre. Cost Converter. Accessed August 22, 2025. https://eppi.ioe.ac.uk/costconversion/.

Geographic inequalities

Where you live matters. We have explored the state of men's health so far at a national level. A state-level view is particularly revealing when it comes to men's causes and rates of premature mortality.

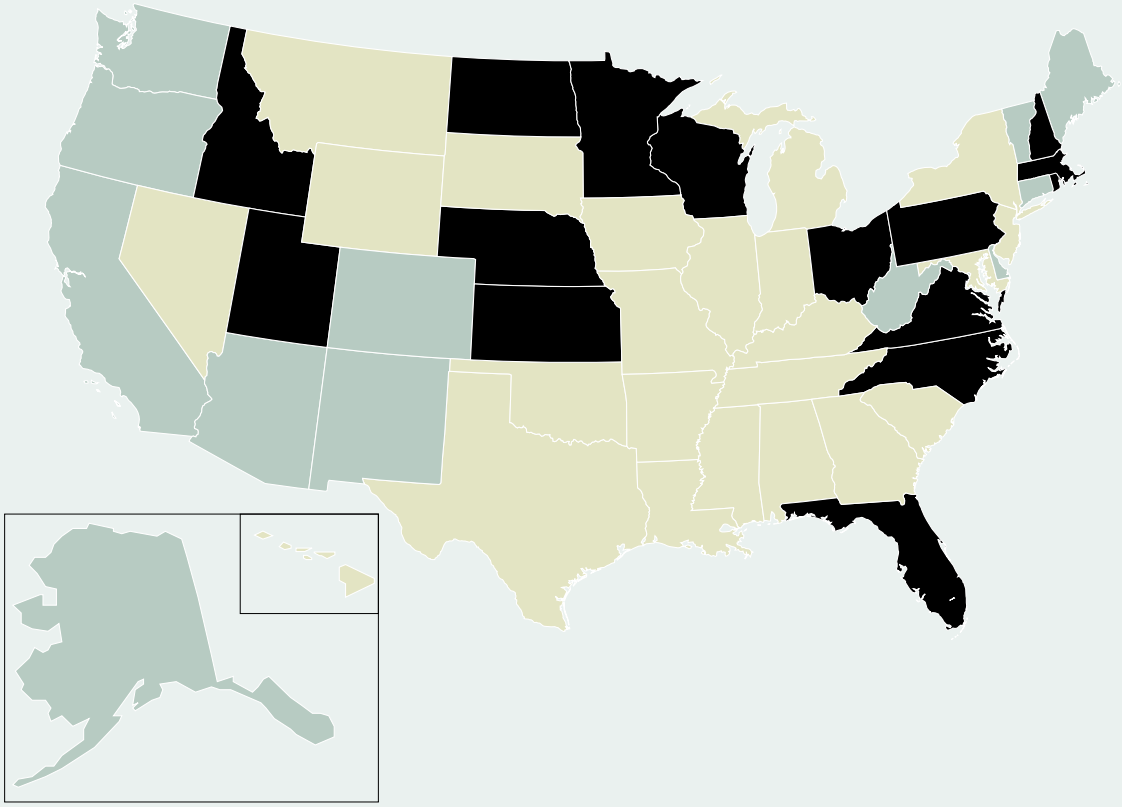
CAUSES OF PREMATURE MORTALITY

Across the United States, the leading cause of premature mortality for men varies from state to state. In 23 states, it is heart disease. In 15 states, cancer takes the top spot. And remarkably, in 12 states plus the District of Columbia, accidents are the leading cause of premature mortality of men. For a high-income country, it is striking to see so many states where injury-related deaths – often linked to motor vehicle crashes, workplace hazards, firearm injuries, or overdoses – outpace all diseases.

These state-level differences matter. They reflect how geography, work environments, state-level policies, and social conditions combine to shape men's health. Yet focusing only on a state's single leading cause can be misleading. For example, in West Virginia, accidents rank first, followed by heart disease and cancer. Yet West Virginia's cancer rate for men is higher than that of neighboring Virginia, where cancer tops the list.

Figure 7.

LEADING CAUSES OF PREMATURE MORTALITY BY STATE, BASED ON AGE-STANDARDIZED PREMATURE MORTALITY RATES (<75 YEARS, US 2000 STANDARD POPULATION)

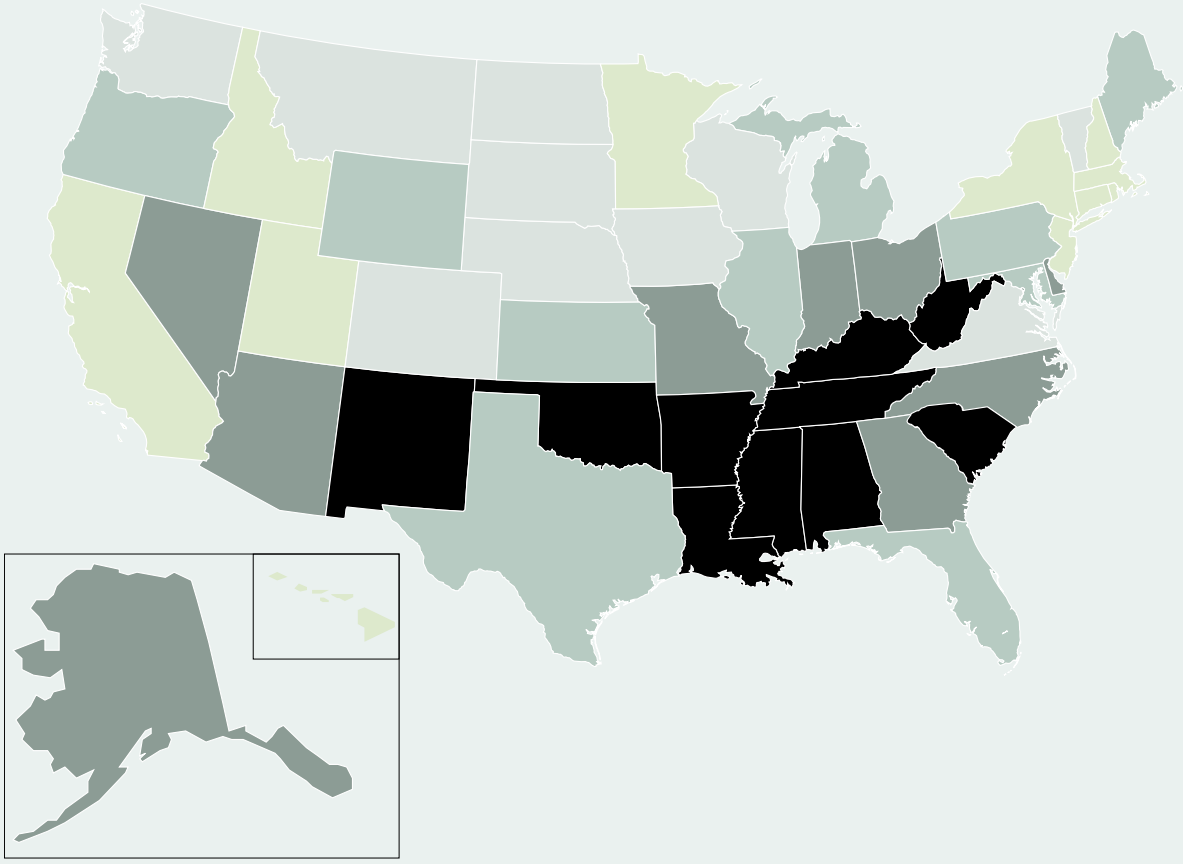


Accidents	Heart Disease	Cancer
Alaska	Alabama	Florida
Arizona	Arkansas	Idaho
California	Georgia	Kansas
Colorado	Hawaii	Massachusetts
Connecticut	Illinois	Minnesota
Delaware	Indiana	Nebraska
District of Columbia	Iowa	New Hampshire
Maine	Kentucky	North Carolina
New Mexico	Louisiana	North Dakota
Oregon	Maryland	Ohio
Vermont	Michigan	Pennsylvania
Washington	Mississippi	Rhode Island
West Virginia	Missouri	Utah
	Montana	Virginia
	Nevada	Wisconsin
	New Jersey	
	New York	
	Oklahoma	
	South Carolina	
	South Dakota	
	Tennessee	
	Texas	
	Wyoming	

Continue ›

Figure 8.

AGE-ADJUSTED PREMATURE MORTALITY RATE (<75), MEN ONLY, DEATHS OUT OF 100,000 IN THE US, 2023



Mississippi	671	District of Columbia	536	Michigan	459	Virginia	421	Hawaii	389
West Virginia	662	Missouri	528	Kansas	458	Iowa	421	New Hampshire	382
Louisiana	631	Alaska	512	Maine	457	North Dakota	418	Rhode Island	379
Alabama	631	Indiana	510	Oregon	456	Montana	418	Idaho	377
Arkansas	611	North Carolina	510	Wyoming	440	Vermont	416	California	375
Kentucky	611	Ohio	507	Pennsylvania	439	Washington	415	New York	364
Tennessee	608	Georgia	496	Texas	439	South Dakota	410	Connecticut	360
New Mexico	607	Nevada	490	Florida	434	Wisconsin	402	Minnesota	354
Oklahoma	588	Arizona	473	Illinois	433	Nebraska	397	Utah	351
South Carolina	553	Delaware	466	Maryland	429	Colorado	395	Massachusetts	347
								New Jersey	344

Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

PREMATURE MORTALITY RATES

In the United States, the odds of a man reaching his 75th birthday depend on intersections of race, ethnicity, gender, and geography. In New Jersey, just 344 men per 100,000 die before age 75 – the lowest rate in the nation. In Mississippi, the figure is nearly double, at 671 per 100,000. That's a gap of more than 300 deaths per 100,000 between the two states, translating to thousands of lives each year. Eight states have rates of men dying prematurely above 600 per 100,000: Mississippi, West Virginia, Louisiana, Alabama, Arkansas, Kentucky, Tennessee, and New Mexico. At the other end of the spectrum, 13 states have rates below 400 per 100,000: New Jersey, Massachusetts, Utah, Minnesota, Connecticut, New York, California, Idaho, Rhode Island, New Hampshire, Hawaii, Colorado, and Nebraska.

These geographic patterns make clear that any national effort to improve men's health must also be locally informed. State-level decisions on spending, regulation, healthcare coverage, tax policy, and social programs all shape the conditions in which men live and die. The challenges facing men in rural Mississippi differ sharply from those in urban New Jersey, and so do the levers for change. State-level variation reflects differences in economic opportunity, healthcare access, public health investment, and the social and environmental conditions that shape daily life.

There is obvious geographic variation across states; however, this can disguise that the variation continues at lower levels, with individuals in each state experiencing very different levels of health and life expectancies.

There is obvious geographic variation across states; however, this can disguise that the variation continues at lower levels, with individuals within each state experiencing very different levels of health and life expectancies.












Mental health and suicide

MENTAL HEALTH CHALLENGES AMONG MEN ARE RISING, ESPECIALLY IN YOUNGER AGE GROUPS.

Mental health and suicide have emerged as defining health issues for men in the United States. Rising prevalence rates, coupled with unprecedented social isolation, economic uncertainty, and contemporary stressors, have made this a crisis we can no longer ignore.

While women still report higher rates of mental ill-health than men overall (26% versus 19% in 2023), the gap has narrowed sharply over the past decade due to significant increases in men's rates.[21] Among younger men, the picture is especially troubling. More than one in four men ages 18 to 34 reported experiencing mental ill-health in the last year, with the highest rate among men ages 30 to 34 (32%).[22] Men ages 35 to 39 also report elevated rates of mental ill-health (25%), but prevalence drops with age, falling to between 12% and 18% for men ages 40 to 64 and just 8% for men 65 and older.[23] Notably, suicide rates rise in these older age groups despite their lower reported rates of mental illness.

1/4

More than one in four men ages 18 to 34 reported experiencing mental ill-health in the last year, with the highest rate among men ages 30 to 34 (32%).

Trends over the past decade underscore the urgency of this issue. Since 2014, reported rates of mental ill-health in the past year have increased by 85% among men ages 30 to 34, by 73% among men ages 18 to 25, and by more than 60% across all men ages 18 to 39.[24] As this group of men navigates an unstable workforce in the midst of a cost of living crisis and rapid technological change – while also balancing intimate relationships and potential fatherhood – these contemporary stressors call for equally contemporary approaches to support and intervention.

HELP-SEEKING REMAINS LOW, AND CARE OFTEN MISSES THE MARK.

Despite the clear need for support, men in 2023 were far less likely to seek care for mental health issues than women (18% versus 30% in the past 12 months). Nonetheless, there has been a clear shift in help-seeking rates over the past decade as awareness has increased, with more than three times as many men seeking help (4.6% in 2014). For these men who overcome the plethora of barriers to care, both structural (e.g., cost and convenience) and attitudinal (e.g., stigma and mental health literacy)[25] outcomes can often fall short.[26] Many men who engage with mental health providers describe feeling misheard, misunderstood, or underestimated.[27]

Research suggests that gender biases in clinical settings contribute to missed or incorrect diagnoses, as some providers expect men to conform to stereotypical expressions of mental health problems.[28] Providers may mislabel men's symptoms, downplay the severity of their distress, or fail to recognize how depression and anxiety can present differently in men.[29] According to one US study measuring all deaths by suicide in a 10-year period across eight states, in the year prior to death, 81% of men who died by suicide interacted with the healthcare system; 40% had a mental health diagnosis during that year; and 21% had a mental health visit *in the final month of life*.[30] These encounters were all missed opportunities for prevention.

This misalignment between men's experiences and the care they receive can deepen disillusionment, increase dropout from treatment, and leave underlying issues unresolved. In 2023, 32% of men said they had an unmet mental health treatment need because they didn't think treatment would help, a quantifying of this overarching distrust of and dissatisfaction with service offerings, an experience most felt by young men ages 12 to 25.[31] In order to effectively respond to men's worsening mental health outcomes, it is essential to both expand access to care and transform how that care is delivered, ensuring it reflects men's diverse lived experiences, recognizes different manifestations of distress, and meets them with genuine engagement rather than preconceived assumptions.

SUICIDE IS A TOP-FIVE CAUSE OF PREMATURE MORTALITY AMONG US MEN, THOUGH RATES OF DEATH BY SUICIDE VARY DRAMATICALLY AMONG MEN BY RACE, ETHNICITY, AND AGE.

Men are 3.6 times as likely to die prematurely by suicide as women, with suicide being the fourth leading cause of premature mortality among men compared to eighth among women. These rates make suicide a significant cause of death, particularly for men.

For most men under 75, the age when they are most likely to die by suicide is between 25 and 34. American Indian and Alaska Native men in this age range have the highest rate of suicide death of any racial or ethnic group under age 75, and importantly, have the highest rates of suffocation as the leading suicide method (55%) compared to all other groups, for whom firearm use remains the most common method.

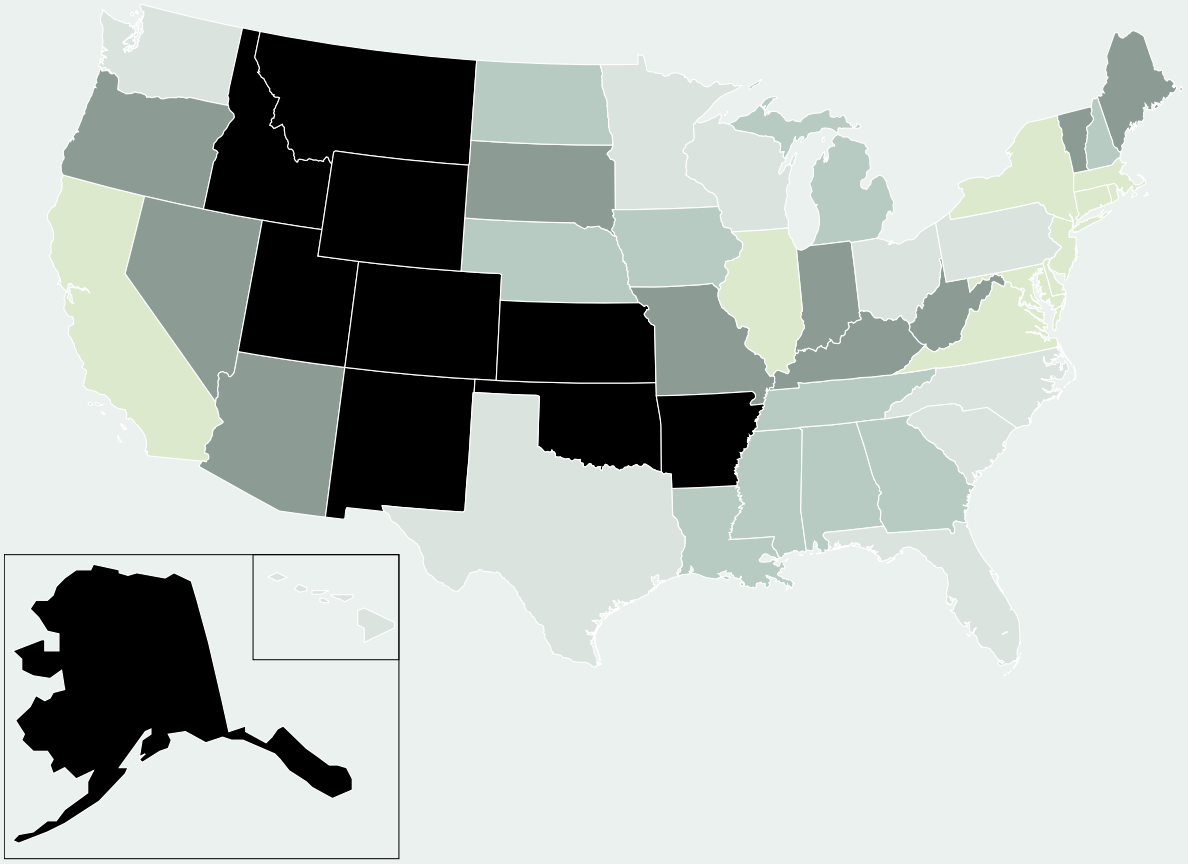
As shown in Figure 9, the five states presently holding the highest rates of men's death by suicide are Wyoming, Montana, Alaska, New Mexico, and Idaho, while the five with the lowest are New Jersey, Rhode Island, New York, Massachusetts, and Maryland. These contrasts likely reflect differences in rurality, access to care, firearm availability, and demographic patterns, though it's important to note that state averages can conceal significant variation across communities.

25-34

For most men under 75, the age when they are most likely to die by suicide is between 25 and 34.

Figure 9.

AGE-STANDARDIZED PREMATURE MORTALITY RATE (<75 YEARS) FOR INTENTIONAL SELF-HARM IN THE US



Wyoming	41.4	West Virginia	28.7	Tennessee	26.4	Ohio	23	Delaware	20.8
Montana	39.8	Nevada	28.6	Alabama	25.7	Washington	22.9	Virginia	20.3
Alaska	39.3	South Dakota	28.4	North Dakota	25.1	Wisconsin	22.9	Illinois	18.1
New Mexico	37.5	Arizona	28.2	Louisiana	24.7	Hawaii	22.7	California	14.9
Idaho	34.3	Vermont	28.2	Iowa	24.6	South Carolina	22.4	Connecticut	14.5
Oklahoma	33.9	Maine	27.9	New Hampshire	23.9	Pennsylvania	22.2	Maryland	14.3
Utah	33.3	Missouri	27.9	Georgia	23.4	North Carolina	21.9	Massachusetts	12.8
Arkansas	31.8	Indiana	27.5	Nebraska	23.4	Texas	21.6	New York	12.2
Kansas	30.6	Oregon	27.5	Mississippi	23.2	Florida	21.3	Rhode Island	12
Colorado	30.1	Kentucky	27	Michigan	23	Minnesota	21.1	New Jersey	10.9

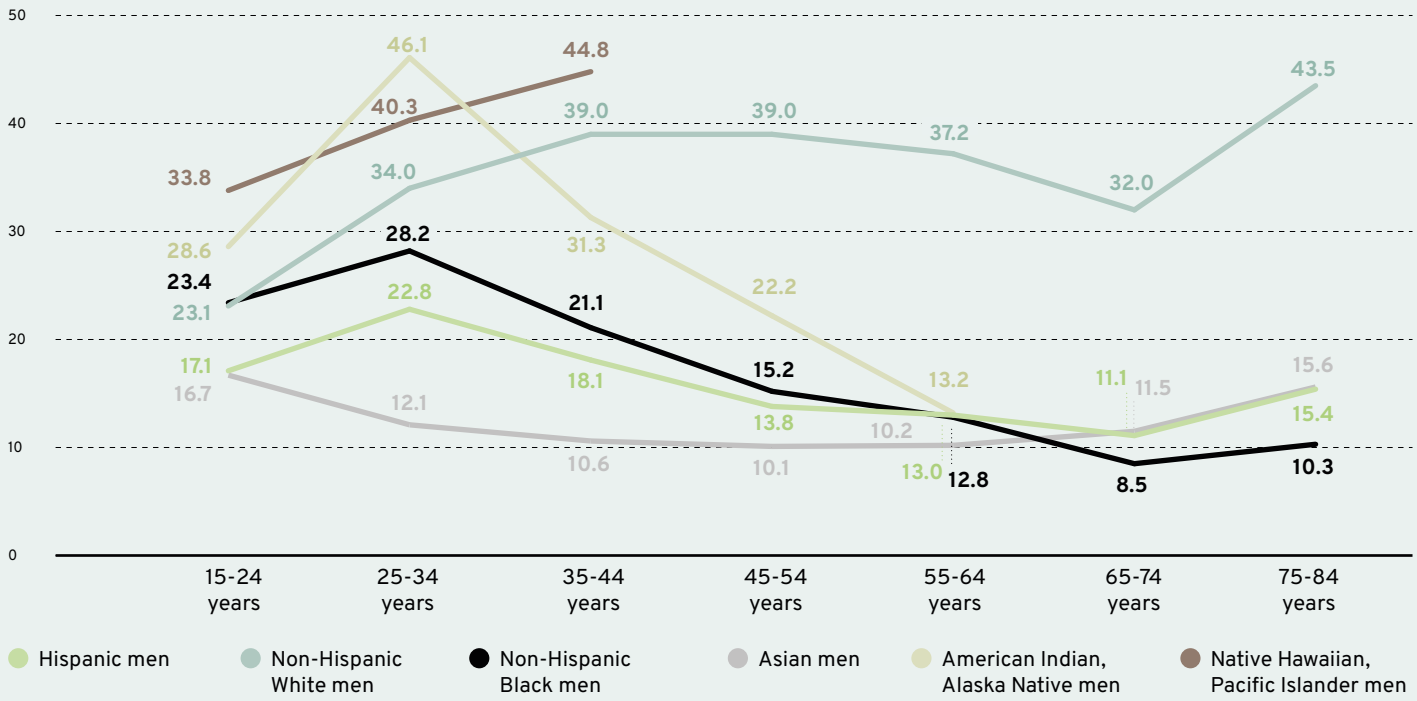
Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

Compared to all other groups where younger men's risk is highest, non-Hispanic White men's rate of dying by suicide is higher at ages 35 to 44 and 45 to 54. In addition, White men 55 and older have significantly higher rates of dying by suicide, three to four times as much as other racial and ethnic groups in their later years (see Figure 10). As White men age, their likelihood of suicide death by firearm increases, and suffocation becomes a far less likely method, a distinct pattern compared to other groups.

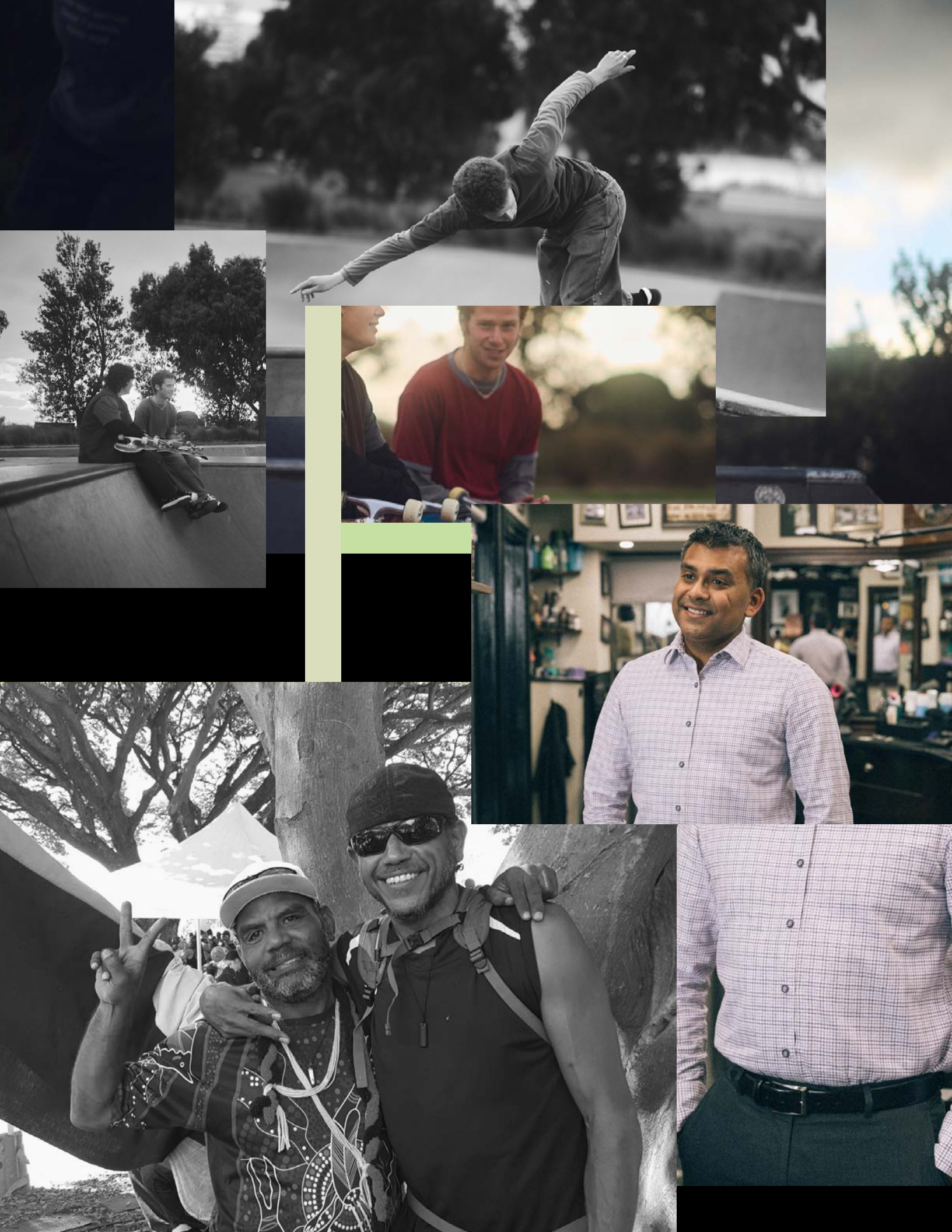
These data suggest that White men face unique or compounding risk factors as they age, and much like young American Indian and Alaskan Native men, require specific exploration of their lived experience alongside targeted interventions to respond to these distinctly high suicide rates. As an example, for older White men, risk factors that might help explain the rise in suicides could include chronic health conditions, loss of identity tied to work or traditional masculine roles after retirement, access to firearms, and less robust social support networks in later life compared to other communities.[32]

Figure 10. **RATES OF DEATH BY SUICIDE (INTENTIONAL SELF-HARM) PER 100,000 AMONG US MEN BY RACE, HISPANIC ORIGIN, AND 10-YEAR AGE GROUPS, 2023**



Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024. Data for Native Hawaiian and Pacific Islander men age 45 and older are not available in this dataset.



Social connection

SOCIAL CONNECTION IS ESSENTIAL TO HEALTH AND WELL-BEING, BUT MEN ARE INCREASINGLY DISCONNECTED.

In 2023, the US Surgeon General declared an "epidemic of loneliness and isolation," elevating social connection to a public health imperative.[33] Social connection – our ties with family, friends, colleagues, and community – is as vital to our survival as food, water, and shelter. We must consider social connection in the context of men's health, given its absence has such a severe toll: loneliness raises the risk of premature death by over a quarter, rivaling the health impact of smoking 15 cigarettes a day and outpacing obesity and inactivity.[34]

In Gallup's 2023-2024 global survey of loneliness across 38 OECD countries, younger American men emerged as a distinct outlier.[35] A full 25% of US men ages 15 to 34 said they felt lonely "a lot" of the previous day, far above both the national average (18%) and the rate for young American women (18%). This gap is larger than in any other wealthy nation surveyed, with no other OECD country showing a greater difference between young men's loneliness and that of the rest of its population. While most US age and gender groups report loneliness levels similar to those in other high-income countries, there is one other exception: US women ages 35 to 54. In this group, 20% reported feeling lonely, a rate notably higher than the OECD median for midlife women (14%).[36]

Pew's January 2025 study on social connections[37] deepens the analysis by underscoring the ways in which men and women try to meet their need to belong. The study reports that only 38% of men would lean on a friend for emotional support (versus 54% of women). When men don't proactively reach out for support, they talk less with friends and receive less care as a result.

MEN'S SOCIAL NETWORKS ARE OFTEN THINNER AND LESS EMOTIONALLY ENGAGED, LEAVING MANY WITH NO COMFORTABLE PLACE TO TURN WHEN LIFE GETS HARD.

The 2021 State of American Friendship study[38] labeled this the "friendship recession," shining a light on the staggering rise in men reporting no close friends, from 3% in 1990 up to 15% in 2021. This study traces the friendship decline to macro-trends such as later marriage, greater geographic mobility, busier work lives, and parents devoting twice as much time to childrearing as a generation ago. These pressures squeeze out time for friendship. Add to this the Surgeon General's warning that digital

connections rarely match the protective power of in-person ties, and it becomes clear why men, already less practiced at asking for help, face unique headwinds in sustaining the social connections that keep us healthy.

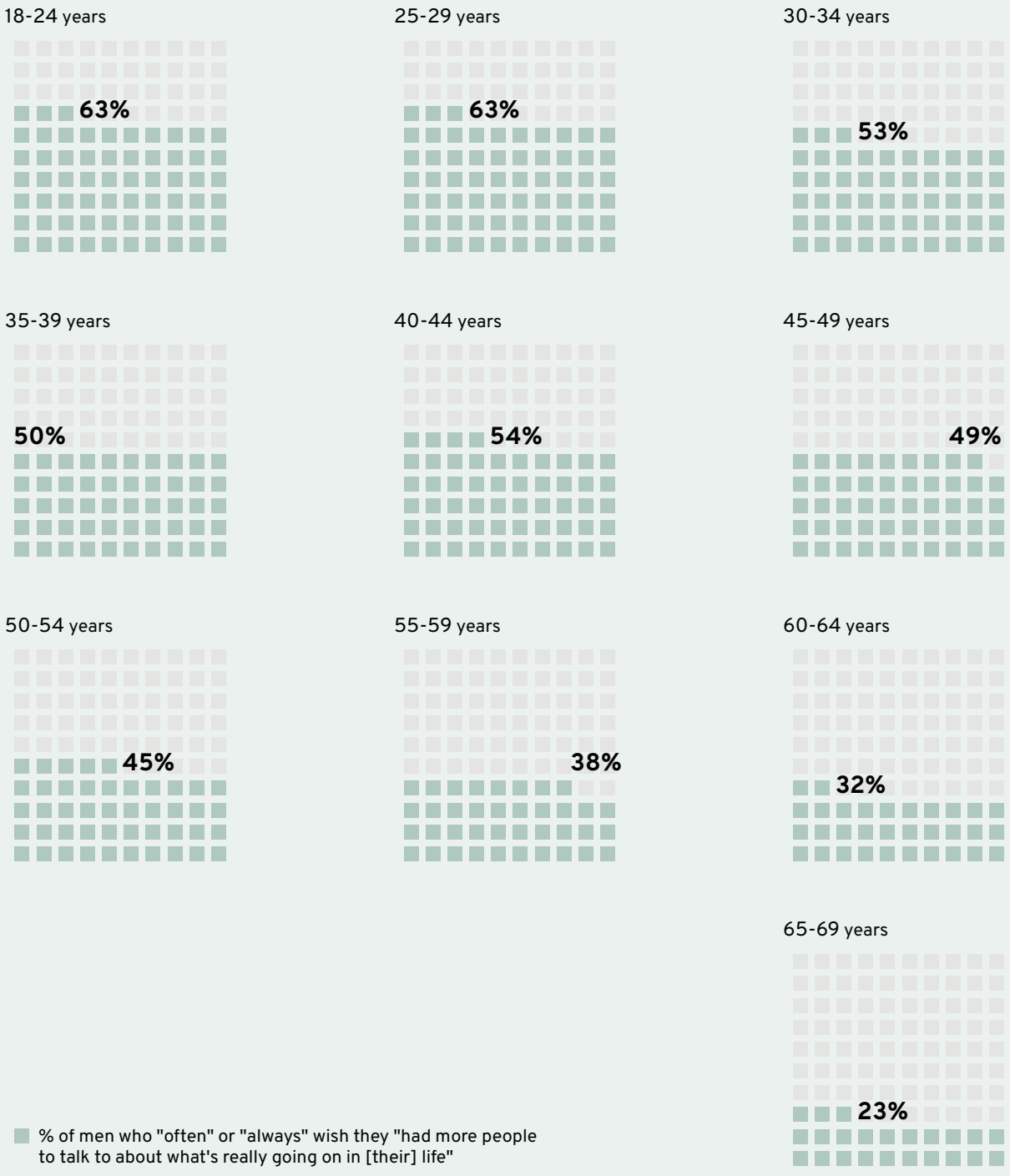
We know from our own research at Movember that these trends are especially worrying in young men (ages 16 to 25). When surveying a representative US sample of 1,022 young men for our 2025 report *Young Men's Health in a Digital World*, 64% told us they lack companionship some or all of the time, and 71% felt isolated from others.[39] As a means of understanding the root of these cultural trends, pervasive online narratives promoting rigid ideals of what it means to be a man arise as driving this crisis of connection. Among US young men, 54% agreed that successful men must be lone wolves (disconnected from others), and 58% agreed that "I don't need friends as I need to focus on my success and reaching my goals." Both of these responses were significantly more common among young men who regularly engaged with popular men and masculinity influencers online who tout these ideas, underscoring the importance of reaching men and boys where they are at online, with pro-social and health promotional messaging that resonates with them.[40]

IN OUR SURVEY, MEN LONG FOR STRONGER FRIENDSHIPS AND SOCIAL CONNECTION.

In the "Men's Experiences of Care and Connection" survey conducted for this report, we asked over 4,000 men directly for their reflections, hopes, and challenges related to building stronger social connections. The clearest finding that emerged was that men consistently long for more people to turn to. As Figure 11 demonstrates, significant majorities of men at younger ages say they often or always wish they "had more people to talk to about what's really going on in [their] life," with an overall average of 47% of all men sharing this feeling. If we expand to men who report this feeling "sometimes" as well, then the sentiment is nearly universal.

We also asked men more specifically, "How interested are you in having more close friendships in your life?" When presented this way, a starker contrast among age groups emerged. Younger men were particularly likely to say that they were "very" or "extremely" interested in having more close friendships, with 69% of men ages 18 to 24 holding these views, closely followed by men ages 25 to 34 (65%) and 35 to 44 (64%).

Figure 11. **PERCENTAGE OF MEN WHO "OFTEN" OR "ALWAYS" WISH THEY "HAD MORE PEOPLE TO TALK TO ABOUT WHAT'S REALLY GOING ON IN [THEIR] LIFE"**



Source: New data, Movember "Men's Experiences of Care and Connection" survey, 2025

Movember's Making Connections Initiative: A philosophy centered on social connection

A decade ago, Movember's Making Connections Initiative set out to change how we support men and boys' mental health by moving beyond crisis-driven, clinic-only models and investing in community-led, locally rooted strategies. Making Connections supported 16 community coalitions in the US between 2015 and 2024, with a dozen proceeding to a full implementation phase. These coalitions work in the everyday settings where men and boys already gather, including barbershops, sports teams, tribal community centers, and schools. These coalitions tested community-rooted approaches such as mentorship, healing circles, and culturally resonant practices to build trust and belonging, often amid challenging structural circumstances.

Across all sites, the core belief was that mental well-being thrives when people are connected to each other, to purpose, to place, and to culture. That belief led us to tackle root causes such as racism, economic exclusion, intergenerational trauma, and rigid gender norms through interventions designed with and for each community rather than imposing one-size-fits-all solutions. The initiative also worked to change larger systems by partnering with both clinical and non-clinical institutions so that these approaches could become standard practice.

For example, in Hawaii's Kalihi Valley, KVIBE's youth bike-building workshops and civic engagement programs foster leadership and healing among Pacific Islander boys, while older interns mentor younger boys and the bike shop serves as an informal caregiving support for families. In San Diego, Movember's Making Connections supported United Women of East Africa (UWEAST) to found The HUB, a drop-in center where young men can gather for mentorship, meals, and practical support. The HUB arose in response to UWEAST's program participants – predominantly women – encouraging the organization to support men's health for the benefit of families and communities writ large. UWEAST also runs a community basketball league that brings participants together weekly to build relationships and connect youth with mental-health and social-service partners.

Evaluation of the program showed that peer support and intergenerational connections were central to healing, that grounding programs in cultural identity consistently drove engagement and well-being, and that familiar settings such as schools, barbershops, and sports teams served as vital entry points for mental health conversations. Throughout the initiative, genuine social connection remained the guiding thread. It strengthened individual resilience and sparked ripple effects across sectors, inspiring other organizations and communities to adopt similar approaches and build on this work in their own programs.

Social norms

SOCIAL STEREOTYPES ABOUT MASCULINITY ACT AS BOTH BARRIERS TO AND ENABLERS OF BETTER HEALTH.

We know that the beliefs, roles, and norms tied to men in our society can affect their health and well-being. While one man may prize self-reliance and delay reporting chest pain until he has a heart attack, another may learn that strength and resilience lie in truly looking after himself and reach out to a trusted source at the first sign of distress. While sometimes presented as a simple picture in media narratives, the interactions between what it means to be a man and how men look after their health are complex and ever-changing. Men experience tensions in the interplay among what has been passed down from previous generations, what has been shown in TV and movies, what they believe their friends think, and what emerges authentically from their own lived experience. These competing influences complicate how they navigate daily health decisions.

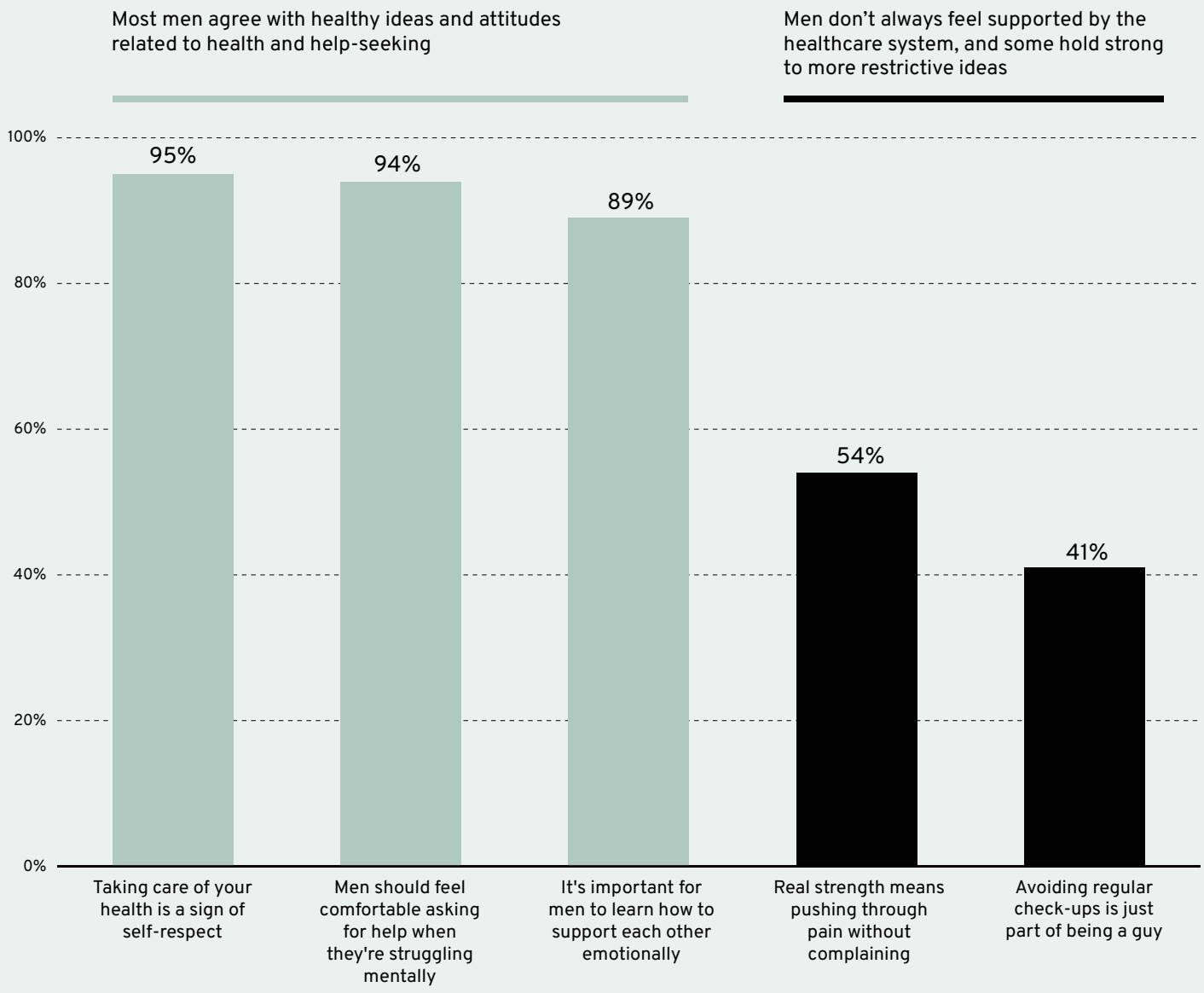
Men today are grappling with these questions and challenging ideas that their fathers and grandfathers once took as fact. Many aspire to be the kinds of role models who show their children that asking for help, scheduling regular checkups, and speaking openly about mental health are essential steps on the path to thriving. But it's not always that simple, and gaps nonetheless remain.

OUR SURVEY DATA SHOW THAT MEN IN THE US HOLD POSITIVE ATTITUDES ABOUT HELP-SEEKING AND MENTAL HEALTH OVERALL.

Nearly universally, men agree that "taking care of your health is a sign of self-respect" (95%), "men should feel comfortable asking for help when they're struggling mentally" (94%), and "it's important for men to learn how to support each other emotionally" (89%) (see Figure 12). While the stereotype for men to "suck it up" might remain culturally pervasive, these findings suggest that when we take the time to ask, men on the ground actually have more positive, open attitudes toward help-seeking.

While most men have pro-health attitudes, they are clear on the deeply rooted social pressures surrounding them, which often act as barriers to action: 54% agree that "real strength means pushing through pain without complaining," while 41% say that "avoiding regular check-ups is just part of being a guy." These findings clarify the challenge as we build out a contemporary understanding of what it means to be healthy: helping men overcome the rigid norms preventing them from looking after themselves and others.

Figure 12. **PERCENTAGE OF MEN WHO "MOSTLY" OR "COMPLETELY" AGREE WITH STATEMENTS ON HELP-SEEKING AND HEALTH-RELATED ATTITUDES**



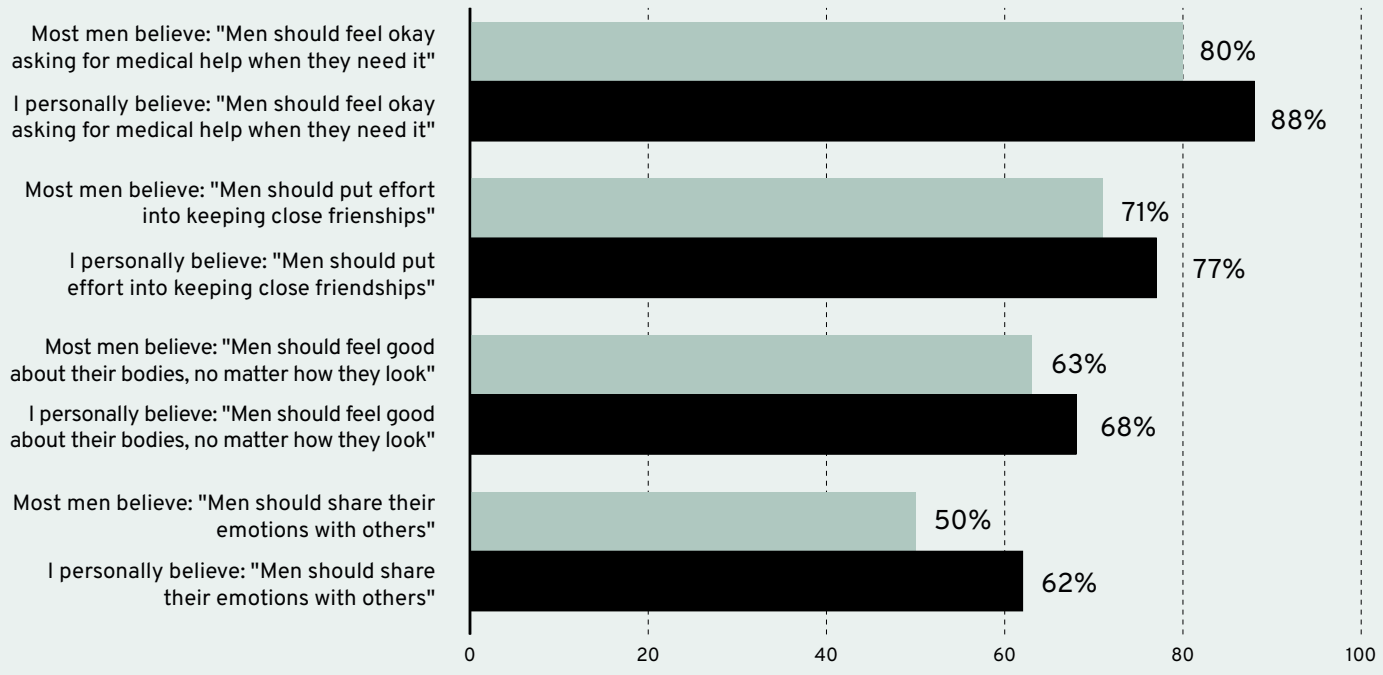
Source: New data, Movember "Men's Experiences of Care and Connection" survey, 2025

MEN CONSISTENTLY OVERESTIMATE HOW MANY OF THEIR PEERS HOLD RESTRICTIVE IDEAS ABOUT MASCULINITY.

We presented survey participants with several positively framed messages related to health and social connection, asking them how widely men as a whole support these ideas and then asking whether they themselves support these ideas. Across the board, men were significantly more likely to personally agree with these positive ideas than they estimated "most men" did. This speaks to the power of the silence and stigma that have typified men's health for decades, driving a chasm – the perception gap – between how men feel about their health and well-being, and what they think others believe.

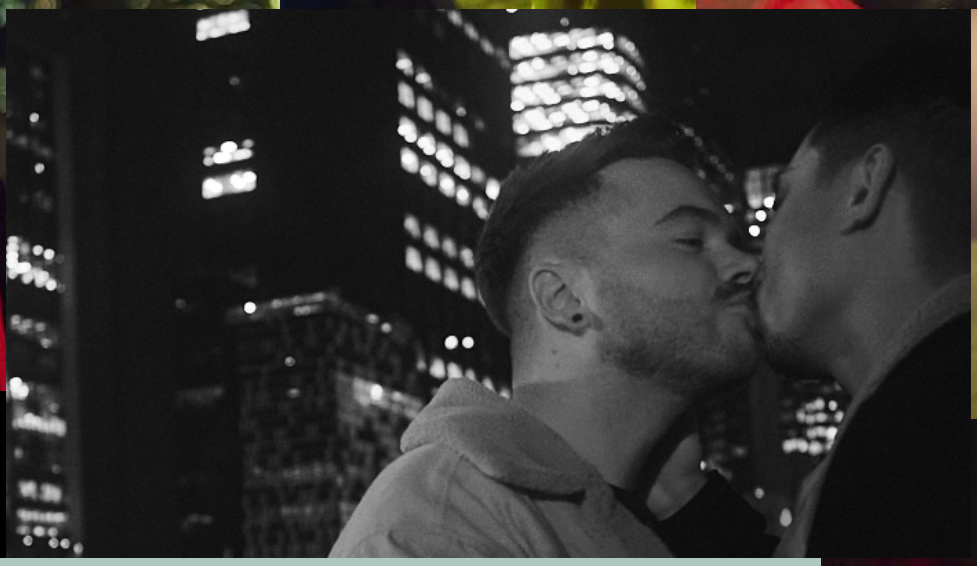
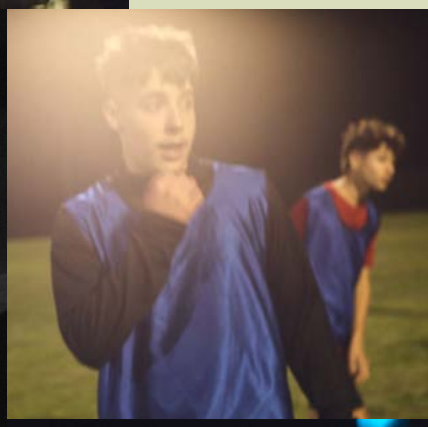
What this means is that men have an exaggerated idea of how popular restrictive ideas about masculinity and health are. Closing this perception gap is a key priority for programs and policies focused on promoting men's health and social connection. It could produce a powerful revelation for men struggling to open up and seek connection that they are not alone in their attitudes, and that more men actually support men's active efforts in seeking friendship and openly sharing emotions than they may think.

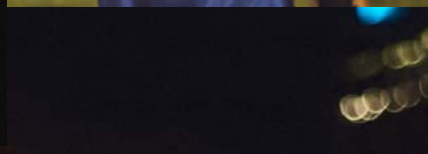
Figure 13. **PERCENTAGE OF MEN WHO "MOSTLY" OR "COMPLETELY" AGREE WITH STATEMENTS ON THEIR OWN AND OTHERS' HEALTH-RELATED BELIEFS**



Source: New data, Movember "Men's Experiences of Care and Connection" survey, 2025









Economic costs of men's poor health

MEN'S PREMATURE MORTALITY GENERATES SIGNIFICANT FINANCIAL COSTS.

Men's poor health carries a steep price, not only in lives lost but also in the strain it places on the US healthcare system and the economy. These costs show up both in the money spent to treat men's illnesses and in the economic contributions lost when men die early or live with serious health problems.

In 2023, treating just five major causes of premature mortality among men – heart disease, opioid use disorder, chronic obstructive pulmonary disease (COPD), lung cancer, and suicide – cost the US healthcare system an estimated **$120.8 billion** in direct medical spending. This includes expenses for inpatient and outpatient care, nursing facilities, prescribed medications, and emergency services – for only five of the myriad causes of premature mortality. The price tag is highest for heart disease, at more than $63 billion, followed by opioid use disorder ($25 billion), COPD ($23 billion), lung cancer ($9 billion), and suicide ($215 million).

The impact doesn't end there. Men's premature mortality generates indirect costs as well: a staggering additional **$299.8 billion**. This mostly arises from lost wages and work productivity. These indirect costs include the full economic loss from suicide and opioid use disorder.

Strikingly, 85% of these costs are considered preventable, meaning they could be avoided through better public health measures, timely medical care, and changes to harmful commercial and environmental conditions. Combined, direct and indirect costs *for only the five leading causes of premature mortality* total **$420.6 billion** in a single year, most of it preventable.

Figure 14. **DIRECT COSTS (IN BILLIONS USD) OF TOP FIVE CAUSES OF MEN'S AVOIDABLE MORTALITY IN THE US, 2023**

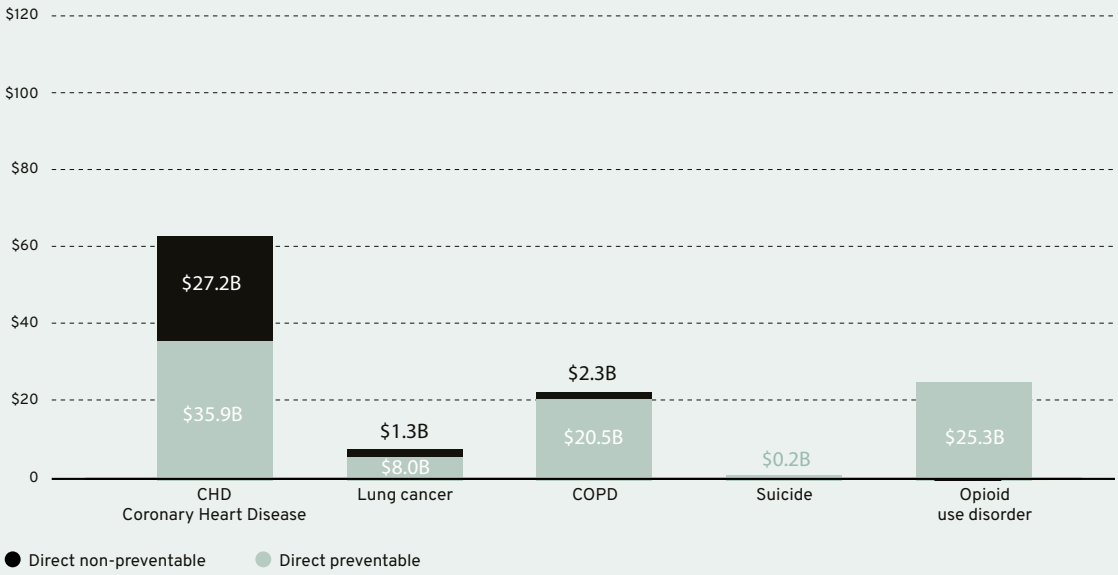
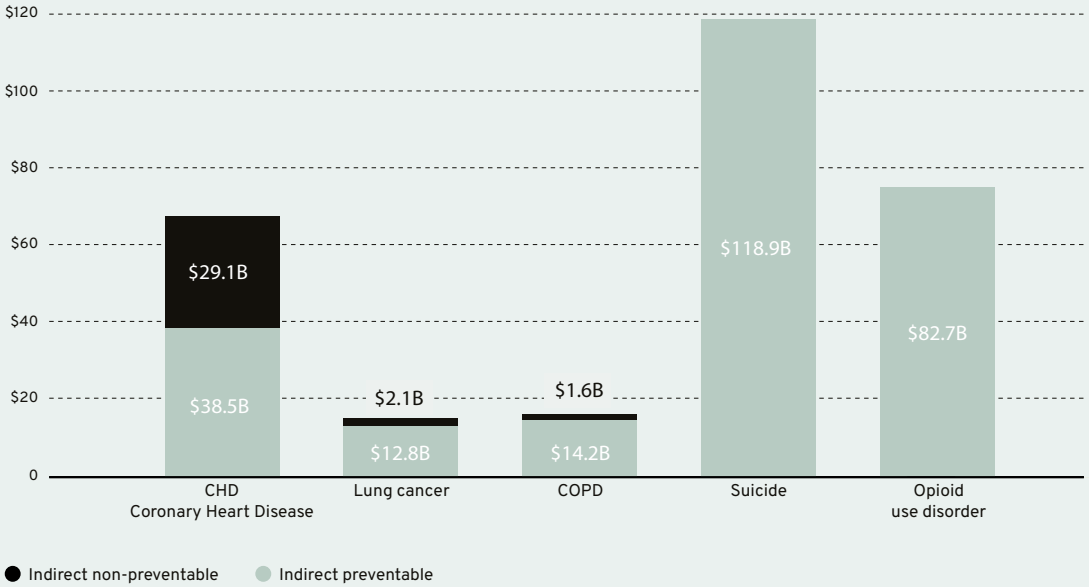


Figure 15. **INDIRECT COSTS (IN BILLIONS USD) OF TOP FIVE CAUSES OF MEN'S AVOIDABLE MORTALITY IN THE US, 2023**



Source: Schieb LJ, Greer SA, Ritchey MD, George MG, Casper ML. Vital signs: avoidable deaths from heart disease, stroke, and hypertensive disease—United States, 2001–2010. MMWR Morb Mortal Wkly Rep. 2013;62(35):721-727; Institute for Health Metrics and Evaluation. Global burden of disease (GBD). Accessed August 22, 2025. https://www.healthdata.org/research-analysis/gbd; CCEMG – EPPI-Centre. Cost Converter. Accessed August 22, 2025. https://eppi.ioe.ac.uk/costconversion/.

Help-seeking and healthcare

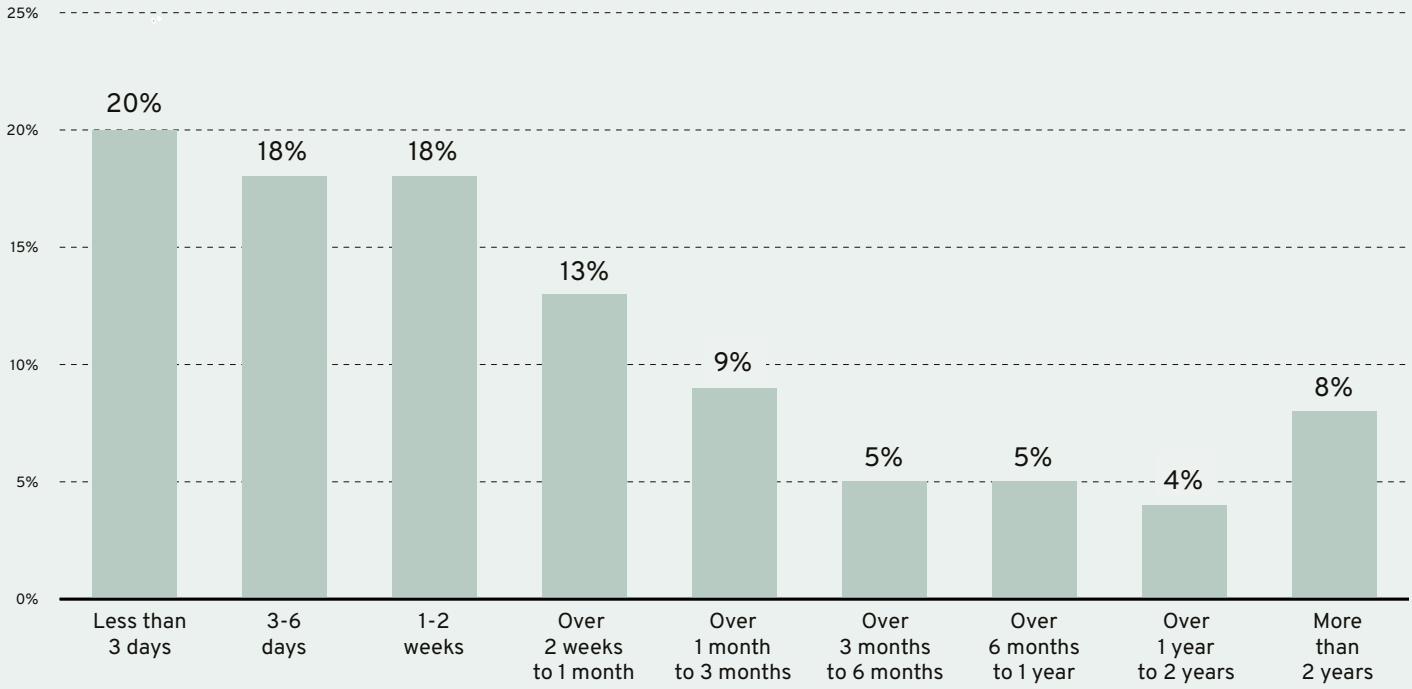
MEN HOLD A PARADOXICAL RELATIONSHIP WITH THE HEALTHCARE SYSTEM IN A FEW WAYS.

Clinicians and researchers once built health systems around a proposed "male norm," yet the sheer breadth of men's lived realities (shaped by race, class, sexuality, geography, disability, and age) as well as the role of gender norms and culture remained unexamined. This has resulted in a present-day paradox, whereby men can often be an "absent presence" when it comes to health: simultaneously everywhere in the data and nowhere in the solutions.[41] A health equity lens also reveals that health services rarely account for how different groups of men interpret symptoms, communicate distress, or decide whether a clinic is "for people like me." Nonetheless, formal health services are an obvious point of focus for strategies to improve men's health. Although health behaviors (smoking, diet, physical activity) and social drivers (income, education, neighborhood conditions) still drive most disease risk, engagement with healthcare remains a key lever and one we can modify with thoughtful interventions. Routine screenings, early diagnosis, timely behavioral counseling, and thoughtful, gender-sensitive care can save lives.

ACCORDING TO OUR NEW SURVEY, MEN'S HEALTHCARE DECISIONS ARE MORE SELF-DIRECTED THAN POPULAR NARRATIVES SUGGEST, YET OFTEN POSTPONED UNTIL PROBLEMS BECOME SEVERE.

In our survey, we investigated the experiences of men who had a healthcare encounter in the previous 12 months. In total, 62% of respondents had an annual physical in the past year, 32% saw a doctor for a new health issue, and 14% visited an emergency department. When asked what prompted their help-seeking, the vast majority relied on their own judgment (71%), while a partner's advice was pivotal for 26% and family input for 23% of men. These figures challenge the common assumption that men are largely indifferent to their health and depend on others' urging; instead, most say their decision to engage begins with their own appraisal of symptoms.One in five men acted immediately when symptoms began disrupting sleep or daily routines. Three in five men (62%) endured symptoms for more than six days before seeing a physician, nearly a third waited over a month, and 17% delayed care for six months or longer (Figure 16). These data underscore the need for outreach strategies that engage men proactively, further normalize help-seeking, make it easier for men to access quality care when they do reach out, and leverage trusted influencers in their lives.

Figure 16. **MEN'S REPORTED TIME BETWEEN EXPERIENCING SYMPTOMS AND APPROACHING THE HEALTHCARE SYSTEM**



Source: New data, Movember "Men's Experiences of Care and Connection" survey, 2025

62%

of men endured symptoms for more than six days before seeing a physician; nearly a third waited over a month, and 17% delayed care for six months or longer.

FINDINGS REVEAL MISSED OPPORTUNITIES AT EVERY TOUCHPOINT FOR HEALTHCARE PROVIDERS TO HOLD "GATEWAY CONVERSATIONS" WITH MEN.

Access to healthcare alone is not tantamount to achieving health. But each encounter with the formal healthcare system is nonetheless a critical "touchpoint" – a moment to build trust, tailor communication, and link men to ongoing support.[42] To ensure men get the timely care they need, and stop them from slipping through the cracks when they do, we need a health system that makes every contact count. This means going beyond treating symptoms to understanding the whole person.

Our current survey found that 52% of men agreed that "men's health needs aren't always taken seriously by the healthcare system." This common feeling of being in a foreign and unaccommodating environment can have dire long-term consequences on men's healthcare engagement.[43] Instead, regular, open conversations about a man's social life, emotional well-being, and relationships can uncover stressors driving poor health that ripple out to affect families and communities. These "gateway" conversations tell a man that he belongs and are a way to get the most out of each touchpoint, turning every clinic visit into an opportunity to spot emerging issues early, offer targeted support, and build trust so men feel safe sharing concerns that might otherwise go unspoken.

52%

of men agreed that "men's health needs aren't always taken seriously by the healthcare system."

Yet our survey shows that only 21% of men say their healthcare practitioner "always" asks about personal or social factors that could influence their health. While most say that this happens at least sometimes, nearly one in five men (18%) say that this happens "rarely" or "never." Without these deeper questions, practitioners miss chances to identify loneliness, relationship stress, violence, sexual dysfunction, and financial strain, among many other potential risk factors for poor mental health or chronic disease. Similarly, only 27% of men report that clinicians "always" inquire about health concerns beyond the immediate issue. Again, most men say that this happens at least sometimes, but gaps remain. American Indian and Alaska Native men face the highest rate of neglect, with 17% reporting that such questions are rare or absent, compared to 9% of non-Hispanic White men.

When practitioners do not ask gateway questions, they forgo critical prevention opportunities, moments that could connect men to mental health support, relationship counseling, or community resources. Training that equips practitioners to better engage with men's diverse experiences in practice by teaching how to overcome these barriers – using language and approaches that resonate with men – must become a priority. By making every healthcare encounter count, we can shift care from a narrow clinical focus to a broad, person-centered partnership that truly advances men's health.

A Closer Look

Movember's Men in Mind program

Movember's Men in Mind is a world-first, research-backed online training program for mental health professionals. It builds practitioners' understanding of the complexities of men's mental health and masculinities, and it provides practical skills to engage and motivate men in care.

Proven in a randomized controlled trial, the program improves practitioners' knowledge, confidence, and skills in supporting men, including those experiencing depression and suicidality. These improvements are sustained at 12 months, helping more men get the right support, stay engaged in care, and achieve improved mental health outcomes over time.[44]

IN ANOTHER PARADOX, AMERICAN MEN GIVE THE HEALTHCARE SYSTEM GLOWING REVIEWS IN OUR SURVEY, EVEN AS THEIR HEALTH OUTCOMES LAG AND THEY ROUTINELY POSTPONE CARE.

In our survey, 94% of men said they were at least somewhat satisfied with their healthcare interactions in the past year. When we limit only to those who were "very satisfied," we still find majorities among all identity groups and some 59% of all men reporting this satisfaction level. Satisfaction rose with age: just 55% of men ages 18 to 24 were very satisfied compared to 69% of those ages 65 to 69. Satisfaction varied by race and ethnicity, too. Non-Hispanic White men were most likely to be very satisfied (62%), while Hispanic/Latino (55%), South Asian (53%), East Asian (50%), and American Indian or Alaska Native men (53%) had somewhat lower rates.

This result points to yet another paradox: high satisfaction coexists with delayed help-seeking and poor health outcomes among men. Several data considerations help explain why many men leave clinics satisfied yet remain at heightened risk of preventable illness. Firstly, at a methodological level, a single satisfaction question may prompt respondents to focus on practitioner courtesy or demeanor, and responses can be skewed by social-desirability bias. Secondly, men tend to rate their quality of life higher than women do, even while facing greater disease burden and shorter life expectancy. A non-clinical parallel comes from Movember's recent study on online masculinity influencers: male viewers reported feeling more optimistic after watching this content, even as they also

Figure 17. **HEALTHCARE SATISFACTION RATES, PRESENCE OF A UNIVERSAL HEALTHCARE SYSTEM, AND LIFE EXPECTANCY**

	Men at least somewhat satisfied with healthcare (%)	Universal healthcare system (yes/no)	Men's life expectancy at birth (2023)
United States	94%	No	76
Australia	84%	Yes	81
Canada	79%	Yes	80
United Kingdom	76%	Yes	79

Source: For column 1: New data, Movember "Men's Experiences of Care and Connection" survey, 2025; for column 3: World Bank. Life expectancy at birth, male (years). Accessed August 22, 2025. https://data.worldbank.org/indicator/SP.DYN.LE00.MA.IN.

reported higher distress and risk-taking. Self-ratings, in short, can diverge sharply from objective risk.[45]

Political and economic context also matter. In the US, most healthcare visits involve direct or insurance-linked payments. Having paid, patients may unconsciously inflate perceived value to avoid buyer's remorse. The intentional, sometimes costly effort to seek care can make it uncomfortable to admit dissatisfaction. This effect is less common in countries with universal healthcare systems, where out-of-pocket costs are minimal and satisfaction scores tend to be lower (see Figure 17).[46] There, care is judged against whether public funds are well spent, not personal expenditure. As Figure 17 demonstrates, despite a lower life expectancy at birth and the absence of universal healthcare, men in the US paradoxically report higher satisfaction than men in the illustrative comparison countries.[47]

33%

of men report feeling a sense of stigma in engaging with health education as a man.

MEN RARELY FIND USEFUL HEALTH INFORMATION IN FORMAL HEALTHCARE SETTINGS – A KEY BARRIER TO IMPROVING HEALTH LITERACY.

While many men in our survey report positive experiences with healthcare engagement in general, far fewer say the same about finding and using health information to guide self-care or decide when to seek help. Nearly half (45%) agree that health information can be overwhelming, while 37% say it is confusing and 29% find reliable information hard to access. A full 37% feel that health information is not prioritized for men.

Personal and systemic barriers compound these challenges: 33% of men report feeling a sense of stigma in engaging with health education as a man, and 28% agree that resources are not tailored to their needs as members of a specific racial or ethnic group. The latter figure rises to 37% among Black men, the group most likely to hold this view. The youngest men face these barriers most acutely. Across all questions, men ages 18 to 24 (those often approaching adulthood's first major health decisions) are significantly more likely than older men to report these challenges. This includes being more likely than men overall to say resources are not tailored to their racial or ethnic identity.

These findings point to a clear opportunity: targeted, reliable, and culturally relevant health literacy resources (especially for young men) are essential to fostering early and lifelong habits of seeking, understanding, and acting on health information. Without such supports, independence and agency risk becoming liabilities rather than strengths in managing health.

A Closer Look

A new component of the health literacy landscape: AI-powered health information

Young men and boys are rapidly embracing artificial intelligence (AI) technology for health information, creating both opportunities and risks that demand our attention. A recent Movember study revealed that over 60% of US boys ages 12 to 17 now use ChatGPT, with 44% actively searching for physical health information online and 28% seeking mental health resources.[48] While Google remains their primary search platform (80%), AI tools like ChatGPT (24%) and Gemini (17%) are quickly gaining ground as trusted sources for health guidance alongside traditional online platforms like YouTube (38%).

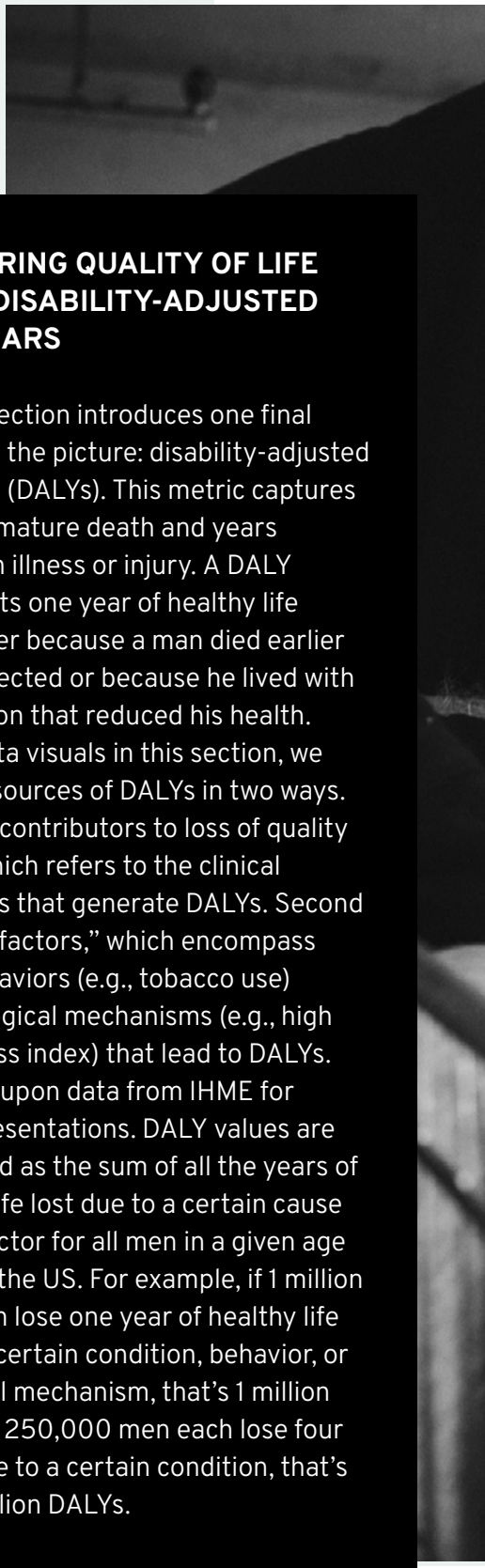
The concerning reality is that nearly three-quarters of participants (73%) express high confidence in their ability to detect fake health information online – a level of self-assurance that may not match their actual digital literacy skills. While it's encouraging that most would consult parents (67%) or verify information through multiple sources (55%) when uncertain, these data suggest a generation that increasingly turns to AI for health answers, with potentially misplaced confidence in their ability to discern quality health information. As AI becomes more sophisticated and persuasive, healthcare providers, educators, and parents must prioritize digital health literacy to ensure young men can navigate this new landscape safely while harnessing AI's genuine benefits for health education and support.

WHILE FORMAL HEALTHCARE IS NOT A PANACEA, SOLVING THE PARADOXES EXPLORED HERE IS A CRITICAL PIECE OF THE PUZZLE.

It is important to emphasize that an exclusive focus on "doctor visits" as the solution to all men's health issues risks implying their ill health is simply a result of individual behaviors and choices, disregarding the significant role of structural and systemic forces like work hours, social ties, neighborhood walkability, economic security, and many other factors in men's stress, diet, exercise level, and overall well-being. As these findings show, it is also not enough to simply exhort men to "seek help" – we must also interrogate the quality of help they access. Ultimately, the picture that emerges is not one of universal apathy or inevitability, but of misalignment. Men are showing up in the system, yet sometimes later than ideal, often reporting high satisfaction, yet with crucial dimensions of their lives and risks remaining unaddressed. Recognizing a paradox is the first step; the next steps are to treat every encounter as a gateway conversation, tailor outreach to the full diversity of men's experiences, build and disseminate culturally responsive health literacy resources, and transform momentary approval into sustained, life-lengthening outcomes for all men.

It is not enough to simply tell men to "seek help" - we must also interrogate the quality of help available to them and consider the role of structural forces like work hours, social ties, neighborhood walkability, economic security, and more.

Life course lens



IT IS ESSENTIAL TO EXPLORE MEN'S HEALTH BY RACE AND ETHNICITY AT ALL STAGES OF LIFE, NOT JUST OLD AGE.

When we talk about the burden of disease or death among men, the conversation often skews toward older men. But men's health is shaped over an entire lifetime. Good health is not just the absence of illness or the delaying of death; it is the ability to live well and thrive at every age. Becoming an adult man is not a single event, but a process shaped by experiences, opportunities, and exposures over time. A life course lens helps us see how these factors influence men differently at various stages of life.[49] In this report, we group men into three phases: adolescence and young adulthood (ages 15 to 34), middle years (ages 35 to 64), and older age (ages 65 and above), adding the intersecting lens of race and ethnicity at each life stage as well. Each stage comes with unique events and pressures – be they educational transitions, career and caregiving demands, or health challenges – that can have lasting impacts on well-being.

MEASURING QUALITY OF LIFE USING DISABILITY-ADJUSTED LIFE YEARS

This section introduces one final metric to the picture: disability-adjusted life years (DALYs). This metric captures both premature death and years lived with illness or injury. A DALY represents one year of healthy life lost, either because a man died earlier than expected or because he lived with a condition that reduced his health. In the data visuals in this section, we present sources of DALYs in two ways. First are contributors to loss of quality of life, which refers to the clinical outcomes that generate DALYs. Second are "risk factors," which encompass both behaviors (e.g., tobacco use) and biological mechanisms (e.g., high body mass index) that lead to DALYs. We draw upon data from IHME for these presentations. DALY values are presented as the sum of all the years of healthy life lost due to a certain cause or risk factor for all men in a given age group in the US. For example, if 1 million men each lose one year of healthy life due to a certain condition, behavior, or biological mechanism, that's 1 million DALYs. If 250,000 men each lose four years due to a certain condition, that's also 1 million DALYs.

Age 15-34 – Adolescence and Young Adulthood

This is the period when adulthood arrives. Men complete education or training, enter the workforce, form adult relationships, and in many cases, start families. It is also a stage marked by identity-building, greater independence, and for many, risk-taking in sports, social life, and other settings.[50] When serious health problems strike in these years, they can derail milestones that shape the rest of a man's life.

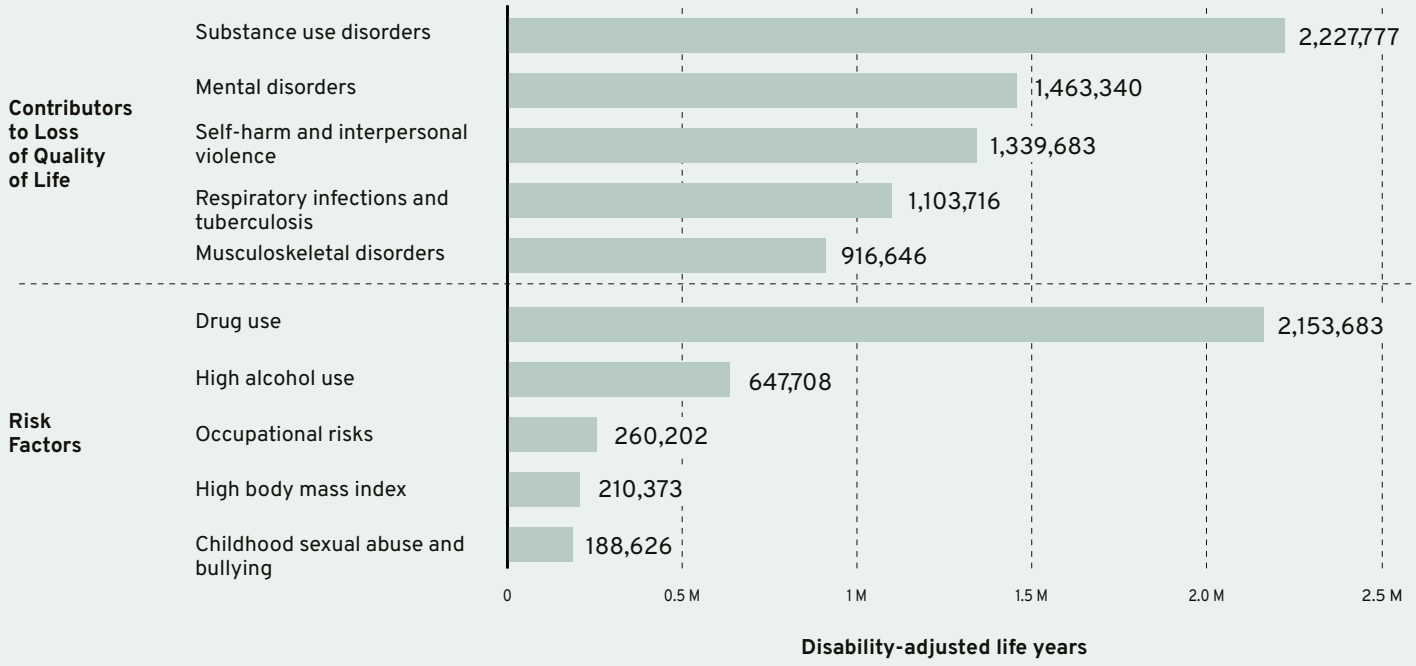
Continue ›

QUALITY OF LIFE (15-34)

For men ages 15 to 34, the biggest drains on healthy life are substance use disorders and mental health conditions. These problems can cut across education, work, and relationships, leaving lasting effects well beyond the initial crisis. The biggest DALY-generating risk factors for poor health in this stage are drug use and alcohol use, with drug-related loss of healthy years climbing sharply between the early 20s and early 30s. For men ages 15 to 24, a third major factor is childhood sexual abuse and bullying, showing how early-life trauma can reverberate into adulthood. By ages 25 to 34, occupational hazards – from dangerous job sites to shift work – emerge as a top contributor.

Gender gaps, though not shown in the graphic, are stark. Men ages 15 to 24 lose more than 3.5 times as many healthy years to self-harm and interpersonal violence as women of the same age. Among men ages 25 to 34, the gap remains over three times as high. Substance use also shows a large difference: young men lose about two-thirds more healthy years to substance use disorders than young women, a gap that widens to nearly three-quarters in the late 20s and early 30s.

Figure 18. **TOP FIVE LEADING CONTRIBUTORS TO LOSS OF QUALITY OF LIFE AND TOP FIVE RISK FACTORS AMONG US MEN AGES 15 TO 34, 2023**



Source: Institute for Health Metrics and Evaluation. GBD Results Tool. Accessed August 22, 2025. https://vizhub.healthdata.org/gbd-results?params=gbd-api-2021-permalink/f00675307147eadebba47c802810a2c6.

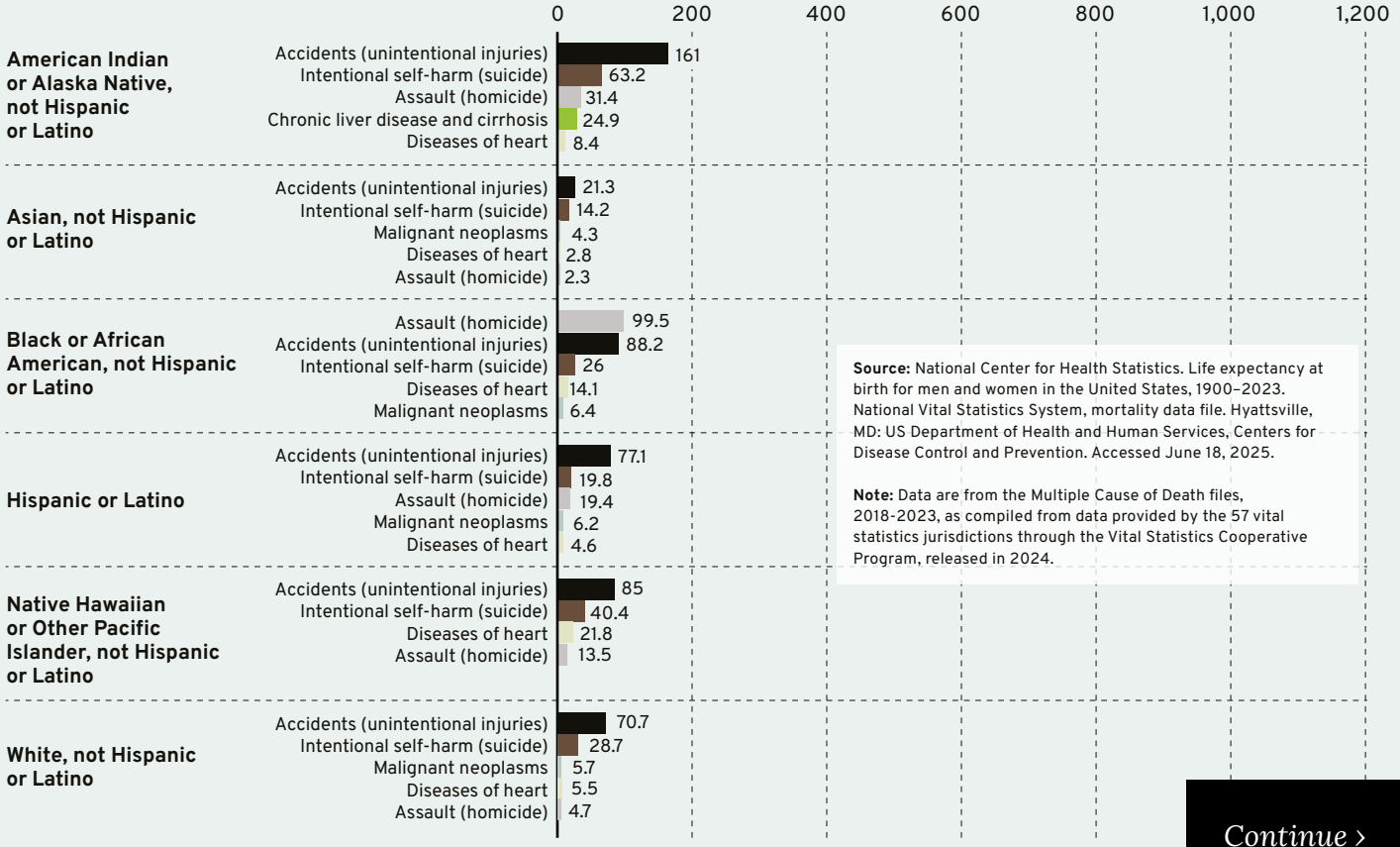
CAUSES OF DEATH (15-34)

Across most racial and ethnic groups, the same four threats dominate the top five causes of death for young men: accidents, suicide, heart disease, and homicide. Key findings include:

- **Accidents** lead for most groups – often tied to vehicle crashes, substance use, or dangerous work conditions.
- **Suicide** risk is especially high – for most racial and ethnic groups, suicide risk peaks during this life stage.
- **Cancer** appears in the top five for several groups – including Asian American, Black or African American, Hispanic or Latino, and White men.

These patterns show that young men's risks are shaped by both individual behavior and the systems and environments they live in. In some communities, structural racism and policy decisions have concentrated exposure to gun violence so severely that homicide now claims more young Black men's lives than any other cause. Addressing patterns like these requires prevention strategies as varied as the threats themselves – ranging from violence reduction and community safety initiatives to workplace protections and mental health supports.

Figure 19. **LEADING CAUSES OF DEATH AMONG US MEN AGES 15 TO 34 BY RACE OR ETHNICITY, 2023**



Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

Continue ›

Age 35-64 – Men in Their Middle Years

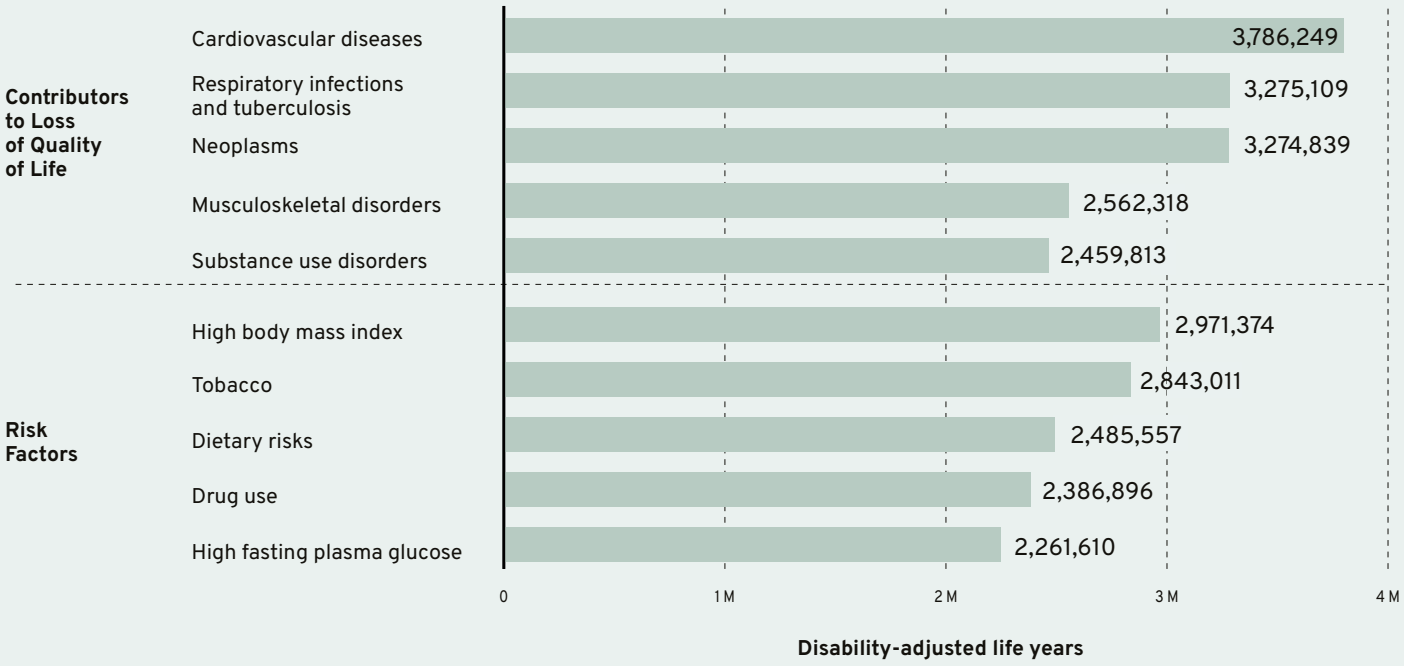
During their middle years, although individual experiences differ, many men define themselves by how well they fulfill roles such as provider, father, partner, worker, and community member.[51]

Research with men in midlife has shown that they often define their value through the physicality of their work or the income it provides.[52] Studies also find that between ages 35 and 64, men may tend to emphasize and idealize traits such as toughness (e.g., physical strength, denying pain),[53] positive character (e.g., commitment, self-control, hard work, achievement),[54] and power. Yet this stage of life is about more than roles or traits alone: it spans the majority of adulthood, when many men are raising children, navigating long-term relationships, building careers, managing financial responsibilities, and encountering the first signs of aging. It is a period of profound responsibility, change, and growth that leaves a lasting imprint on health and identity.

QUALITY OF LIFE (35-64)

In the first half of their middle years (ages 35 to 44), men lose more healthy years to substance use disorders than to any other cause. Drug and alcohol use drive much of this toll, with the absolute gap between men's and women's drug-related DALYs peaking in this decade – over 413,000 more healthy years lost for men than women. Alcohol-related loss is also at its highest here, with men losing more than 150% as many healthy years as women. From the mid-40s onward, the picture shifts. For men ages 45 to 54 and 55 to 64, cardiovascular disease becomes the top drain on healthy life, with cancer close behind. By the late 50s and early 60s, the overall gender gap in DALYs reaches its widest point in adulthood. In these years, high body mass index, poor diet, and tobacco use are major risk factors; tobacco alone accounts for over 737,000 more healthy years lost for men than for women in this age group. Alcohol use remains a persistent driver, with the largest gender gap in alcohol-related DALYs of any life stage.

Figure 20. **TOP FIVE LEADING CONTRIBUTORS TO LOSS OF QUALITY OF LIFE AND TOP FIVE RISK FACTORS AMONG US MEN AGES 35 TO 64, 2023**



Source: Institute for Health Metrics and Evaluation. GBD Results Tool. Accessed August 22, 2025. https://vizhub.healthdata.org/gbd-results?params=gbd-api-2021-permalink/f00675307147eadebba47c802810a2c6.

Continue ›

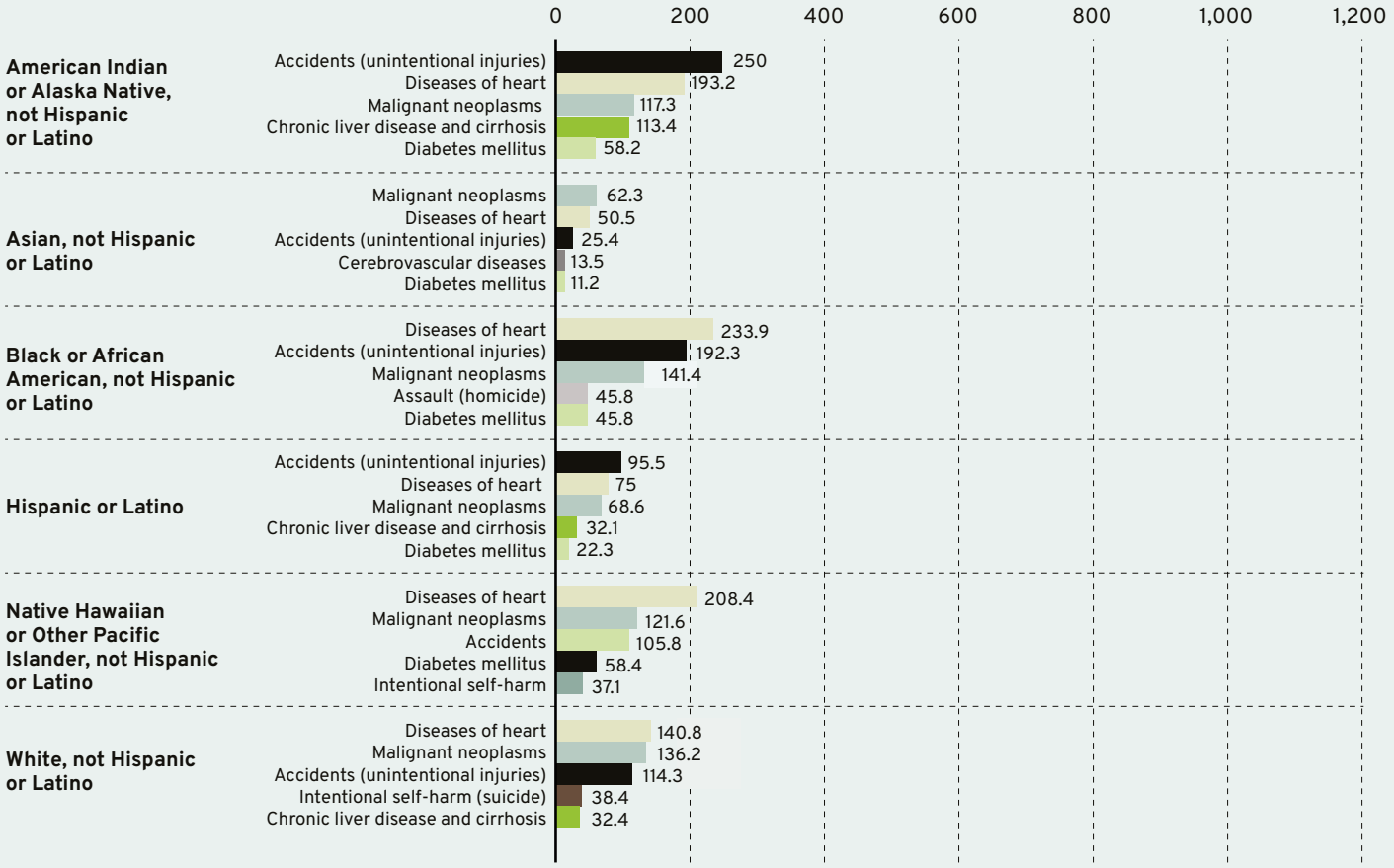
CAUSES OF DEATH (35-64)

Across all racial and ethnic groups of men in their middle years, accidents, heart disease, and cancer appear among the top five causes of death. But the rankings and patterns vary in important ways:

- **Diabetes** is a leading cause of death for every group except White men.
- **Chronic liver disease and cirrhosis** is a top-five killer for American Indian and Alaska Native, Hispanic or Latino, and White men – and for American Indian and Alaska Native men, it is a crisis-level threat. They are the only group for which liver disease ranks in the top five for every 10-year age band from 35 to 64, and their death rates are at least twice as high as the next-closest group.
- **Suicide** is among the top five causes for Native Hawaiian or Other Pacific Islander men and for White men.
- For Black men ages 55 to 64, **heart disease** deaths (453.6 per 100,000) are higher than for any other group in any decade of the middle years – underscoring a severe disparity in cardiovascular health outcomes.
- Among White men approaching retirement (ages 55 to 64), **cancer and heart disease** dominate the rankings, each far exceeding the combined death rates of the next three causes.

These patterns make clear that middle-aged men face a shifting mix of threats – some rooted in long-term lifestyle and health exposures, others in persistent inequities in care, work environments, and public health interventions. Tackling them requires not only better treatment but also aggressive prevention strategies: cardiovascular screening and management, targeted substance use interventions, culturally specific diabetes and liver disease prevention programs, and workplace safety measures.

Figure 21. **LEADING CAUSES OF DEATH AMONG US MEN AGES 35 TO 64 BY RACE OR ETHNICITY, 2023**



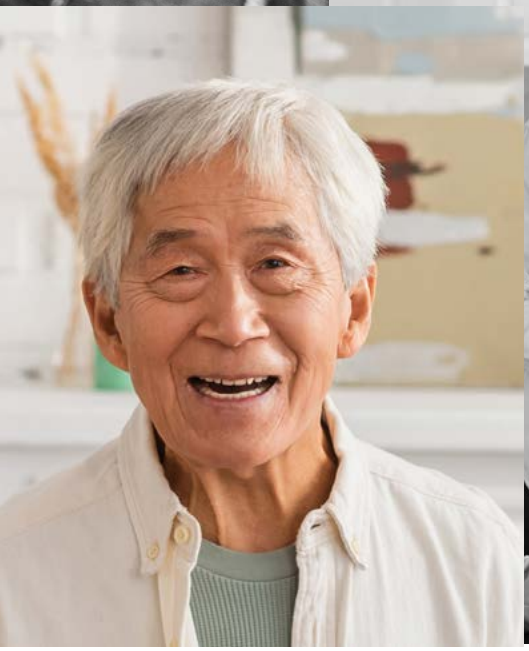
Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

Continue ›

Age 65+ – Older Men

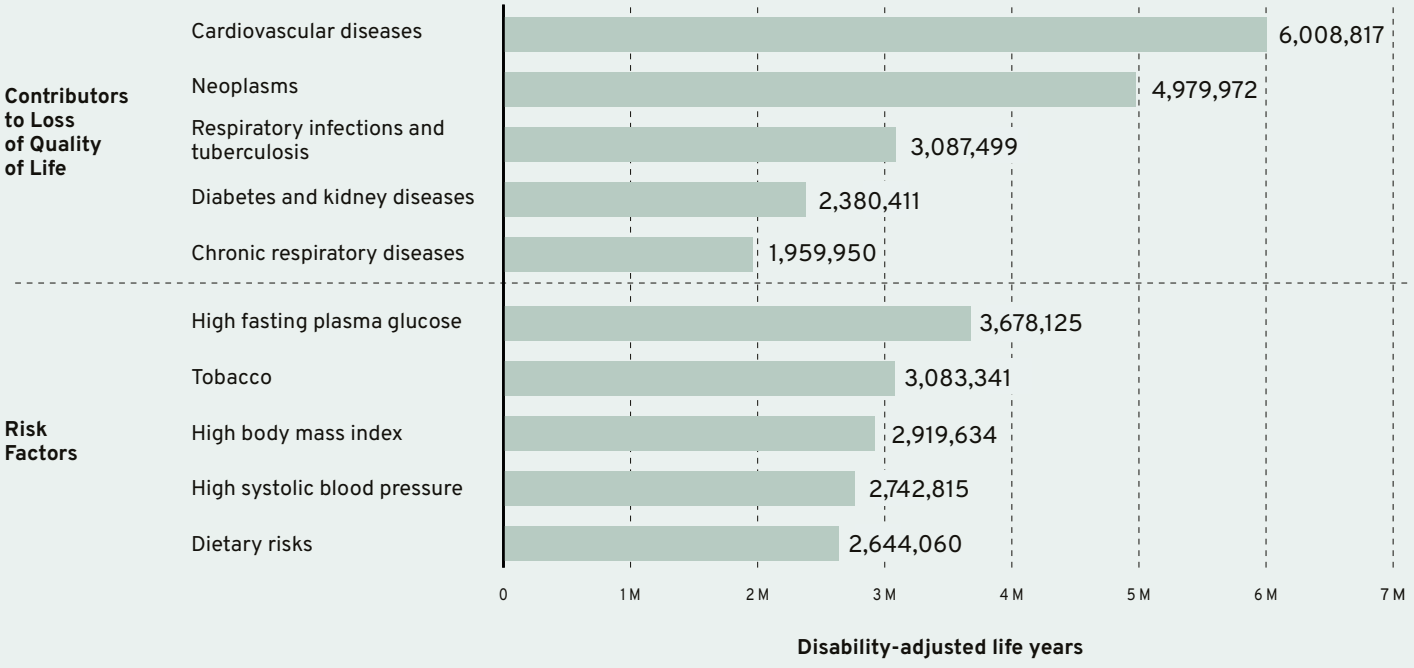
For men 65 and older, health is about more than just living longer – it's about staying strong enough to remain active in families, communities, and the pursuits that matter most.[55] Many still value physical capability and independence, and for those who are able or choose to retire, this stage can be a marker of having fulfilled responsibilities and earned the freedom to focus on passions beyond work.[56]



QUALITY OF LIFE (65+)

The biggest drains on healthy life in these years are cardiovascular disease and cancer, just as in the middle years. Among men ages 65 to 74, high blood sugar and tobacco use are the largest risk factors linked to quality-of-life loss. For those 75 and older, high blood sugar, high blood pressure, and high body mass index dominate the list. Even past retirement age, certain disparities remain sharp: older men lose far more healthy years to occupational risks and alcohol use than women of the same age (187% and 67% more, respectively), showing that lifetime exposures and habits continue to shape well-being well into later life.

Figure 22. **TOP FIVE LEADING CONTRIBUTORS TO LOSS OF QUALITY OF LIFE AND TOP FIVE RISK FACTORS AMONG US MEN AGES 65 AND OLDER, 2023**



Source: Institute for Health Metrics and Evaluation. GBD Results Tool. Accessed August 22, 2025. https://vizhub.healthdata.org/gbd-results?params=gbd-api-2021-permalink/f00675307147eadebba47c802810a2c6.

Continue ›

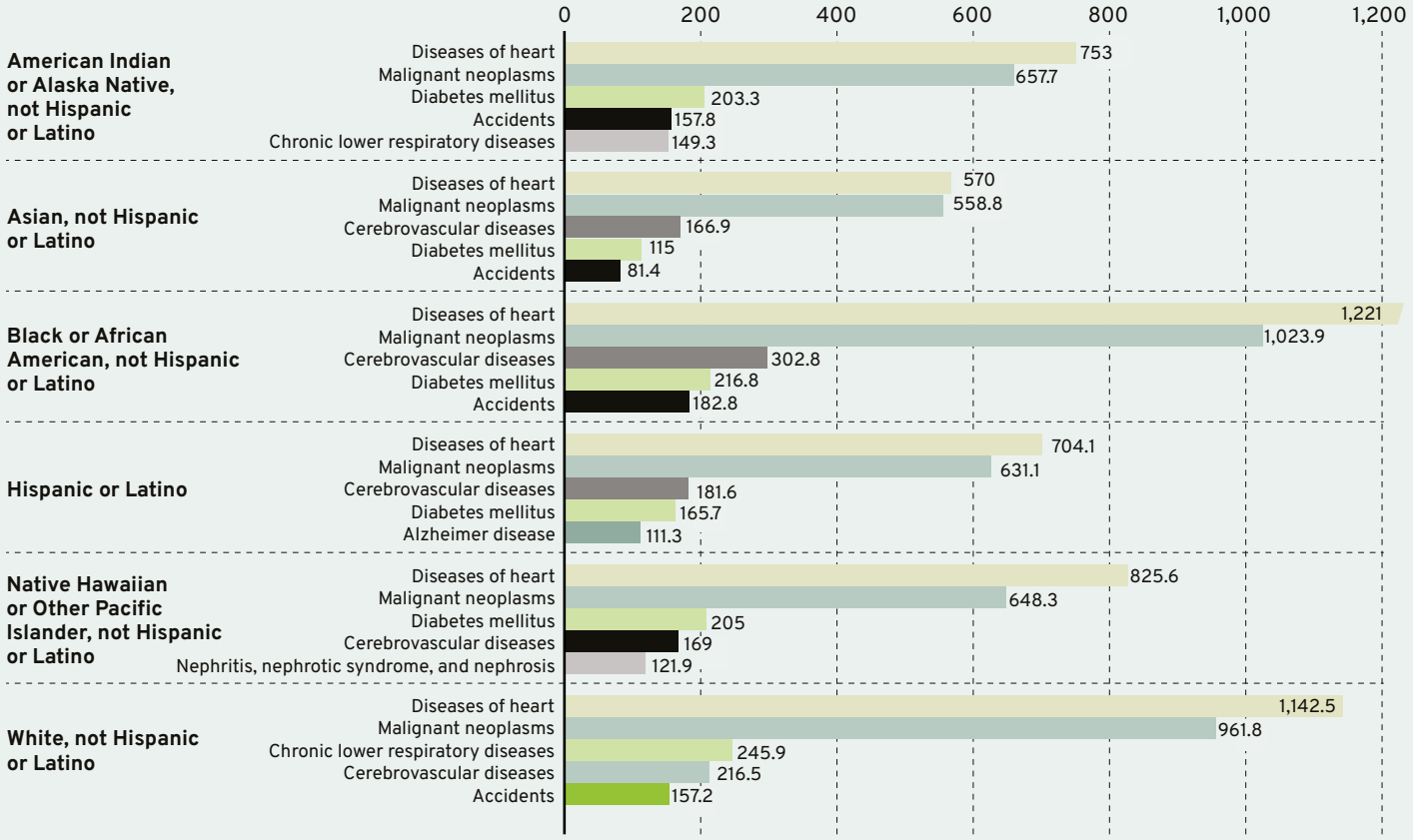
CAUSES OF DEATH (65+)

Mortality rates peak in this stage of life, and the patterns are remarkably consistent: for all racial and ethnic groups of older men, heart disease is the leading cause of death, followed by cancer. For older White men, suicide rates spike in later years and firearms become a far more common suicide method. For every group, heart disease and cancer combined far exceed the toll of all other leading causes. Beyond these two, the rankings vary:

- **Diabetes** is a top-five cause for all but White men.
- **Stroke** (cerebrovascular disease) is in the top five for all but American Indian and Alaska Native men.
- **Accidents** remain a leading cause for most groups, except Hispanic or Latino men and Native Hawaiian or Other Pacific Islander men, often reflecting falls, transportation incidents, or other unintentional injuries.

This phase of life underscores the long reach of earlier risks: habits and exposures built over decades shape the late-life burden of disease. Efforts to improve older men's health must pair strong clinical care with prevention and management strategies: aggressive cardiovascular and cancer screening, better diabetes and blood pressure control, fall prevention programs, and targeted supports for those with a history of high occupational or alcohol-related risk.

Figure 23. **LEADING CAUSES OF DEATH AMONG US MEN AGES 65 AND OLDER BY RACE OR ETHNICITY, 2023**



Source: National Center for Health Statistics. Life expectancy at birth for men and women in the United States, 1900–2023. National Vital Statistics System, mortality data file. Hyattsville, MD: US Department of Health and Human Services, Centers for Disease Control and Prevention. Accessed June 18, 2025.

Note: Data are from the Multiple Cause of Death files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, released in 2024.

Chapter

03

The Unexpected Faces of Men's Health

CAREGIVERS OF MEN NEED SUPPORT

Men's health is everyone's business.

Men's health doesn't merely exist in the body of a man. When men are unwell, the effects ripple outward to partners, children, relatives, friends, coworkers, and communities. Likewise, when any member of a family or community is thriving, the positives manifest outwardly as well. That's because health is social: how we cope, communicate, and seek care can either lighten or increase the load others carry.

Those ripples are clearest at home. A father's physical and mental health shapes children's development and habits, from nutrition to emotional well-being.[57] Paternal depression, for example, is associated with a significantly higher risk of depression in children.[58] Partners also feel the burden. Serious conditions such as prostate cancer can strain intimacy and trigger uncertainty, anxiety, and depression for those who love and care for a man.[59]

Coping behaviors can compound the harm. When distress turns into gambling or heavy alcohol use, family finances, safety, and relationships can be collateral damage.[60] And when illness or disability limits a man's ability to pitch in, then care work shifts even more heavily onto others.[61] In the hardest moments, after a death, the emotional and financial shocks to surviving family and friends can be profound and long-lasting.[62]

THIS IS WHY FOCUSING ON INFORMAL CAREGIVERS, WHETHER SPOUSES, SIBLINGS, ADULT CHILDREN, OR FRIENDS WHO PROVIDE UNPAID SUPPORT, IS ESSENTIAL.

These caregivers perform tasks ranging from scheduling and attending medical appointments to helping with personal hygiene, wound care, and emotional support. They are the unexpected faces of men's health, delivering critical day-to-day care that keeps households functioning. Yet while they are essential to men's health journeys, caregivers often navigate a system that is fragmented, under-resourced, and unprepared for their needs. And their capacity to care depends on their own health, time, and resources, and on whether the men they support can share the load.

In this section, we map out the challenges men's caregivers face, the financial and logistical burdens they shoulder, and the rewards and personal growth that can also emerge when care is given and received with compassion. This chapter offers world-first data from Movember's 2025 "Healthy Men, Healthy World" survey of 2,109 informal caregivers of men across the United States. Built into this research, we invited participants to share their experiences in their own words, which have been woven throughout this chapter to bring caregivers' voices to life.

CAREGIVING TAKES A SIGNIFICANT EMOTIONAL TOLL, OFTEN LEAVING CAREGIVERS IN OUR STUDY OVERWHELMED AND ANXIOUS.

In our survey, more than three-quarters of informal caregivers agreed that the man they care for needs a broader emotional support network, and nearly three in five say they "often feel like an unpaid emotional therapist" for him.

As a result, 44% of caregivers report that their own mental health has declined due to caregiving duties, with 30% also noting negative impacts on their physical well-being.

"

It is an overwhelming issue and it has taken time to adjust and manage the stress and enormity of it.

"

—WOMAN, AGE 59, CAREGIVER FOR SPOUSE (AGE 55 TO 64) WITH A MEN'S CANCER

"

[There is] worry and anxiety always in my mind.

"

—MAN, AGE 48, CAREGIVER FOR FATHER (AGE 65 TO 74) WITH A MEN'S CANCER, TYPE 2 DIABETES, HEART DISEASE, LIVER DISEASE, ADDICTION OR SUBSTANCE USE DISORDER, AND DEPRESSION

48%

OF CAREGIVERS REPORT DECREASED ENERGY LEVELS

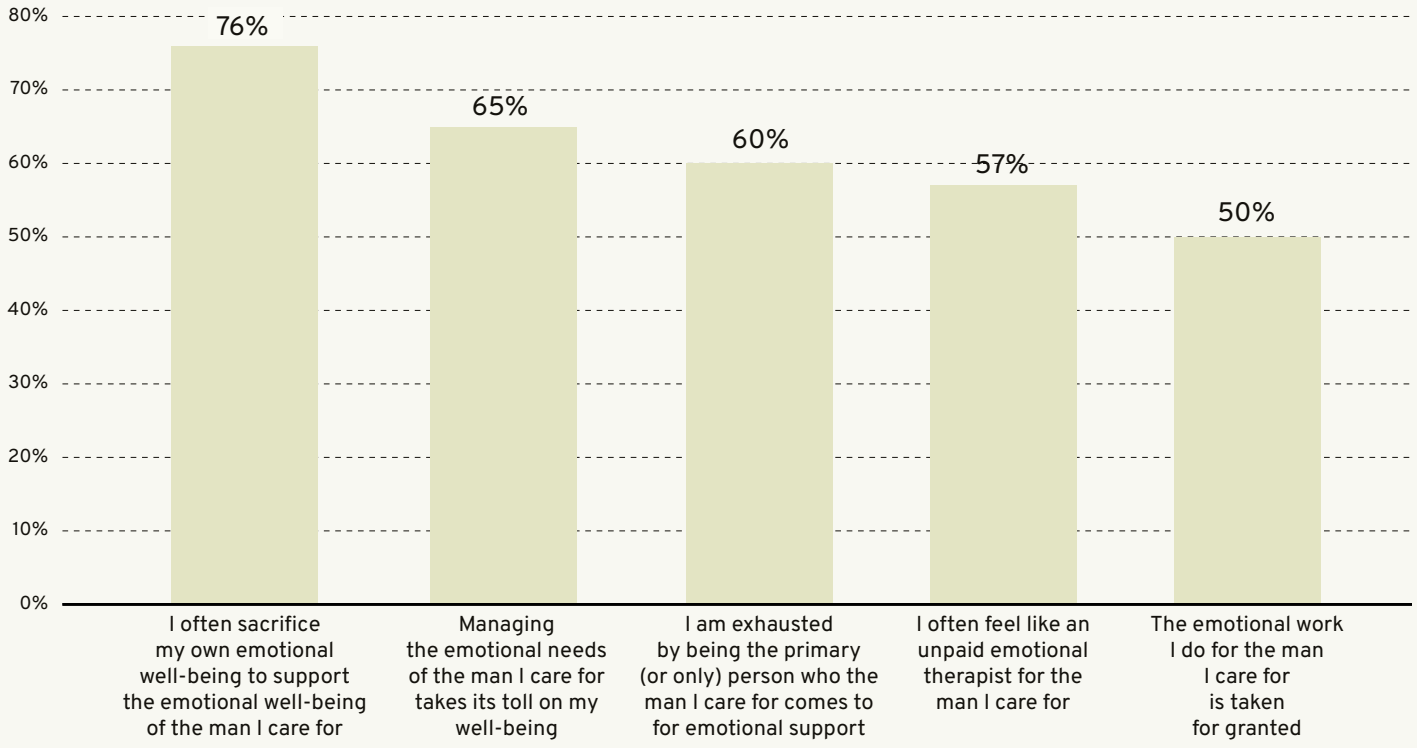
50%

SAY THEIR PERSONAL TIME SUFFERS

37%

NOTE A TOLL ON THEIR SOCIAL LIFE, UNDERSCORING HOW EMOTIONAL LABOR SEEPS INTO EVERY CORNER OF THEIR LIVES.

Figure 24. **PERCENTAGE OF CAREGIVERS WHO AGREE WITH STATEMENTS ON THE EMOTIONAL ASPECTS OF CAREGIVING**



Source: New data, Movember "Healthy Men, Healthy World" survey, 2025

“

I underestimated how isolating the experience would feel, and how little outside support there would be, even from family members I thought would share the responsibility. I also didn’t expect how much I would have to become an advocate – dealing with confusing healthcare systems, insurance paperwork, and coordinating care among professionals. It often felt like a second full-time job, but with no training, no pay, and no days off.

”

—WOMAN, AGE 39, CAREGIVER FOR SPOUSE (AGE 35 TO 44) WITH ADDICTION OR SUBSTANCE USE ISSUES

CAREGIVERS IN OUR STUDY SPEND A SIGNIFICANT AMOUNT OF TIME COORDINATING CARE ACROSS OFTEN-FRAGMENTED SERVICES.

Our average survey respondent reported spending six to 10 hours per week on tasks like scheduling medical visits, arranging transportation, and following up with providers, with many logging upwards of 24 hours weekly. This burden falls heavily on caregivers, who become de facto care coordinators, and for some, the work feels endless.

Administrative hurdles multiply when visits must be scheduled with multiple specialists, insurance authorizations are laborious, or transportation is unreliable.

38%

SAY THAT THEIR FINANCES HAVE SUFFERED BECAUSE OF CAREGIVING

42%

HAVE ADJUSTED THEIR JOBS TO ACCOMMODATE CARE RESPONSIBILITIES

67%

HAVE TAKEN TIME OFF IN THE PAST YEAR TO MEET THOSE DEMANDS.

"I spend a lot of time arranging appointments ... for example one provider being unavailable and having to find another one ... also the need to travel to see some of these people."

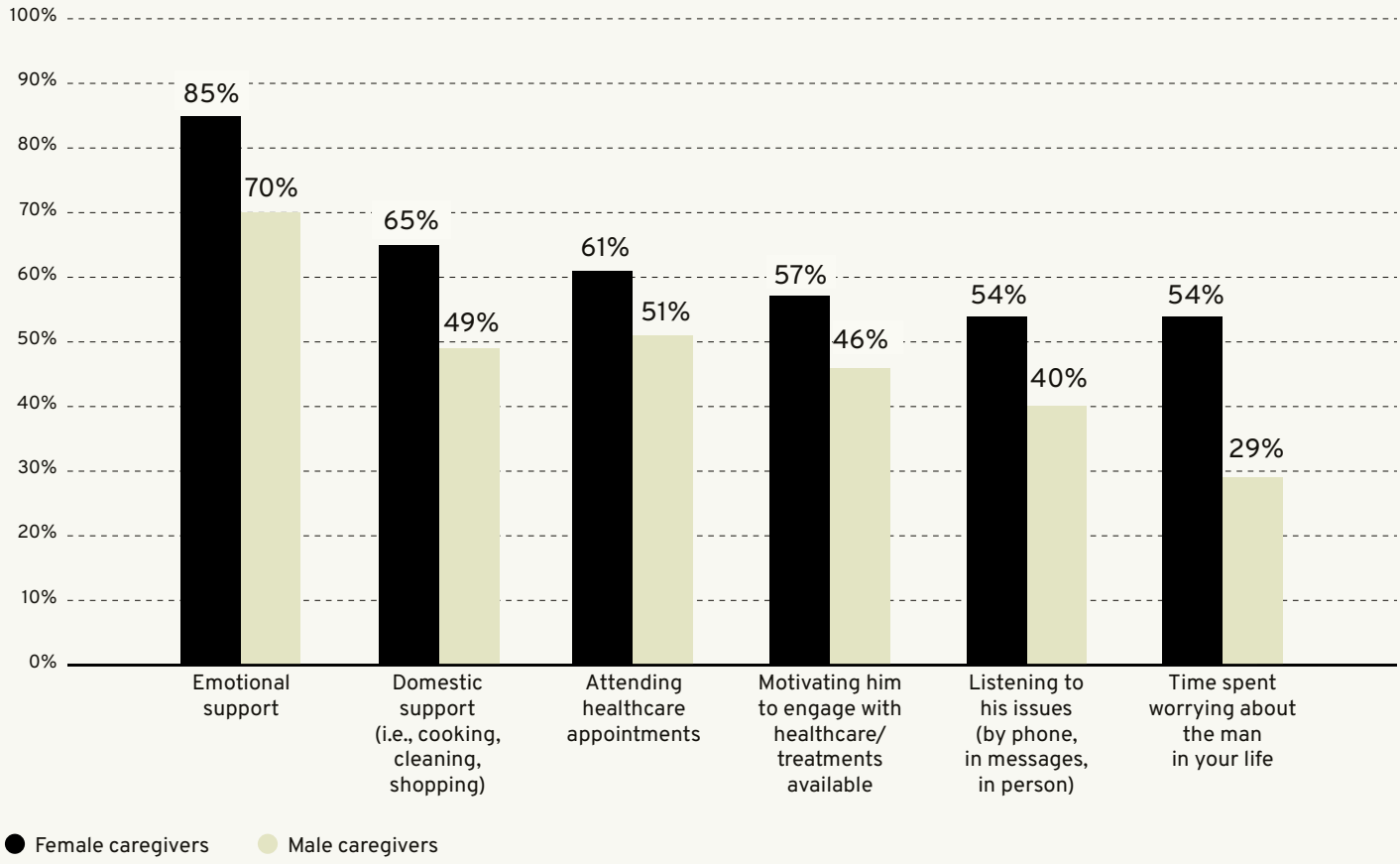
—WOMAN, AGE 54, CAREGIVER FOR SPOUSE (AGE 55 TO 64) WITH HEART DISEASE AND SLEEP APNEA

CARE TAKES DIFFERENT FORMS DEPENDING ON WHO'S DOING IT.

Our dataset speaks to the experiences of 1,290 women (61% of the sample) and 818 men, all of whom are actively engaged in the vital work of informal caregiving for a man in their life. Further investigation revealed, however, that the shape, nature, and impact of informal care work fall differently upon women than men. When asked to enumerate the types of care they provide, women were significantly more likely to report six forms of care work than men, as presented in Figure 25. These forms of care are not mutually exclusive, suggesting that women caregivers are often engaged in more forms of care when they are called upon to play a caregiver role.

The data also reveal that women devote more hours and generally support younger or mid-life men, while male caregivers spend slightly less time and tend to look after older men (see Figure 27 and Figure 28).

Figure 25. **PERCENTAGE OF CAREGIVERS WHO SAY THEY PROVIDE SPECIFIC FORMS OF CARE**



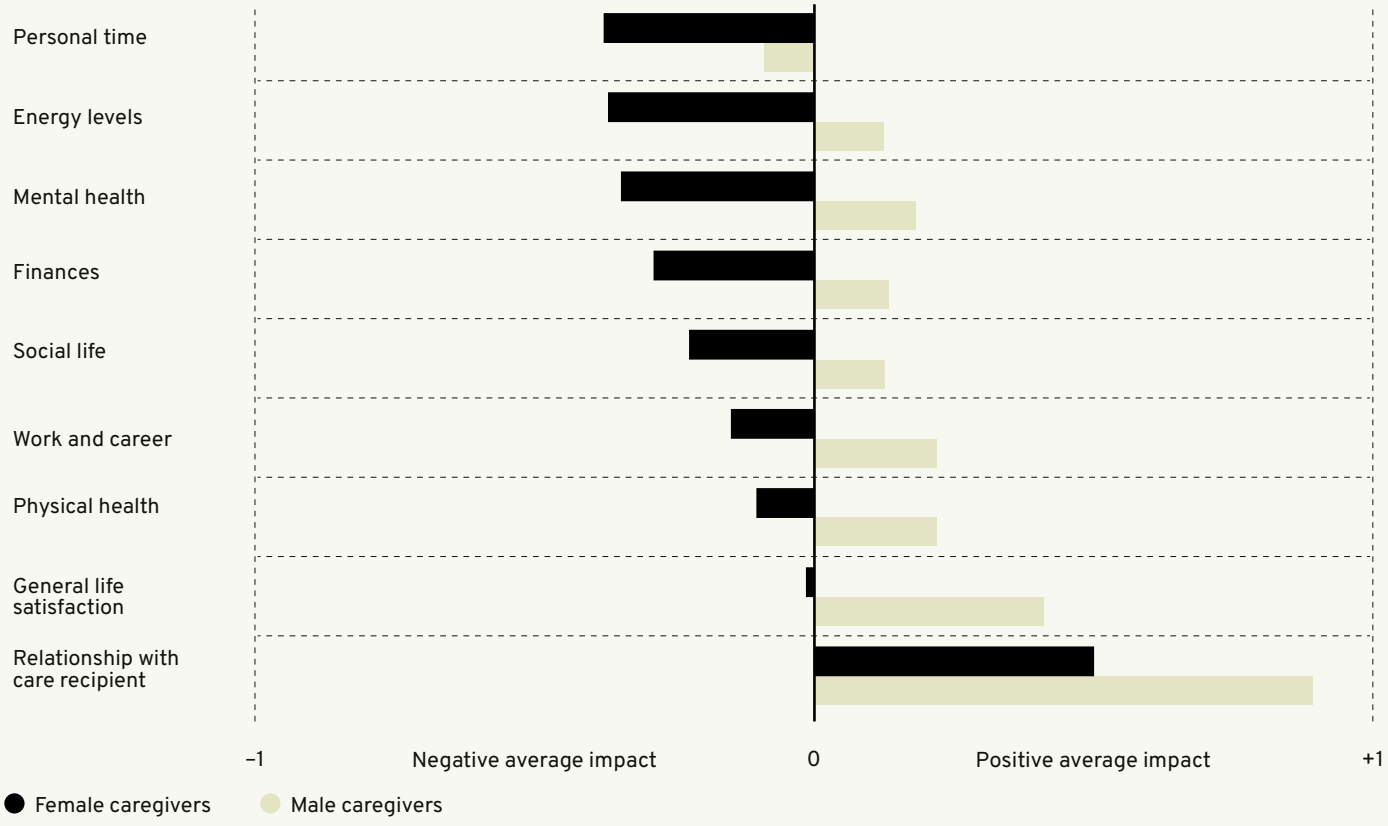
Source: New data, Movember "Healthy Men, Healthy World" survey, 2025

FOR WOMEN CAREGIVERS OF MEN, THE TOLL OF CAREGIVING IS IMMENSE.

Figure 26 presents the results of survey items exploring the broad impacts of caregiving responsibility on nine domains of the respondents' lives. When averaged as a group, the women caregivers show net negative effects in eight of the nine: personal time, energy levels, mental health, finances, social life, career, physical health, and general life satisfaction. By contrast, men caregivers as a whole show a net positive experience in all domains apart from personal time.

These findings paint a sobering picture of caregiving's impacts. Women in our study not only shoulder more hours of care, often for partners or relatives still in the thick of work and family life, but they also absorb a broad, cumulative loss: less personal time, drained energy, strained mental and physical health, hits to income and career, and more. These findings speak to an erosion of their own well-being even as they keep men in their lives afloat. Male caregivers, in the aggregate, typically step in later, tending to older men and reporting mostly positive returns.

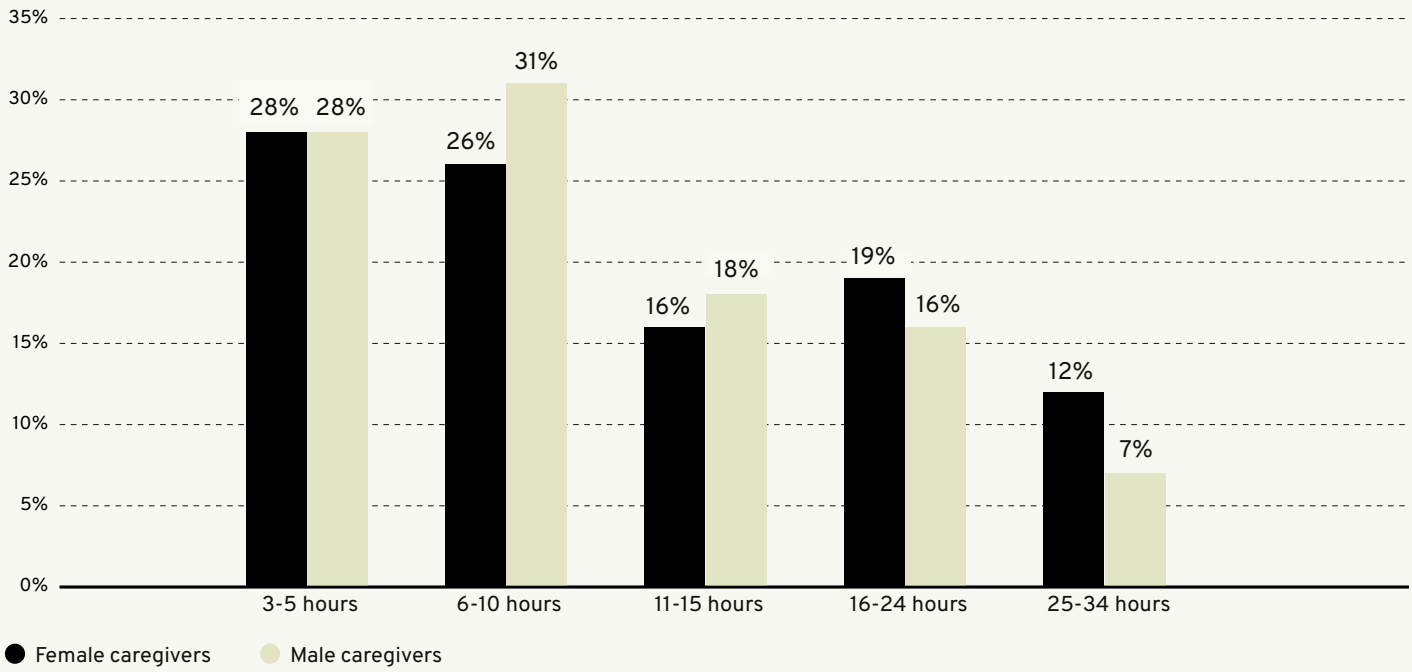
Figure 26. **CAREGIVERS' REPORTING ON HOW THIS RESPONSIBILITY HAS AFFECTED NINE AREAS OF THEIR LIVES**



Source: New data, Movember "Healthy Men, Healthy World" survey, 2025

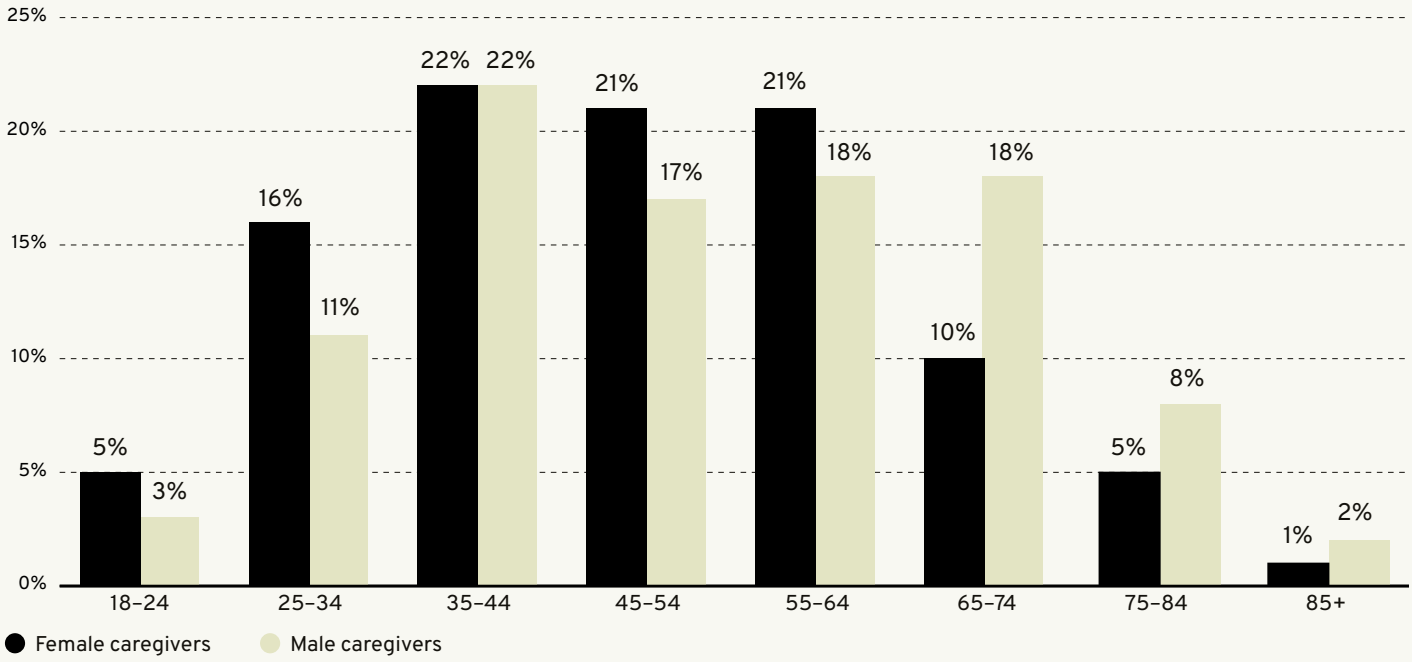
Note: This figure presents average responses among all surveyed male and female caregivers on the scale: large negative impact (-2), small negative impact (-1), no impact (0), small positive impact (+1), large positive impact (+2). Negative numbers in the figure represent a net negative impact, and vice versa.

Figure 27. **HOURS PER WEEK CAREGIVERS REPORT PROVIDING CARE**



Source: New data, Movember "Healthy Men, Healthy World" survey, 2025

Figure 28. **AGE OF THE MAN FOR WHOM CAREGIVERS PROVIDE CARE**



Source: New data, Movember "Healthy Men, Healthy World" survey, 2025

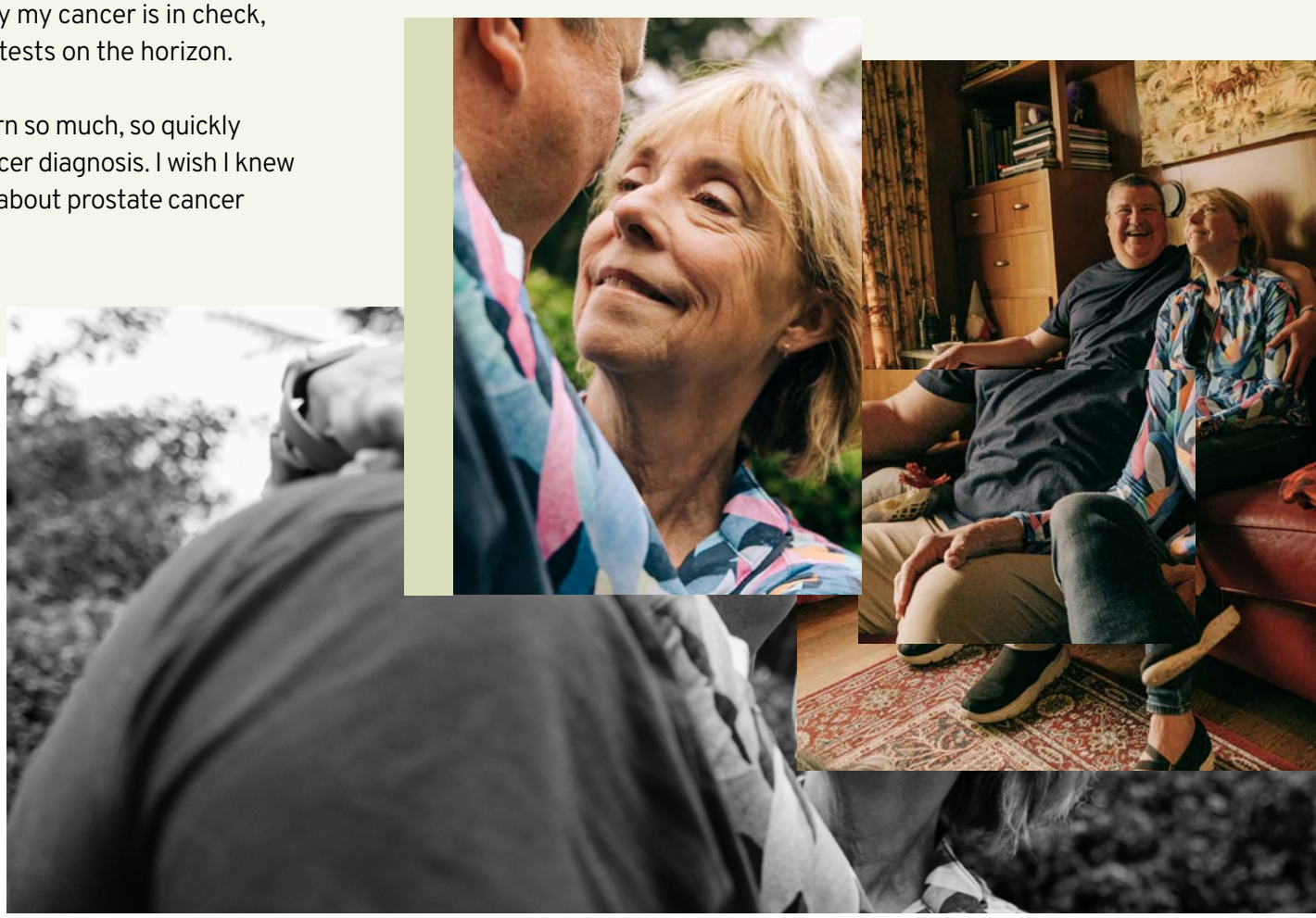
Real Stories

Mike's Story

My name is Mike Scott, and I've spent the last few years fighting prostate cancer alongside my greatest teammate, my wife Laurie. We first heard the words "you have prostate cancer" on November 3, 2021 at 4:30 pm. Four minutes later I retired from work to focus on my health. Since then I have had appointments, tests, scans, surgery, radiation and hormone deprivation shots. As of spring 2025, my doctors say my cancer is in check, with more tests on the horizon.

You learn so much, so quickly after a cancer diagnosis. I wish I knew the basics about prostate cancer risk sooner. Prostate cancer is the second most common cancer in men worldwide and even though risk rises with age, it is not only an older man's disease. Men of African ancestry and those with a father or brother who have had prostate cancer face a two and a half times greater chance of developing it. A simple PSA blood test can measure your prostate-specific antigen level. If you are fifty you should ask your doctor about it. If you are African American or have a close family history, start that conversation at forty-five.

The hardest part of this journey has been seeing how much Laurie carries for both of us. As I told her, what she's doing for me, I need to make sure that I'm doing that and so



much more for her. I can't imagine life without her. We've faced questions about where our lives will take us, and the answer has been clear: we journey together. But the battle for her is much more difficult than it is for me. She is the one sitting in the waiting room when I go in for surgery, the one who has to pat me on the back and say, "Hey Mike, this is going to be good." My health is her health, and her health is my health. I didn't expect to be sitting here at sixty-eight years old having cancer, but I'm not going to wish away the life I have now.

Through every step, Laurie has been my rock. She waits in clinic corridors, holds my hand when radiation leaves me worn down and reminds me that our fight is a shared one. My mustache came back as a small sign of normalcy after my diagnosis, a daily reminder that I am not fighting alone. The Movember community's wisdom and good cheer travel with me.

If you have a dad, brother, partner, friend or neighbor, ask how they are doing, encourage regular checkups and remind them that early detection saves lives. When one of us is well, the whole community is stronger.

DESPITE ITS DEMANDS, CAREGIVING OFTEN BRINGS CAREGIVERS AND CARE RECIPIENTS CLOSER TOGETHER, FOSTERING RESILIENCE, EMPATHY, AND SHARED PURPOSE.

Amid the many trade-offs of caregiving, one bright thread runs through the data: the caregiver–recipient bond consistently grows stronger. Caregivers describe richer time together, clearer communication, and a deeper grasp of each other's needs. As shown in Figure 26, both women and men mark "relationship with [the] care recipient" as a net gain. In other words, while caregiving can drain energy, strain finances, or crowd out personal time, it simultaneously forges a more resilient, mutually appreciative relationship.

"

Being a caregiver fosters deep connections, personal growth, and a sense of purpose. It's rewarding to make a tangible difference in someone's life, creating moments of gratitude and love.

"

—MAN, AGE 45, CAREGIVER FOR SPOUSE (AGE 45 TO 54) WITH DIABETES AND SLEEP APNEA

“

I have found that I am a stronger person than I thought. I’ve also learned that I can do a lot more than I thought. … We work at it every day and it has really made a difference.

”

—WOMAN, AGE 47, CAREGIVER FOR MAN (AGE 55 TO 64) WITH ADDICTION OR SUBSTANCE USE DISORDER

Many describe a newfound resilience, a sense that they can “do a lot more than I thought,” and a powerful bond of shared purpose. Small victories – everything from helping a father stand without assistance to sharing a laugh over a difficult day – become moments of profound connection. Caregiving teaches patience, emotional strength, and gratitude for moments that might otherwise go unnoticed. These positive elements fuel motivation to persevere and serve as a reminder that caregiving can be both humbling and empowering.

This section underscores how critical it is to bring attention to the people who quietly hold men’s health journeys together and seek to reduce the overwhelming burden many feel. In doing so, we honor their labor, enhance the quality of care, and move closer to a system where informal and formal care work hand in hand to help every man thrive.

OUR SURVEY FOUND MANY POSITIVE REFLECTIONS ON RELATIONSHIP IMPACTS:

84%

AGREED CAREGIVING LED TO MORE QUALITY TIME TOGETHER

84%

SAID IT BROUGHT THEM CLOSER

83%

FELT IT IMPROVED THEIR UNDERSTANDING OF EACH OTHER'S NEEDS

82%

NOTED BETTER COMMUNICATION

77%

EXPERIENCED AN INCREASED SENSE OF SHARED GOALS

Chapter

04

A Brighter Picture

WHAT IS MAKING A DIFFERENCE IN MEN'S HEALTH IN THE US?

The outlook for men's health in the United States need not be bleak. Across the country, advocates, community leaders, clinicians, and researchers are already building momentum through creative policies and hands-on programs that show real promise. This chapter lifts up those efforts, celebrating active achievements while also mapping the larger policy landscape that can help their efforts grow. We begin by surveying where **national** frameworks stand today and where they still fall short. We then showcase examples of **states** leading the way with new initiatives and policies, and finish with a thorough review of inspiring **community programs** that prove progress is possible. Taken together, these stories and strategies offer solid grounds for optimism and the beginnings of a road map for what comes next.

Chapter 04 — 1

National leaders, campaigns, and policies

A BROADER FEDERAL POLICY ON MEN'S HEALTH IS VITAL.

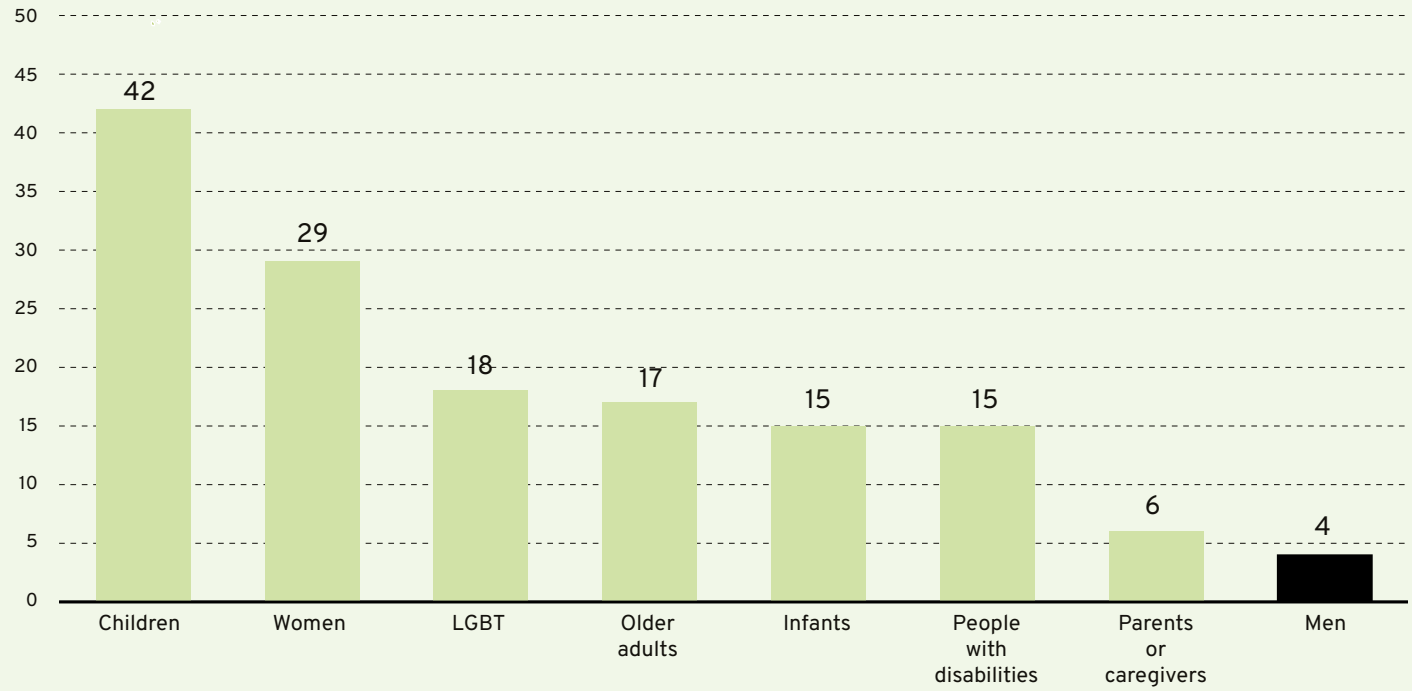
Despite increasing public awareness and media coverage of men's health needs, there has been limited corresponding policy action at the federal level.[63] Undeterred, policy progress has nonetheless been vigorously pursued by leaders in the field, including Men's Health Network, the Men's Health Caucus of the American Public Health Association, the Alliance for Boys and Men of Color, the My Brother's Keeper Alliance, the National Compadres Network, Equimundo: Center for Masculinities and Social Justice, the American Society for Men's Health, the American Institute of Boys and Men, the Partnership for Male Youth, Global Action on Men's Health, the American Association for Men in Nursing, Movember, and many issue-focused advocacy groups.

For more than two decades, Men's Health Network and other advocacy organizations have partnered with the Congressional Men's Health Caucus[64] to introduce the Men's Health Awareness and Improvement Act,[65] which calls for an Office of Men's Health within the Department of Health and Human Services.[66] Experience with the federal Office on Women's Health shows how a dedicated office can set priorities, coordinate research and interagency collaboration, and mobilize funding to advance health for a specific population.[67] Unfortunately, this men's health legislation has gotten stuck in committee without advancing further. In 2010, Congress authorized the establishment of an Office of Indian Men's Health within the Indian Health Service,[68] but such an office has yet to be created.[69] Men's Health Network led the efforts to establish Men's Health Week and Men's Health Month in the United States.[70] These awareness activities have been celebrated for over two decades, and proclamations have been issued by federal, state, and local governments to raise awareness of men's health.

Existing healthcare policies often do make mention of men's health issues, but these mentions tend to be marginal, and the resulting impact is insufficient. Every decade, the US Surgeon General issues *Healthy People*, the agenda-setting blueprint for public-health priorities.[71] Of the 357 objectives in *Healthy People 2030*, four measurable objectives explicitly mention men – none of which address the five leading causes of male mortality (see Figure 29).

The Affordable Care Act contains only two references to men,[72] although importantly, its preventive services mandate has expanded access to screenings that benefit men. However, that mandate is now under legal threat for more than 150 million Americans.[73]

Figure 29. **US SURGEON GENERAL HEALTHY PEOPLE OBJECTIVE TOPICS**



Source: Office of Disease Prevention and Health Promotion. Healthy People 2030: building a healthier future for all. US Department of Health and Human Services. Accessed August 21, 2025. https://odphp.health.gov/healthypeople.

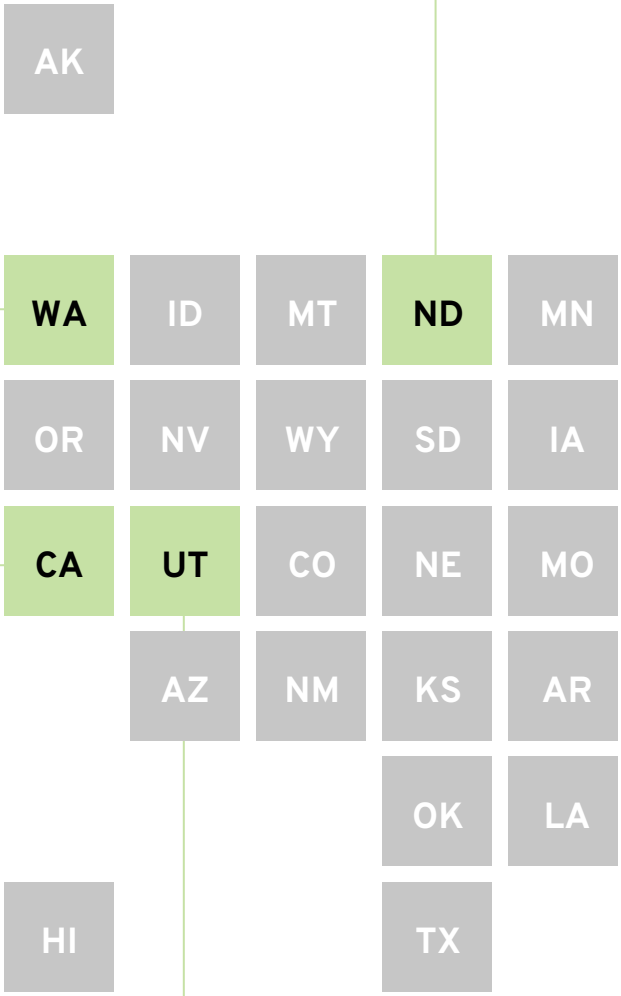
SOME FEDERAL EFFORTS, WHILE NOT COMPREHENSIVE, HAVE DEMONSTRATED HOW TARGETED INVESTMENT CAN ADDRESS MEN'S HEALTH NEEDS:

- **Equity-focused initiatives for specific populations** include the bipartisan US Commission on the Social Status of Black Men and Boys,[74] which proposes policy to address disparities within health, criminal justice, and other social drivers of health, and the My Brother's Keeper initiative of former President Barack Obama,[75] whose work continues through the Obama Foundation[76] as a culturally focused platform to improve outcomes for boys and young men of color.
- **Disease-specific programs with proven impact** include federal policies to prevent and treat HIV/AIDS – a disease that disproportionately impacts the LGBTQ+ community. These policies have shown evidence of being cost-effective[77] and of increasing testing, expanding access to care, and lowering infection rates.[78] Should programs such as Ending the HIV Epidemic in the US and the Ryan White HIV/AIDS Program experience cuts or removal, there would be detrimental effects to not only GBTQ+ men but also other disproportionately affected groups and overall population health.[79]
- **Family and fatherhood programs** such as the National Responsible Fatherhood Clearinghouse[80] and the Congressional Dads Caucus[81] are framed primarily around responsible parenting and family-friendly policies, not men's health per se. Still, federally funded fatherhood programs have been shown to improve dads' involvement, parenting skills, and cooperative co-parenting,[82] and research links fatherhood itself to better physical, mental, and social health for men.[83]
- **Military members and veterans who are men** have also received specific federal policy attention.[84] The congressionally directed Department of Defense Prostate Cancer Research Program, which distributed over $100 million in the last fiscal year, supports treatment development, quality-of-life improvements, mortality reduction, and disparity elimination among high-risk groups.[85] The Million Veteran Program[86] is one of the largest health research programs in the country, while the Veterans Health Administration's Quality Enhancement Research Initiative has been studied to highlight Veterans Affairs (VA) sites that integrate urological, primary, and mental health care,[87] an approach emphasized in this report as essential for improving men's health.

States leading the way

AS WE AWAIT FURTHER PROGRESS FEDERALLY, SOME STATES ARE PURSUING BOLD INITIATIVES.

Several individual state governments are carving out their own men's health goals and systems, and in doing so, are providing concrete examples of what practical leadership can look like.



Washington has legislators and advocates working to advance a bipartisan bill for a Commission on Boys and Men. The commission would support physical and mental health, social drivers of health, fatherhood, family, and relationships.[88]

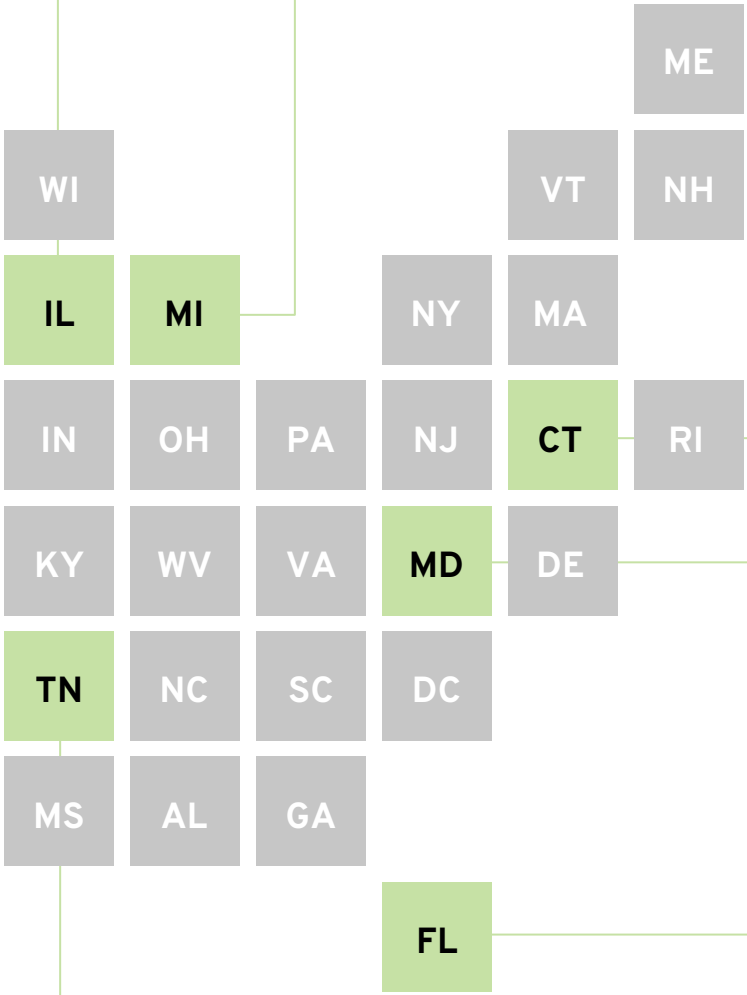
California Governor Gavin Newsom issued an executive order in July 2025 to support young men and boys and address rising suicide rates.[89] This order focuses on ending mental health stigma, increasing mental health supports, and creating more pathways to work and education.

Utah's legislature created a Task Force on the Wellbeing of Men and Boys to study root causes of poor health and recommend policy responses.[90]

North Dakota embeds men's health within a broader family health program, proving that services for men can be integrated seamlessly with maternal and child health rather than compete for attention.[91]

Illinois operates a dedicated men's health section within its Department of Public Health, giving the issue a formal home inside state government and a dedicated staff to coordinate efforts and track progress.[92]

Michigan Governor Gretchen Whitmer, in her 2025 State of the State address, issued an executive directive for state education and labor agencies to reach more men with its tuition-free college and skills training programs, supporting their path to higher earnings and life success.[93]



Connecticut Governor Ned Lamont, in his 2025 State of the State address, called for increased efforts to get more men into teaching, to prevent boys and young men from becoming disconnected from school and work, and to support those who already are.[94]

Maryland previously operated a Commission for Men's Health and is now moving to re-establish it on a permanent basis.[95] Governor Wes Moore used his 2025 State of the State address to commit to implementing targeted solutions to uplift the state's men and boys.[96]

Tennessee has partnered with Vanderbilt University, Vanderbilt University Medical Center, the Tennessee Department of Health, Meharry Medical College, Tennessee Men's Health Network, and health providers and advocates across the state to issue several men's health report cards.[97]

Florida maintains a standing Council on the Social Status of Black Men and Boys that releases annual data-rich reports, proposes strategic measures and funding, and helps to drive community efforts through local councils.[98]

SEVERAL STATE-LEVEL POLICIES THAT SUPPORT MEN'S HEALTH COULD BE EXPANDED.

States have also taken the lead in expanding screening access, addressing addiction, and curbing tobacco use, showing how targeted laws can save lives and close gaps in prevention.

- **Prostate cancer screening access:** Eight states (Tennessee, Kentucky, Delaware, Oregon, Illinois, Rhode Island, Maryland, and New York), plus the District of Columbia, have legislation that eliminates cost-sharing for prostate cancer screening for men at high risk.[99] Besides having more states adopting such measures, the proposed federal Prostate-Specific Antigen Screening for High-risk Insured Men Act (or the PSA Screening for HIM Act) would achieve the same access benefits for high-risk men, defined there as African American men or men with a family history of prostate cancer between ages 55 and 69.[100]
- **Overdose prevention:** The CDC has mapped which states allow for or require delivery of syringe services programs and links to naloxone, both evidence-based strategies to prevent overdose deaths.[101] As men are twice as likely to die of drug overdose deaths as women, these existing state-level programs are saving men's lives – along with women's.[102]
- **Lung cancer prevention:** Research has also shown a link between states with strong tobacco control policies and lower rates of smoking.[103] As smoking is a major contributor to lung cancer, and this is the leading cause of cancer deaths among US men, strong existing state-level policies would improve men's health and reduce risks of death by lung cancer.

Community campaigns, programs, and initiatives

MANY INNOVATIVE HEALTH PROGRAMS ARE MAKING A POSITIVE IMPACT ACROSS THE COUNTRY.

Around the United States, community-led efforts are engaging men in ways that traditional health systems often cannot. These initiatives vary in form, from grassroots campaigns to partnerships with formal health systems. But all reflect creative strategies for building trust, reaching underserved populations, and addressing pressing health needs. While not a comprehensive or systematic list, this section reflects a genuine effort to identify and elevate promising grassroots programs that have demonstrated real impact. The examples vary in their levels of evaluation and evidence, but each offers valuable lessons for engaging men effectively.

CULTURALLY ATTUNED PROGRAMS

BLACK MEN'S HEALTH AND WELL-BEING

Several initiatives have tailored health promotion to the realities of Black men's lives, meeting them in trusted settings with culturally resonant approaches. These programs address unique challenges shaped by systemic inequities and healthcare mistrust by meeting Black men where they're at, in their trusted community spaces. These programs span diverse health areas, from chronic disease prevention to mental health and substance use, with several demonstrating measurable outcomes through rigorous evaluation. **Black Impact (Ohio)** is a 24-week team-based lifestyle program adapted from the Diabetes Prevention Program that combines 45-minute group fitness sessions with 30-minute nutrition coaching sessions, showing reductions

in depressive symptoms and perceived stress among 71 participants.[104] The **YBMen Project (Michigan)** uses private social media groups and popular culture to engage young Black men in mental health discussions online, with a mixed-methods evaluation of 350 participants demonstrating fewer depressive symptoms compared to non-participants.[105] The program has since expanded online and been adapted internationally (e.g., for Black men in Canada and for First Nations men in Australia). **Mighty Men (Georgia, DC)** is a six-month church-based weight loss program combining faith-based community support with structured health sessions and education, with a pilot trial of 71 Black men showing significant decreases in body fat and visceral fat percentage alongside increased physical activity.[106]

A Closer Look

The barbershop as a health promotion hub for Black men

Barbershop-based health programs further exemplify how trusted community spaces can serve as effective venues for health promotion among Black men. The initiatives highlighted here demonstrate significant reach and impact, though these represent only a portion of such programs operating nationwide seeking to "go to where men are."

Barbershop Talk With Brothers (New York) uses barbershops for sexual health and HIV prevention conversations, with a cluster randomized trial across 53 barbershops involving 860 men demonstrating that a single strengths-focused session significantly reduced sexual risk behaviors among high-risk heterosexual Black men.[107] Other programs have also demonstrated impact, such as the **Rebalanced-Life Wellness Association's (RLWA's) Men's Health & Education Center (Wisconsin)**. Located within Madison's largest Black barbershop, RWLA's program provides health preventative screenings and education to local Black men and estimates that the (or its) program has reached more than 30% of Dane County's Black male population. The **Cut Hypertension Program (California)** also trains barbers and cosmetologists as health advocates to provide blood pressure checks and referrals, with their data showing that pairing clinical pharmacists with barbers led to sustained hypertension control in 94% of cases over 12 months, compared to 32% when barbers provided educational materials alone.

BY AND FOR NATIVE COMMUNITIES

Native community-led health programs demonstrate culturally grounded approaches that integrate traditional knowledge with medical guidance, demonstrating how programs rooted in cultural identity can achieve both health outcomes and community engagement. **No Ke Ola Pono o Nā Kāne (Hawaii)** is a train-the-trainer project addressing colon cancer risk among Native Hawaiian men through culturally designed curriculum and small-group "talk story" sessions. For men in the program, 92% of participants valued the approach, most reported improved knowledge of colon health, and three-quarters agreed to take a fecal immunochemical test following the workshops.[108] **Kū Ola (Hawaii)** works with community health advisors to engage Native Hawaiian men in health conversations through partnership with the University of Hawaii Cancer Center; **Strong Men, Strong Communities (Arizona, Minnesota, Oregon, Washington)** adapts the evidence-based Diabetes Prevention Program using peer coaches and cultural practices, with early results indicating strong enrollment and retention; and **KVIBE (Hawaii)**, supported by Movember funding, combines bike mechanics training with cultural "Circles" to build physical skills and emotional resilience among youth, operating through Indigenous educational models.

LATINO AND HISPANIC MEN

Culturally attuned programs for Latino and Hispanic men leverage shared language, traditions, and community networks to overcome barriers such as stigma, immigration stress, and work constraints, creating trusted pathways to health services. These initiatives demonstrate the diverse approaches that exist nationally, from family-centered interventions to peer-led prevention efforts. **Hombres Manteniendo Bienestar y Relaciones Saludables (HoMBReS, North Carolina)** uses a community-based participatory research approach to train "Navegantes" from social networks like soccer teams to deliver HIV and sexually transmitted infection (STI) prevention education to sexually active heterosexual Latino men. In a study of 222 immigrant men across 30 soccer teams, participants showed significantly more consistent condom use and higher HIV testing rates compared to controls, leading to the CDC including the program as a best-evidence community-level HIV prevention intervention in 2015.[109] **Papás Saludables, Niños Saludables (Texas)** is a 10-week program engaging Hispanic fathers and children in obesity prevention through family-based exercise and healthy eating activities, with a trial in a pediatric primary care setting demonstrating feasibility and positive reception among low-income Hispanic families.[110] Additionally, the **National Compadres Network (based in California)** exemplifies a program with significant national reach, operating *Círculos de Hombres* (Men's Circles) in over 50 US cities since 1988. These circles work to provide culturally grounded spaces for men to address substance misuse, mental health, and relationship building while offering training curricula for community-based programs. Their *Joven Noble* program, a culturally rooted youth development and character education curriculum for Latino boys and young men, has shown positive impacts, including increases in cultural esteem, HIV knowledge, and reductions in high-risk behaviors.[111]

SPACES FOR PEER SUPPORT AND CONNECTION

Peer support and community connection programs recognize that many different groups of men benefit from safe, informal spaces to share experiences, build friendships, and find mutual support, creating welcoming environments that reduce isolation and foster belonging. These initiatives span diverse populations and approaches, from specialized support for specific health conditions to broad community-building efforts, representing examples of the wider landscape of men's peer support programming. The **Men's Sheds (multi-state)** program provides an example of a rigorously evaluated peer support intervention where men can meet, learn, and build skills in a community space while taking part in shoulder-to-shoulder activities. Independent peer-reviewed evaluations have found that the program improves self-esteem, physical health, mental well-being, and help-seeking among men who attend Men's Sheds regularly.[112]

Other programs that focus on face-to-face group conversations include **Stay; Man to Man Peer Support Group (Maine)**, which specifically challenges mental health stigma through confidential conversations for men 18 and older; **Male Wellness Collective (Florida)**, which uses research, storytelling, and co-designed gatherings to help men develop meaningful connections and purpose in recognition that many men feel disconnected from themselves and society; and **The Manhood Tree (Connecticut)**, which operates four community-based initiatives that include support groups, storytelling events, health initiatives, and podcasting to create spaces for men's expression, healing, and empowerment. As a further alternative, expert-led men's health group sessions are exemplified by **Dudes and T.A.C.O.S. (Wisconsin)**, which combines monthly social activities with expert-led education on men's mental, emotional, and spiritual health. Specialized support groups serve specific male populations, including **Us Too support groups (Alaska)**, which offers weekly drop-in meetings for men with prostate or testicular cancer and their families, combining emotional support with awareness-raising; and **GBTQ+ Men's Peer Support Group (New York)**, which provides open-topic discussions for men identifying across the sexual and gender spectrum, led by trained peer facilitators.

Men's health podcasts

Podcasts are becoming powerful tools for shifting norms and expanding dialogue on men's health and masculinity. While some creators promote rigid, traditional ideals of masculinity as the path to good health, many others highlight more person-centered, healthy expressions of manhood. Because men often turn to podcasts for both entertainment and learning, they serve as an important space for health promotion beyond the traditional healthcare system. The following podcasts show how a diverse range of scholars, advocates, and storytellers are reshaping conversations on men's health and masculinity – each reaching distinct audiences and making unique contributions:

Breaking the Boy Code
Dear Old Dads
Don't Change Much
Gent's Talk
Healthy Gamer
In Good Company
Let's Talk Bruh
Man of the Year
Modern Manhood
Now and Men
PsychSessions: Inside Men's Health
The Armor Men's Health Show
The Better Man Podcast
Who Cares About Men's Health

ONLINE RESOURCE HUBS

Some programs use digital platforms to make health information, resources, and support more accessible. By meeting men where they are – on their phones, computers, and social media – they lower barriers to care and reach audiences who might not connect with traditional health services. **The Black Barbershop Health Outreach Program (US-wide)** has screened over 30,000 African American men for diabetes, high blood pressure, and prostate cancer by partnering with 1,150-plus barbershops nationwide since 2006, expanding to include telemedicine during COVID-19. **Man Therapy (US-wide)** uses humor and practical tools through an online platform to reduce mental health stigma among working-age men, with CDC-funded research showing reduced depression and suicide risk. Meanwhile, **Brother Be Well (California)** is a multimedia mental health platform and membership community specifically for men of color 13 and older, combining clinical and holistic education with culturally responsive support and resource connections.

INNOVATIVE FORMAL HEALTHCARE APPROACHES

The examples in this section show how targeted innovations within the formal healthcare system can close gaps in prevention, treatment, and recovery for men. These programs demonstrate that when health systems meet men where they are, both trust and health outcomes can improve. **Mobile cancer screening units** (**US-wide)** provide accessible prostate, colorectal, and lung cancer screenings where people live and work, enabling early detection when treatment is most effective. In our research, we uncovered 23 states with some form of mobile prostate cancer screening, 22 states with mobile distribution of colorectal test kits, and 19 with mobile lung-cancer checks. In the Cleveland area, **University Hospitals Cutler Center for Men (Ohio)** consolidates multiple medical specialties into one location while using community engagement and patient navigation services to make healthcare more approachable for men of all backgrounds. Another compelling example is the Medical University of South Carolina, which operates two complementary programs: the **SC AMEN Program (South Carolina)** uses culturally attuned education and navigation to increase prostate cancer screening rates among African American men ages 40 to 69, while **Prostate Cancer Survivors' Strength Camp (South Carolina**) provides a 10-week wellness program to build physical strength and confidence for survivors.

A Closer Look

Movember's investments in promoting health outcomes in sports settings

Sport-based programs can create safe, motivating spaces to explore mental health, build skills, and strengthen social connections. Movember has made significant investments in this area, including these US initiatives:

- **Game Changers:** Co-created with young men through the Making Connections initiative, Game Changers is a mentorship program that uses sport to support mental health, identity development, and emotional skills. Former participants train as mentors and work with youth ages 10 to 24. Pilots are launching in 2025 in Chicago (with Beyond the Ball) and San Diego (with United Women of East Africa Support Team, UWEAST), building on existing community strengths in historically marginalized neighborhoods.
- **Laureus Sport for Good + Movember**: In Chicago, Movember and Laureus USA are expanding sports-based mental health programs with five grassroots groups – America SCORES Chicago, The Bloc, Lost Boyz Inc., UCAN, and Beat The Streets Chicago. These organizations combine trauma-informed sports, mentorship, and academic or leadership opportunities to build resilience and connection. The partnership strengthens youth well-being in divested neighborhoods and draws on both Making Connections and Laureus' Sport for Good Cities model.
- **MindMoves:** An evidence-based digital program for college athletes, MindMoves offers free on-demand and live content on mental health and suicide prevention. It features student athletes sharing their experiences alongside expert guidance from psychologists and diversity, equity, and inclusion (DEI) specialists, making it an accessible resource tailored to the realities of student athletes.

Chapter

05

A Vision for the Future

WHAT CAN IMPROVE MEN'S HEALTH IN THE US?

The evidence in this report makes one point unmistakably clear: improving men's health is a whole-of-society project.

No single policy lever, clinic, or family can fix the structural gaps that leave caregivers overwhelmed, men underserved, and health practitioners lacking confidence. That is why the pages that follow map out tailored actions for key sectors with power to shift the dial: philanthropies that seed innovation, businesses that shape daily life, health systems that control access to care, researchers and educators who set tomorrow's standards, and the men whose choices and voices can open new cultural space. In the following pages, we present:

- **What men can do**
- **What the federal government can do**
- **What state and local governments can do**
- **What philanthropy can do**
- **What employers can do**
- **What the healthcare system can do**
- **What researchers and universities can do**

Taken together, these recommendations form an interconnected agenda for action: align incentives, fund what works, build flexible supports, and normalize shared responsibility so that men's health no longer comes at the expense of those who love them.

What men can do

Men are not just care recipients; they are also potential advocates and caregivers themselves. They are a necessary and active part of solutions to the health disparities they face. Most men value self-care, are open to help-seeking, and want stronger social connections – but there are still gaps between intention and action. While many of the barriers to men's health are structural, men also have the ability to make meaningful changes: through everyday choices and relationships, they can take steps that strengthen their own well-being and contribute to healthier families and communities.

Men can:

- **Find a trusted source of care:** Seek out a regular doctor or clinic you can return to for checkups and ongoing needs – what health systems call a "primary care home." Take advantage of free and low-cost options such as community clinics, 211, and mobile clinics.
- **Prioritize preventive health:** Schedule regular checkups and screenings (e.g., heart health, cancer), and address symptoms early rather than waiting until they disrupt daily life.
- **Build and maintain social connections:** Nurture friendships, join community or interest-based groups, and check in regularly with peers. Use resources like Movember Conversations to start and maintain important conversations with friends.
- **Know where to turn in crisis:** Get familiar with supports like 988 and culturally specific hotlines.
- **Build healthier routines:** Replace risky habits like tobacco use, excessive drinking, and unsafe driving with positive practices such as exercise, good nutrition, rest, and stress management.
- **Learn safety skills:** Consider CPR training, safe firearm storage techniques, and Mental Health First Aid training.
- **Engage in community life:** Volunteer, mentor younger men, or share skills in ways that build purpose, belonging, and stronger ties across generations. For example, Big Brothers Big Sisters has partnered with the NFL on its Big Draft campaign, which is recruiting 10,000 new mentors this season.[113] Answering a call like this one is a powerful way men can support the next generation while also strengthening their own sense of purpose and connection.

The Movember Conversations website includes resources, prompts, and practice scenarios for tackling important conversations.

What the federal government can do

National policy sets the baseline for every other effort. When Congress and federal agencies prioritize caregivers and men's health, they unlock large-scale funding, consistent standards, and cross-agency coordination that states and communities cannot achieve on their own.

The federal government can:

- **Strengthen existing policy infrastructure:** Build on current frameworks for prostate cancer and expand behavioral health policy, particularly around mental health and substance use.
- **Improve health literacy and outreach:** Fund initiatives that raise men's health literacy and mental health literacy and close the perception gap about men's willingness to seek help and support.
- **Invest in awareness year-round:** Expand Men's Health Week and Month campaigns to raise visibility, while ensuring men's health is addressed through continuous, year-round strategies.
- **Create dedicated grant programs:** Establish funding streams, similar to those of the Office on Women's Health,[114] to support innovative, validated approaches for suicide prevention, overdose response, barber shop-based outreach, online mental health, comprehensive men's health clinics, peer support groups, and healthy masculinity programs.
- **Leverage existing care pathways:** Connect with men through the services they already access. For example, South Africa's national men's health policy shows how initial visits for urological care can be used as entry points to a broader range of health services[115].
- **Direct funding to equity-owed communities:** Maintain and expand funding for affordable healthcare and prevention programs, with resources targeted to communities facing the steepest gaps in male life expectancy, disaggregated by race, ethnicity, and geography.

What state and local governments can do

Governors, mayors, and county officials oversee the day-to-day services that touch our lives. Their proximity to residents allows them to tailor programs, pilot innovations, and integrate caregiving supports with housing, transportation, and public-health systems on the ground.

State and local governments can:

- **Create coordinating bodies:** Establish and support offices, commissions, or task forces dedicated to men's health, with staffing and funding to coordinate efforts and link with federal initiatives. Guide men's health policy, programs, research, and investment, with continued facilitation from government – and with input from those with lived and living experience. Identify opportunities to improve men's health outcomes across portfolios, working to foster cross-portfolio collaboration and supporting investment efficiencies.
- **Set measurable goals for men's health:** Ensure state health plans and *Healthy People* implementation explicitly address the five leading causes of death for men, which are too often absent from current objectives.[116] Use local data to prioritize neighborhoods with high preventable mortality among men and direct resources accordingly. Develop practical and rigorous evaluation frameworks that will enable the monitoring of key progress on men's health and on initiatives relating to this strategy.
- **Target equity-owed communities:** Use local data to identify neighborhoods with high rates of preventable male mortality and direct resources and outreach to where the needs are greatest.
- **Adopt a "men's health in all policies" approach:** Develop a framework through which future national strategies and revisions could be shaped to include gender-specific calls to action, helping to address the unique health risks, experiences, and barriers to accessing care for men. From there, integrate men's health needs into wider state-level frameworks so that issues like housing, employment, and fatherhood are linked with physical and mental health outcomes. California's First 5 Fatherhood Initiative offers a model, using tobacco tax revenues to support early childhood, family programs, and men's health as interconnected priorities.[117]
- **Implement proven models:** Identify, disseminate, and scale evidence-based interventions (e.g., Men in Mind, Man Therapy) that enable the health workforce and health system to better respond to the needs of men.

What philanthropy can do

Men's health remains one of the most underfunded areas in public health. Most organizations are operating on minimal resources, despite growing demand and urgent need. Philanthropy has a critical role to play in reversing this trend by investing in research, scaling community programs, and building long-term infrastructure for change. Many small programs are having outsized impact, particularly those that integrate cultural identity, social connection, and trusted community spaces. By funding promising pilots, supporting evaluation, and helping proven approaches scale, philanthropy can accelerate a national transformation in men's health.

Philanthropy can:

- **Convene a national men's health philanthropic circle:** Bring together funders, researchers, advocates, and practitioners to coordinate giving, share evidence, and align efforts around a bold, long-term agenda for impact.
- **Expand beyond narrow issue areas:** Philanthropy has tended to fund men's health through disease-specific efforts or targeted subgroups. These investments matter, especially where they advance health equity for particular communities, but there is a need to embrace men's health more broadly as a priority in its own right. Doing so signals that healthier men strengthen families, communities, and society at large.
- **Invest in research:** Fund innovative, applied, and translational studies that deepen understanding of men's health behaviors and interventions. Prioritize longitudinal evaluations and randomized controlled trials to strengthen the evidence base.
- **Scale up successful grassroots programs:** Support community-based initiatives that address physical, mental, social, and emotional health and well-being, helping them grow sustainably to reach more men and boys. Establish a funding avenue through which promising community-based early intervention programs can access funding to demonstrate their effectiveness through rigorous evaluation, supporting them to maximize their impact and reach more boys and men.
- **Fund culturally relevant innovation:** Prioritize programs rooted in community identity and values, especially in underserved populations.
- **Integrate caregiver support:** Create grants that include caregiver needs within men's health interventions, recognizing the interdependence of family well-being.
- **Promote awareness and culture change:** Invest in campaigns and implementation strategies that normalize preventive care and healthy masculinity, with a focus on culturally responsive approaches in marginalized communities.

What employers can do

Employers have a direct stake in men's health – poor health reduces productivity, increases absenteeism, and drives up healthcare costs. Stronger benefits for all employees, flexible leave policies, specific caregiver benefits, equitable insurance access, and supportive workplace cultures can improve men's health while boosting retention, productivity, and brand reputation. By offering robust benefits, fostering supportive cultures, and partnering with health organizations, businesses can help employees stay healthy and engaged.

Employers can:

- **Measure employee well-being:** Establish benchmarks that capture employees' perceptions of connection, workload, leadership support, and recognition, and use the results to guide organizational improvements.
- **Provide comprehensive benefits:** Offer health plans that cover preventive care, mental health, and substance use treatment without high out-of-pocket costs. Providing benefits responsive to men's health needs can improve equity by engaging a group that traditionally underutilizes health resources.
- **Normalize help-seeking at work:** Create cultures where men feel supported in taking sick leave, attending medical appointments, and openly discussing mental health. Reinforce these expectations during recruitment, orientation and leadership training.[118] Peer testimonials from colleagues, particularly those in leadership positions, can be powerful in shifting perceptions.
- **Support peer networks:** Sponsor employee-led peer support or mentoring programs and resource groups that are tailored to men's health needs, including those of underrepresented employees such as African American men and prostate cancer survivors.
- **Promote work–life balance:** Implement flexible hours, paternity and caregiving leave, and wellness programs, reframing sick leave as part of a holistic approach to health.
- **Partner with health experts:** Collaborate with local organizations to host onsite screenings, expert talks, and interactive workshops that bring men's health resources directly into the workplace.[119]

What the healthcare system can do

Clinicians and payers sit at the front line of prevention and treatment. Designing services that account for men's diverse cultures, schedules, and communication styles, then reimbursing those services fairly, makes it easier for men to engage early and often. This report shows that while many men do seek care, "gateway conversations" about emotional and social well-being are often missed. By consistently taking a whole-person approach, reducing barriers to access, and tailoring care to men's diverse identities and experiences, the health system can deliver better outcomes and stronger trust.

Health professionals, health insurers, and the healthcare system can:

- **Train providers in gender-responsive care:** Build a healthcare system and workforce that responds to the needs of men, including through professional development training like Men in Mind. Incorporate gender-responsive training into health professional certifications.
- **Use every encounter as a "gateway":** Ask about social connection, emotional well-being, and life stressors. Incorporate questions about these topics into routine checkup procedures.
- **Reduce barriers to access:** Improve communication strategies with men, simplify navigation of clinical settings, and proactively reach out to those overdue for preventive services and screenings.
- **Address unmet needs directly:** Ensure men's concerns are proactively identified, link them to appropriate social support services, and reach out to those overdue for preventive care and screenings.
- **Integrate men's and caregivers' voices:** Embed men's perspectives and those of their families into health service design, and use caregiver input to improve treatment planning and quality of care.
- **Increase reach and flexibility:** Extend clinic hours, telehealth options, and language access in facilities serving high-disparity populations, particularly men of color and men in rural areas, while tackling local barriers that discourage men from seeking care.

What researchers and universities can do

Knowledge generation and professional training are two of the most powerful levers for long-term change in men's health. Researchers provide the evidence base that policymakers and practitioners need, while universities shape the next generation of clinicians, educators, and community leaders. Together, these institutions can expand the scope of men's health research, ensure training is gender-responsive and culturally attuned, and connect knowledge to practice.

Researchers and universities can:

- **Disaggregate data:** Collect and analyze men's health data by race, ethnicity, geography, sexual orientation, and socioeconomic status to expose disparities and inform targeted interventions. Show the benefits of programs to populations not identifiable without these data.
- **Advance intersectional models:** Integrate Indigenous, race-/ethnicity-specific, and community-based perspectives on gender, identity, and health to better reflect the diversity of men's lives.[120]
- **Co-design research:** Involve men from marginalized groups and their caregivers as partners in study design, ensuring interventions are relevant, accessible, and effective.[121]
- Evaluate community-based programs: Conduct longitudinal and participatory research to assess the impact of culturally specific interventions, and share findings in actionable ways.
- **Develop evidence-based policy solutions:** Design and disseminate research that informs policies addressing the commercial and social drivers of health.[122]
- **Shape training and curricula:** Embed men's health and gender equity into public health, medical, and social work programs so that future providers are equipped with gender-responsive skills.[123]
- **Strengthen campus supports:** Create peer-support and well-being programs for male students at higher risk of isolation, partnering with student organizations and clubs to normalize help-seeking.[124]
- **Strengthen research infrastructure:** Support faculty through collaborative funding models, such as research excellence clusters, that reduce competition and build interdisciplinary networks. Examples like the University of British Columbia's Reducing Male Suicide Research Excellence Cluster show how coordinated investment can accelerate innovation and impact.[125]
- **Broaden masculinity research:** Move beyond a deficit-only lens by also studying positive, asset-based expressions of manhood and men's contributions to families, relationships, and communities.

Chapter

06

Conclusion

Men's health is never just about men. The way men live, age, struggle, and heal shapes the well-being of their partners, children, coworkers, and communities. When men neglect their health, families and workplaces feel the strain. When men thrive, those closest to them thrive, too. The story of men's health is therefore a collective one, woven through caregiving, connection, and community. Across this report, several truths stand out:

CONNECTION MATTERS.

Social ties are protective, while disconnection fuels crises of mental health, substance use, and premature mortality. Programs that strengthen belonging through mentorship, peer groups, and intergenerational networks consistently show benefits.

CAREGIVERS MATTER.

Behind men's health are caregivers, most often women, who carry an immense share of the load. They provide emotional support, coordinate medical care, and shoulder financial and time pressures that affect their own health in turn. Supporting these caregivers is inseparable from supporting men themselves. At the same time, men – as fathers, partners, and friends – also play caregiving roles that, when nurtured, strengthen families and communities alike.

CULTURE MATTERS.

Norms around masculinity shape how men talk about stress, whether they seek care, and how they connect with others. Community-rooted programs show that when men are engaged in ways that honor identity, culture, and tradition, they respond with openness and trust. Changing the story of what it means to be healthy and strong can dismantle stigma, expand help-seeking, and ripple outward into healthier families and communities.

STRUCTURES MATTER.

Men's health is shaped not only by individual choices but also by the systems around them. Racial inequities, economic inequality, and geographic isolation all deepen health gaps: Black and Indigenous men face the highest premature mortality rates, rural men struggle with limited access to care, and low-income men often forgo treatment due to cost. Policies that expand insurance coverage, extend clinic hours, embed men's voices in service design, and direct resources to the communities with the greatest disparities are essential to making care equitable and effective.

Momentum is building. Though men's health has often been overlooked in national priorities, some states have begun to establish men's health offices, commissions, and targeted initiatives, providing a road map for others. At the community level, there are already proven models: mobile screening units that reach underserved men, workplace policies that normalize self-care, and local organizations that integrate culture and health. What is needed now are scale and alignment, sustained investment from philanthropy, coordination from government, commitment from healthcare leaders, and active participation from men.

The real face of men's health is not a single male patient in a clinic. It is the network of relationships and responsibilities that shape, and are shaped by, his health and well-being. By supporting men's health as a shared concern – of families, workplaces, and communities – we create a healthier society for all.

Endnotes

1 Burgess SN. Understudied, Under-recognized, underdiagnosed, and undertreated: Sex-based disparities in cardiovascular medicine. *Circ Cardiovasc Interv.*

2 Meit M, Heffernan M, Tanenbaum E, Hoffmann T. *Appalachian diseases of despair.* Bethesda, MD: Walsh Center for Rural Health Analysis, NORC at the University of Chicago; 2017; Case A, Deaton A. Mortality and morbidity in the 21st century. *Brookings Pap Econ Act.* 2017;2017:397-476; Gaydosh L, Hummer RA, Hargrove TW, et al. The depths of despair among US adults entering midlife. *Am J Public Health.* 2019;109(5):774-780. doi:10.2105/AJPH.2019.305001; Roux AV. Despair as a cause of death: more complex than it first appears. *Am J Public Health.* 2017;107(10):1566-1567. doi:10.2105/AJPH.2017.304041; Erwin PC. Despair in the American heartland? A focus on rural health. *Am J Public Health.* 2017;107(10):1533-1534. doi:10.2105/AJPH.2017.304029; Stein EM, Gennuso KP, Ugboaja DC, Remington PL. The epidemic of despair among White Americans: trends in the leading causes of premature death, 1999-2015. *Am J Public Health.* 2017;107(10):1541-1547. doi:10.2105/AJPH.2017.303941.

3 Woolf SH. Falling behind: the growing gap in life expectancy between the United States and other countries, 1933-2021. *Am J Public Health.* 2023;113(9):970-980. doi:10.2105/AJPH.2023.307310; Woolf SH, Aron L. *US health in international perspective: shorter lives, poorer health.* Washington, DC: National Academies Press; 2013..

4 Elder K, Griffith DM. Men's health: beyond masculinity. *Am J Public Health.* 2016;106(7):1157. doi:10.2105/AJPH.2016.303237; Reeves R. *Of Boys and Men: Why the Modern Male Is Struggling, Why It Matters, and What to Do About It.* Washington, DC: Brookings Institution Press; 2022..

5 Barr E, Belaunzarán-Zamudio PF, Clayton JA, et al. Workshop summary: National Institutes of Health (NIH) 2022 scientific workshop on gender and health. *Soc Sci Med.* 2024;351:116435. doi:10.1016/j.socscimed.2021.116435

6 Marmot M. Action on health disparities in the United States: commission on social determinants of health. *JAMA.* 2009;301(11):1169-1171. doi:10.1001/jama.2009.330; Marmot M, Allen JJ. Social determinants of health equity. *Am J Public Health.* 2014;104(S4):S517-S519. doi:10.2105/AJPH.2014.302200; Woo J, Chung GK, Chung RY, et al. Rich people have better health than the poor: health equity in an unequal world. *Environ Public Health Res.* 2025;3(1):2361. doi:10.59400/ephr2361; Benjamin GC, DeVoe JE, Amankwah FK. Ending unequal treatment and achieving optimal health for all. *JAMA.* 2024;332(14):1143-1144. doi:10.1001/jama.2024.14268; Nass SJ, Amankwah FK, DeVoe JE, Benjamin GC; National Academies of Sciences, Engineering, and Medicine. *Unequal treatment: 20 years after. Ending unequal treatment: strategies to achieve equitable health care and optimal health for all.* Washington, DC: National Academies Press; 2024; Oliffe JL, Gao N, Kelly MT, et al. The commercial determinants of nonalcoholic beer: redemption, revenue, or men's harm reduction? *Am J Mens Health.* 2025;19(1):15579883251317096. doi:10.1177/15579883251317096.

7 Griffith DM. Antiracism and health equity science: overcoming scientific obstacles to health equity. *Public Health Rep.* 2024;0(0):00333549241236089. doi:10.1177/00333549241236089; Griffith DM. Achieving men's health equity. In: Smalley KB, Warren JC, Fernández MI, eds. *Health Equity: A Solutions-Focused Approach.* New York, NY: Springer Publishing Company; 2020:197-215; Griffith DM. Promoting men's health equity. *Am J Mens Health.* 2020;14(6):1557988320980184. doi:10.1177/1557988320980184; Griffith DM. Gender health equity: the case for including men's health. *Soc Sci Med.* 2024;351(Suppl 1); Griffith DM, Bruce MA, Thorpe RJ Jr. *Men's Health Equity: A Handbook.* Routledge; 2019.

8 Woolf SH. Falling behind: the growing gap in life expectancy between the United States and other countries, 1933-2021. *Am J Public Health.* 2023;113(9):970-980. doi:10.2105/AJPH.2023.307310; Griffith DM. Gender health equity: the case for including men's health. *Soc Sci Med.* 2024;351(Suppl 1); Beltrán-Sánchez H, Finch CE, Crimmins EM. Twentieth century surge of excess adult male mortality. *Proc Natl Acad Sci USA.* 2015;112(29):8993-8998; Centers for Disease Control and Prevention. Ten great public health achievements—United States, 1900–1999. *MMWR Morb Mortal Wkly Rep.* 1999;48(12):241-243; Woolf SH, Aron L. *US Health in International Perspective: Shorter Lives, Poorer Health.* National Academies Press; 2013; Woolf SH, Chapman DA, Lee JH, et al. The lives lost to inequities: avertable deaths from neurologic diseases in the past decade. *Neurology.* 2023;101(7 Suppl 1):S9-S16. doi:10.1212/wnl.0000000000207561.

9 Woolf SH. Falling behind: the growing gap in life expectancy between the United States and other countries, 1933-2021. *Am J Public Health.* 2023;113(9):970-980; Woolf SH, Aron L. *US Health in International Perspective: Shorter Lives, Poorer Health.* National Academies Press; 2013; Woolf SH, Chapman DA, Lee JH, et al. The lives lost to inequities: avertable deaths from neurologic diseases in the past decade. *Neurology.* 2023;101(7 Suppl 1):S9-S16. doi:10.1212/wnl.0000000000207561.

10 Bird CE, Rieker PP. *Gender and Health: The Effects of Constrained Choices and Social Policies.* Cambridge University Press; Rieker PP, Bird CE. Rethinking gender differences in health: why we need to integrate social and biological perspectives. *J Gerontol B Psychol Sci Soc Sci.* 2005;60(Spec No 2):40-47; Bird CE, Rieker PP. Gender matters: an integrated model for understanding men's and women's health. *Soc Sci Med.* 1999;48(6):745-755. doi:10.1016/S0277-9536(98)00402-X.

11 Substance Abuse and Mental Health Services Administration. Data from: 2023 National Survey on Drug Use and Health (NSDUH) Releases. 2025. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023.

12 Substance Abuse and Mental Health Services Administration. Data from: 2023 National Survey on Drug Use and Health (NSDUH) Releases. 2025. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023.

13 Nass SJ, Amankwah FK, DeVoe JE, Benjamin GC; National Academies of Sciences, Engineering, and Medicine. *Unequal treatment: 20 years after. Ending unequal treatment: strategies to achieve equitable health care and optimal health for all.* Washington, DC: National Academies Press; 2024; Pan American Health Organization. *Leading Causes of Death and Disease Burden in the Americas: Noncommunicable Diseases and External Causes.* PAHO Technical Report; 2024:112 p. ISBN 978-92-75-12862-6.

14 American Cancer Society. *Cancer Facts & Figures 2025.* American Cancer Society; 2025. Accessed August 21, 2025. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2025/2025-cancer-facts-and-figures-acs.pdf

15 National Cancer Institute. *Cancer Stat Facts: Prostate Cancer. Surveillance, Epidemiology, and End Results Program (SEER)*; 2025. Accessed August 21, 2025. https://seer.cancer.gov/statfacts/html/prost.html

16 American Cancer Society. *Cancer Facts & Figures for African Americans 2022–2024.* American Cancer Society; 2022. Accessed August 21, 2025. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/2022-2024-cff-aa.pdf

17 Mazzuco S, Suhrcke M, Zanotto L. How to measure premature mortality? A proposal combining "relative" and "absolute" approaches. *Popul Health Metr.* 2021;19(1):41. doi:10.1186/s12963-021-00267-y.

18 Papanicolas I, Niksch M, Figueroa JF. Avoidable mortality across US states and high-income countries. *JAMA Intern Med.* 2025;185(5):583-590. doi:10.1001/jamainternmed.2025.0155; Ilze B. Avoidable mortality: OECD/Eurostat lists of preventable and treatable causes of death (January 2022 version). 2022.

19 Papanicolas I, Niksch M, Figueroa JF. Avoidable mortality across US states and high-income countries. *JAMA Intern Med.* 2025;185(5):583-590. doi:10.1001/jamainternmed.2025.0155.

20 Rieker PP, Bird CE. Rethinking gender differences in health: why we need to integrate social and biological perspectives. *J Gerontol B Psychol Sci Soc Sci.* 2005;60(Spec No 2):40-47.

21 Substance Abuse and Mental Health Services Administration. Data from: 2023 National Survey on Drug Use and Health (NSDUH) Releases. 2025. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023.

22 Substance Abuse and Mental Health Services Administration. Data from: 2023 National Survey on Drug Use and Health (NSDUH) Releases. 2025. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023.

23 Substance Abuse and Mental Health Services Administration. Data from: 2023 National Survey on Drug Use and Health (NSDUH) Releases. 2025. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023.

24 Substance Abuse and Mental Health Services Administration. Data from: 2023 National Survey on Drug Use and Health (NSDUH) Releases. 2025. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023.

25 Griffith DM. Achieving men's health equity. In: Smalley KB, Warren JC, Fernández MI, eds. *Health Equity: A Solutions-Focused Approach.* New York, NY: Springer Publishing Company; 2020:197-215; Seidler ZE, Rice SM, Kealy D, Oliffe JL, Ogrodniczuk JS. What gets in the way? Men's perspectives of barriers to mental health services. *Int J Soc Psychiatry.* 2020;66(2):105-110. doi:10.1177/0020764019886336.

26 Seidler ZE, Wilson MJ, Kealy D, Oliffe JL, Ogrodniczuk JS, Rice SM. Men's dropout from mental health services: results from a survey of Australian men across the life span. *Am J Mens Health.* 2021;15(3):15579883211014776. doi:10.1177/15579883211014776.

27 Seidler ZE, Rice SM, Oliffe JL, Fogarty AS, Dhillon HM. Men in and out of treatment for depression: strategies for improved engagement. *Aust Psychol.* 2018;53(5):405-415. doi:10.1111/ap.12331.

28 Seidler ZE, Rice SM, Kealy D, Oliffe JL, Ogrodniczuk JS. What gets in the way? Men's perspectives of barriers to mental health services. *Int J Soc Psychiatry.* 2020;66(2):105-110. doi:10.1177/0020764019886336.

29 Fisher K, Rice SM, Oliffe JL, King K, Seidler ZE. Young men and anxiety: resisting, reckoning, and responding. *Sociol Health Illn.* 2023;45(7):1462-1482. doi:10.1111/1467-9566.13641; Seidler ZE, Dawes AJ, Rice SM, Oliffe JL, Dhillon HM. The role of masculinity in men's help-seeking for depression: a systematic review. *Clin Psychol Rev.* 2016;49:106-118. doi:10.1016/j.cpr.2016.09.002.

30 Ahmedani BK, Simon GE, Stewart C, et al. Health care contacts in the year before suicide death. *J Gen Intern Med.* 2014;29(6):870-877. doi:10.1007/s11606-014-2767-3.

31 Substance Abuse and Mental Health Services Administration. Data from: 2023 National Survey on Drug Use and Health (NSDUH) Releases. 2025. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2023.

32 Cortero H, McCullom W, Kochuba M. Increased suicide risk among older white males. *Curr Trauma Rep.* 2022;8(3):179-184. doi:10.1007/s40719-022-00233-5; Canetto SS. Suicide: why are older men so vulnerable? *Men Masc.* 2017;20(1):49-70. doi:10.1177/1097184X15613832; Apesoa-Varano EC, Barker JC, Hinton L. "If you were like me, you would consider it too": suicide, older men, and masculinity. *Soc Ment Health.* 2018;8(2):157-173. doi:10.1177/2156869317725890.

33 US Department of Health and Human Services. Our epidemic of loneliness and isolation: The U.S. Surgeon General's advisory on the healing effects of social connection and community. Washington, DC; 2023. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf.

34 US Department of Health and Human Services. Our epidemic of loneliness and isolation: The U.S. Surgeon General's advisory on the healing effects of social connection and community. Washington, DC; 2023. https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf.

35 Vigers B. Younger men in the U.S. among the loneliest in West. Gallup. 2025. https://news.gallup.com/poll/690788/younger-men-among-loneliest-west.aspx.

36 Vigers B. Younger men in the U.S. among the loneliest in West. Gallup. 2025. https://news.gallup.com/poll/690788/younger-men-among-loneliest-west.aspx.

37 Goddard I, Parker K. Men, women and social connections. Pew Research Center. 2025. January 16, 2025. https://www.pewresearch.org/social-trends/2025/01/16/men-women-and-social-connections/.

38 Cox DA. The state of American friendship: change, challenges, and loss. Survey Center on American Life. 2021;8.

39 Fisher K, Rice S, Seidler Z. Young men's health in a digital world. Movember. 2025. https://movember.com/movember-institute/masculinities-report.

40 Cox DA. The state of American friendship: change, challenges, and loss. Survey Center on American Life. 2021;8.

41 Griffith DM. Gender health equity: the case for including men's health. *Soc Sci Med.* 2024;351(Suppl 1); Griffith DM, Bruce MA, Thorpe RJ Jr. *Men's Health Equity: A Handbook*. Routledge; 2019; Griffith DM. "Centering the margins": moving equity to the center of men's health research. *Am J Mens Health.* 2018;12:1557988318773973. doi:10.1177/1557988318773973.

42 Leone JE, Rovito MJ, Mullin EM, Mohammed SD, Lee CS. Development and testing of a conceptual model regarding men's access to health care. *Am J Mens Health.* 2017;11(2):262-274.

43 Seidler ZE, Rice SM, Kealy D, Oliffe JL, Ogrodniczuk JS. Once bitten, twice shy: dissatisfaction with previous therapy and its implication for future help-seeking among men. *Int J Psychiatry Med.* 2020;55(4):255-263. doi:10.1177/0091217420905182; Seidler ZE, Sheldrake M, Rice S, et al. "Just treat me delicately": a qualitative exploration of what works to engage Australian men in health care encounters. *Am J Mens Health.* 2025;19(2):15579883241311557. doi:10.1177/15579883241311557.

44 Seidler ZE, Wilson MJ, Benakovic R, et al. A randomized wait-list controlled trial of Men in Mind: enhancing mental health practitioners' self-rated clinical competencies to work with men. *Am Psychol.* 2024;79(3):423-436. doi:10.1037/amp0001242; Wilson MJ, Benakovic R, O'Gorman K, et al. Keeping men in mind: practitioner self-efficacy and e-learning implementation one year following training to engage men in therapy. *Couns Psychol Q.* 2025:1-21. doi:10.1080/09515070.2025.2536555.

45 Fisher K, Rice S, Seidler Z. Young men's health in a digital world. Movember. 2025. https://movember.com/movember-institute/masculinities-report.

46 United Nations University, World Population Prospects. Data from: Life expectancy at birth, male (years). 2025.

47 United Nations University, World Population Prospects. Data from: Life expectancy at birth, male (years). 2025.

48 Fisher K, Rice S, Seidler Z. Young men's health in a digital world. Movember. 2025. https://movember.com/movember-institute/masculinities-report.

49 Lohan M. How might we understand men's health better? Integrating explanations from critical studies on men and inequalities in health. *Soc Sci Med.* 2007;65(3):493-504. doi:10.1016/j.socscimed.2007.04.020.

50 Evans J, Frank B, Oliffe JL, Gregory D. Health, illness, men and masculinities (HIMM): a theoretical framework for understanding men and their health. *J Mens Health.* 2011;8(1):7-15; Cunningham M, White A. Young adulthood and health disparities in African American males. In: Griffith DM, Bruce MA, Thorpe RJ Jr, eds. *Men's Health Equity: A Handbook*. Routledge; 2019; Griffith DM, Jaeger EC. Becoming: an intervention to promote mental wellbeing of young Black men in the United States. In: Smith JA, Watkins DC, Griffith DM, eds. *Health Promotion with Adolescent Boys and Young Men of Colour: Global Strategies for Advancing Research, Policy, and Practice in Context.* Springer International Publishing; 2023:17-31.

51 Watkins DC. Depression over the adult life course for African American men: toward a framework for research and practice. *Am J Mens Health.* 2012;6(3):194-210. doi:10.1177/1557988311424072; Griffith DM, Jaeger EC, Sherman LD, Moore HJ. Middle-aged men's health. In: Griffith DM, Bruce MA, Thorpe RJ Jr, eds. *Men's Health Equity: A Handbook.* 2019:7.

52 Evans J, Frank B, Oliffe JL, Gregory D. Health, illness, men and masculinities (HIMM): a theoretical framework for understanding men and their health. *J Mens Health.* 2011;8(1):7-15.

53 Evans J, Frank B, Oliffe JL, Gregory D. Health, illness, men and masculinities (HIMM): a theoretical framework for understanding men and their health. *J Mens Health.* 2011;8(1):7-15.

54 Griffith DM, Cornish EK. "What defines a man?": perspectives of African American men on the components and consequences of manhood. *Psychol Men Masc.* 2018;19(1):78-88. doi:10.1037/men0000083.

55 Griffith DM, Cornish EK, Bergner EM, Bruce MA, Beech BM. "Health is the ability to manage yourself without help": how older African American men define health and successful aging. *J Gerontol B.* 2017;72(6):1025-1035.

56 Griffith DM, Cornish EK, Bergner EM, Bruce MA, Beech BM. "Health is the ability to manage yourself without help": how older African American men define health and successful aging. *J Gerontol B.* 2017;72(6):1025-1035.

57 Kotelchuck M. The impact of fatherhood on men's health and development. In: Grau M, las Heras Maestro M, Riley Bowles H, eds. *Engaged Fatherhood for Men, Families and Gender Equality: Healthcare, Social Policy, and Work Perspectives.* Springer International Publishing; 2022:63-91; Campbell JM, McPherson NO. Influence of increased paternal BMI on pregnancy and child health outcomes independent of maternal effects: a systematic review and meta-analysis. *Obes Res Clin Pract.* 2019;13(6):511-521. doi:10.1016/j.orcp.2019.11.003; Park E, Jang M, Jung MS, Dlamini NS. Meta-synthesis of qualitative studies to explore fathers' perspectives of their influence on children's obesity-related health behaviors. *BMC Nurs.* 2024;23(1):78. doi:10.1186/s12912-024-01728-z; Ramchandani P, Psychogiou L. Paternal psychiatric disorders and children's psychosocial development. *Lancet.* 2009;374(9690):646-653. doi:10.1016/S0140-6736(09)60238-5.

58 Dachew B, Ayano G, Duko B, Lawrence B, Betts K, Alati R. Paternal depression and risk of depression among offspring: a systematic review and meta-analysis. *JAMA Netw Open.* 2023;6(8):e2329159. doi:10.1001/jamanetworkopen.2023.29159.

59 Lee TK, Handy AB, Kwan W, et al. Impact of prostate cancer treatment on the sexual quality of life for men-who-have-sex-with-men. *J Sex Med.* 2015;12(12):2378-2386. doi:10.1111/jsm.13030; Gupta N, Zebib L, Wittmann D, et al. Understanding the sexual health perceptions, concerns, and needs of female partners of prostate cancer survivors. *J Sex Med.* 2023;20(5):651-660. doi:10.1093/jsxmed/qdad027.

60 Oliffe JL, Gao N, Kelly MT, et al. The commercial determinants of nonalcoholic beer: redemption, revenue, or men's harm reduction? *Am J Mens Health.* 2025;19(1):15579883251317096. doi:10.1177/15579883251317096; Seidler Z. *Masculinities and Mental Health in Young Men.* Springer Nature; 2024.

61 Bom J, Bakx P, Schut F, van Doorslaer E. The impact of informal caregiving for older adults on the health of various types of caregivers: a systematic review. *Gerontologist.* 2018;59(5):e629-e642. doi:10.1093/geront/gny137.

62 Blanner Kristiansen C, Kjær JN, Hjorth P, Andersen K, Prina AM. Prevalence of common mental disorders in widowhood: a systematic review and meta-analysis. *J Affect Disord.* 2019;245:1016-1023. doi:10.1016/j.jad.2018.11.088.

63 Elder K, Griffith DM. Men's health: beyond masculinity. *Am J Public Health.* 2016;106(7):1157. doi:10.2105/AJPH.2016.303237; Reeves R. *Of Boys and Men: Why the Modern Male Is Struggling, Why It Matters, and What to Do About It.* Washington, DC: Brookings Institution Press; 2022.

64 Congressman Troy A. Carter Sr. Congressman Carter launches men's health caucus in the 119th Congress. 2025. https://troycarter.house.gov/media/press-releases/congressman-carter-launches-mens-health-caucus-119th-congress.

65 Addressing Social Isolation and Loneliness in Older Adults Act of 2023, S 3437, 118th Cong (2023). Accessed August 21, 2025. https://www.congress.gov/bill/118th-congress/senate-bill/3437/all-actions.

66 Griffith DM. Gender health equity: the case for including men's health. *Soc Sci Med.* 2024;351(Suppl 1); Bruckbauer S. Proposed Office of Men's Health would address "silent health crisis." *JNCI J Natl Cancer Inst.* 2003;95(14):1038-1039. doi:10.1093/jnci/95.14.1038; Fontanarosa PB, Cole HM. Theme issue on men's health: call for papers. *JAMA.* 2006;295(4):440-441. doi:10.1001/jama.295.4.440; Garfield CF, Clark-Kauffman E, Davis MM. Fatherhood as a component of men's health. *JAMA.* 2006;296(19):2365-2368. doi:10.1001/jama.296.19.2365; Fossella V. Focusing on men's health. *The Hill.* Politics Blog. 2007. https://thehill.com/blogs/congress-blog/politics/25114-focusing-on-mens-health/; Men's Health Network. We need to establish a federal Office of Men's Health now. *The AFRO.* Blog. 2021. https://afro.com/we-need-to-establish-a-federal-office-of-mens-health-now/.

67 Barr E, Belaunzarán-Zamudio PF, Clayton JA, et al. Workshop summary: National Institutes of Health (NIH) 2022 scientific workshop on gender and health. *Soc Sci Med.* 2024;351:116435. doi:10.1016/j.socscimed.2024.116435; Office of Research on Women's Health. ORWH 30th anniversary. US Department of Health and Human Services. Accessed August 21, 2025. https://orwh.od.nih.gov/orwh-anniversary; Brott A. Why we need an Office of Men's Health—now! *Talking About Men's Health.* Blog. 2021. https://tamh.menshealthnetwork.org/why-we-need-an-office-of-mens-health-now/; Obias-Manno D, Scott PE, Kaczmarczyk J, et al. The Food and Drug Administration Office of Women's Health: impact of science on regulatory policy. *J Womens Health.* 2007;16(6):807-817. doi:10.1089/jwh.2007.0404.

68 25 USC §1621v. Subchapter II—Health Services. Chapter 18—Indian Health Care. 2010.

69 Bothwell E, James T. Let's not forget the Office of Indian Men's Health. *The Hill.* Healthcare Blog. 2016. https://thehill.com/blogs/congress-blog/healthcare/301786-lets-not-forget-the-office-of-indian-mens-health/.

70 JVF Solutions. Men's Health Week celebrates 25 years. Men's Health Network. 2021. https://menshealthnetwork.org/mens_health_week_turns_25/#:~:text=The%20legislation%20creating%20NMHW%20was,and%20jurisdictions%20throughout%20the%20country.

71 Office of Disease Prevention and Health Promotion. Healthy People 2030: building a healthier future for all. US Department of Health and Human Services. Accessed August 21, 2025. https://odphp.health.gov/healthypeople.

72 Heidelbaugh J. The Affordable Care Act: how it has impacted men's health. *Urology Times.* 2016. https://www.urologytimes.com/view/affordable-care-act-how-it-has-impacted-mens-health.

73 Garrett AB, Gangopadhyaya A. Who gained health insurance coverage under the ACA, and where do they live? Urban Institute. 2016. https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf; Gutierrez CM, Pettit B. Employment and health among recently incarcerated men before and after the Affordable Care Act (2009–2017). *Am J Public Health.* 2020;110(suppl 1):S123-S129. doi:10.2105/AJPH.2019.305475; Skopec L, Banthin J. Free preventive services improve access to care. Washington, DC: Urban Institute; 2022; Sobel L, Salganicoff A, Felix M. ACA preventive services are back at the Supreme Court: Kennedy v Braidwood. *KFF.* 2023. https://www.kff.org/womens-health-policy/issue-brief/aca-preventive-services-supreme-court-kennedy-braidwood/.

74 US Commission on the Social Status of Black Men and Boys. Welcome. Accessed August 21, 2025. https://cssbmb.gov/.

75 The White House Office of the Press Secretary. Opportunity for all: President Obama launches My Brother's Keeper initiative to build ladders of opportunity for boys and young men of color [fact sheet]. February 27, 2014. https://permanent.fdlp.gov/gpo46431/www.whitehouse.gov/the-press-office/2014/02/27/fact-sheet-opportunity-all-president-obama-launches-my-brother-s-keeper-.htm.

76 Obama Foundation. My Brother's Keeper Alliance. Accessed August 21, 2025. https://www.obama.org/programs/my-brothers-keeper-alliance/about/our-mission/.

77 Goyal R, Luca D, Klein PW, et al. Cost-effectiveness of HRSA's Ryan White HIV/AIDS Program. *J Acquir Immune Defic Syndr.* 2021;86(2):174-181. doi:10.1097/QAI.0000000000002547.

78 US Centers for Disease Control and Prevention. Fast facts: HIV and gay and bisexual men. October 7, 2024. https://www.cdc.gov/hiv/data-research/facts-stats/gay-bisexual-men.html; US Health Resources and Services Administration. Program parts and initiatives. Ryan White HIV/AIDS Program. December 2024. https://ryanwhite.hrsa.gov/about/parts-and-initiatives.

79 Linas BP, Zheng H, Losina E, Walensky RP, Freedberg KA. Assessing the impact of federal HIV prevention spending on HIV testing and awareness. *Am J Public Health.* 2006;96(6):1038-1043. doi:10.2105/AJPH.2005.074344.

80 National Responsible Fatherhood Clearinghouse. Federal agency initiatives. Accessed August 21, 2025. https://www.fatherhood.gov/for-programs/program-design-planning/federal-agency-initiatives.

81 Congressional Dad's Caucus. About the caucus. Accessed August 21, 2025. https://gomez.house.gov/dadscaucus/.

82 Holmes EK, Egginton BR, Hawkins AJ, Robbins NL, Shafer K. Do responsible fatherhood programs work? A comprehensive meta-analytic study. *Fam Relat.* 2020;69(5):967-982. doi:10.1111/fare.12435; Holmes EK, Thomas CR, Egginton BR, Leiter VK, Hawkins AJ. The effectiveness of responsible fatherhood programs targeting low-income and nonresident fathers: a qualitative meta-synthesis. In: Fagan J, Pearson J, eds. *New Research on Parenting Programs for Low-Income Fathers.* New York, NY: Routledge/Taylor & Francis Group; 2021:12-28. doi:10.4324/9780367363444-2-2.

83 Kotelchuck M. The impact of fatherhood on men's health and development. In: Grau Grau M, las Heras Maestro M, Riley Bowles H, eds. *Engaged Fatherhood for Men, Families and Gender Equality.* Cham, Switzerland: Springer; 2022:63-91. doi:10.1007/978-3-030-75645-1_4.

84 US Department of Defense. Defense Department report shows decline in armed forces population while percentage of military women rises slightly. November 6, 2023. https://www.defense.gov/News/Releases/Release/Article/3580676/defense-department-report-shows-decline-in-armed-forces-population-while-percen/

85 Congressionally Directed Medical Research Program. Prostate cancer. US Department of Defense. July 17, 2025. https://cdmrp.health.mil/pcrp/default.aspx.

86 US Department of Veterans Affairs. Million Veteran Program. 2025. https://www.mvp.va.gov/pwa/.

87 Fenstermaker M, Paknikar S, Rambhatla A, Ohl DA, Skolarus TA, Dupree JM. The state of men's health services in the Veterans Health Administration. *Curr Urol Rep.* 2017;18(11):73. doi:10.1007/s11934-017-0733-4.

88 Washington Commission on Boys and Men. About the bill: HB 1266 / SB 5466. Accessed August 21, 2025. https://waboysandmen.org/about-washington-state-commission-on-boys-and-men-bill-hb-1266-sb-5446/.

89 Governor Gavin Newsom. Governor Newsom issues executive order to support young men and boys, address suicide rates. July 30, 2025.

https://www.gov.ca.gov/2025/07/30/governor-newsom-issues-executive-order-to-support-young-men-and-boys-address-suicide-rates/.

90 Office of Families, State of Utah. Supporting parents. Accessed August 21, 2025. https://governor.utah.gov/office-of-families/supporting-parents/.

91 North Dakota Health and Human Services. Men's health. Accessed August 21, 2025. https://www.hhs.nd.gov/health/men.

92 Illinois Department of Public Health. Men's health. Accessed August 21, 2025. https://dph.illinois.gov/topics-services/life-stages-populations/mens-health.html; Illinois Department of Public Health. Men's health initial assessment 2024-2025. Accessed August 21, 2025. https://dph.illinois.gov/topics-services/life-stages-populations/mens-health/initial-assessment-2024-2025.html.

93 Governor Gretchen Whitmer. Gov. Whitmer's 2025 State of the State address as prepared for delivery. February 26, 2025. https://www.michigan.gov/whitmer/news/press-releases/2025/02/26/whitmer-deliver-2025-state-of-the-state.

94 Governor Ned Lamont. Governor Lamont's 2025 State of the State address. January 8, 2025. https://portal.ct.gov/governor/news/speeches/governor-lamont-2025-state-of-the-state-address.

95 Maryland General Assembly. HB 1552, Maryland Commission for Men's Health – Reestablishment. 2025. https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB1552?ys=2025RS.

96 Maryland Matters. Transcript of Gov. Wes Moore's 2025 State of the State address. February 5, 2025. https://marylandmatters.org/2025/02/05/transcript-of-gov-wes-moores-2025-state-of-the-state-address/.

97 Griffith DM, Semlow AR, Leventhal M, Sullivan C. The Tennessee men's health report card: a model for men's health policy advocacy and education. *Am J Mens Health.* 2019;13(5):1557988319882586. doi:10.1177/1557988319882586.

98 Online Sunshine. The 2024 Florida Statutes. §16.615. Council on the Social Status of Black Men and Boys. Accessed August 21, 2025. http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0000-0099/0016/Sections/0016.615.html.

99 American Cancer Society. Legislation aimed at eliminating financial barriers to prostate cancer screening introduced in US Congress. February 13, 2025. https://www.fightcancer.org/releases/legislation-aimed-eliminating-financial-barriers-prostate-cancer-screening-introduced-us; Delaware General Assembly. House Substitute 1 for House Bill 302, an Act to Amend Title 18 of the Delaware Code relating to prostate cancer screening. 152nd General Assembly. 2024. https://legis.delaware.gov/BillDetail/141173.

100 Zero Prostate Cancer. Overview: PSA Screening for HIM Act (HR 1826/S 2821). Accessed August 21, 2025. https://zerocancer.org/educational-materials/overview-psa-screening-him-act.

101 Carroll JJ, Green TC, Noonan RK. Evidence-based strategies for preventing opioid overdose: what's working in the United States. CDC Stacks ID #59393. 2018. https://stacks.cdc.gov/view/cdc/59393.

102 National Center for Drug Abuse Statistics. Drug overdose death rates. Accessed August 21, 2025. https://drugabusestatistics.org/drug-overdose-deaths/.

103 Levy DT, Huang AT, Havumaki JS, Meza R. The role of public policies in reducing smoking prevalence: results from the Michigan SimSmoke Tobacco Policy Simulation Model. *Cancer Causes Control.* 2016;27(5):615-625. doi:10.1007/s10552-016-0735-4.

104 Joseph JJ, Nolan TS, Brock G, et al. Improving mental health in Black men through a 24-week community-based lifestyle change intervention: the Black Impact program. *BMC Psychiatry.* 2024;24(1):34. doi:10.1186/s12888-023-05064-5.

105 Watkins DC, Goodwill JR, Johnson NC, et al. An online behavioral health intervention promoting mental health, manhood, and social support for young Black men: the YBMen project. *Am J Mens Health.* 2020;14(4):1557988320937215. doi:10.1177/1557988320937215.

106 Griffith DM, Pennings JS, Jaeger EC. Mighty men: a pilot test of the feasibility and acceptability of a faith-based, individually tailored, cluster-randomized weight loss trial for middle-aged and older African American men. *Am J Mens Health.* 2023;17(4):155798832311932. doi:10.1177/155798832311932.

107 Wilson TE, Gousse Y, Joseph MA, et al. HIV prevention for Black heterosexual men: the Barbershop Talk With Brothers cluster randomized trial. *Am J Public Health.* 2019;109(8):1131-1137. doi:10.2105/AJPH.2019.305121.

108 Cassel KD, Hughes C, Higuchi P, et al. No Ke Ola Pono o Nā Kāne: a culturally grounded approach to promote health improvement in Native Hawaiian men. *Am J Mens Health.* 2020;14(1):1557988319893886. doi:10.1177/1557988319893886.

109 Rhodes SD, Leichliter JS, Sun CJ, Bloom FR. The HoMBReS and HoMBReS Por un Cambio interventions to reduce HIV disparities among immigrant Hispanic/Latino men. *MMWR Suppl.* 2016;65(1):51-56. doi:10.15585/mmwr.su6501a8.

110 Perez O, Beltran A, Isbell T, et al. Papás Saludables, Niños Saludables: perspectives from Hispanic parents and children in a culturally adapted father-focused obesity program. *J Nutr Educ Behav.* 2021;53(3):246-253. doi:10.1016/j.jneb.2020.11.006.

111 Tello, J., Cervantes, R. C., Cordova, D., & Santos, S. M. (2010). Joven Noble: Evaluation of a culturally focused youth development program. Journal of Community Psychology, 38(6), 799–811. https://doi.org/10.1002/jcop.20396

112 Cordier R, Wilson NJ. Community-based Men's Sheds: promoting male health, wellbeing, and social inclusion in an international context. *Health Promot Int.* 2014;29(3):483-493. doi:10.1093/heapro/dat033; Heinz M, Kent-Thomas K, Hinders J. US Men's Sheds: promoting meaning, purpose, and connection. *Act Adapt Aging.* 2024;49(2):329-353. doi:10.1080/01924788.2024.2339051; Kelly D, Steiner A, Mason H, Teasdale S. Men's Sheds: a conceptual exploration of the causal pathways for health and well-being. *Health Soc Care Community.* 2019;27(5):1147-1157. doi:10.1111/hsc.12777.

113 Big Brothers Big Sisters of America. Big Draft. Accessed August 21, 2025. https://www.bbbs.org/bigdraft/.

114 US Department of Health and Human Services, Office on Women's Health. Work with us: funding opportunities. Accessed August 21, 2025. https://womenshealth.gov/about-us/work-us/funding-opportunities.

115 National Department of Health. The South African National Integrated Men's Health Strategy 2020–2025. Pretoria, South Africa: Government of South Africa; 2020.

116 US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People in states and territories. Accessed August 21, 2025. https://odphp.health.gov/healthypeople/tools-action/healthy-people-states-and-territories.

117 First 5 California. Fatherhood. Accessed August 21, 2025. https://www.first5california.com/en-us/topics/fatherhood.

118 Hulls PM, Richmond RC, Martin RM, Chavez-Ugalde Y, de Vocht F. Workplace interventions that aim to improve employee health and well-being in male-dominated industries: a systematic review. *Occup Environ Med.* 2022;79(2):77-87. doi:10.1136/oemed-2021-107847.

119 Rauhaus B, Johnson A. Social inequities highlighted by the prolonged pandemic: expanding sick leave. *J Public Nonprofit Aff.* 2021;7(1):154-163. doi:10.20899/jpna.7.1.154-163; Vander Weerdt C, Stoddard-Dare P, DeRigne L. Is paid sick leave bad for business? A systematic review. *Am J Ind Med.* 2023;66(6):429-440. doi:10.1002/ajim.23515.

120 Griffith DM. An intersectional approach to men's health. *J Mens Health.* 2012;9(2):106-112. doi:10.1016/j.jomh.2012.03.001; Sinclair KI, Gonzales K, Woosley C, Cree TR, Garza CM, Buchwald D. An intersectional mixed methods approach to understand American Indian men's health. *Int J Mens Soc Community Health.* 2020;3(2):e66-e89. doi:10.22374/ijmsch.v3i2.30.

121 Jiang Q, Naseem M, Lai J, Toyama K, Papalambros P. Understanding power differentials and cultural differences in co-design with marginalized populations. In: Proceedings of the 5th ACM SIGCAS/SIGCHI Conference on Computing and Sustainable Societies. New York, NY: Association for Computing Machinery; 2022:165-179. doi:10.1145/3530190.3534810.

122 Seidler Z, ed. *Masculinities and Mental Health in Young Men: From Echo Chambers to Evidence.* Cham, Switzerland: Springer Nature; 2024; Macdonald JJ. Shifting paradigms: a social-determinants approach to solving problems in men's health policy and practice. *Med J Aust.* 2006;185(8):456-458. doi:10.5694/j.1326-5377.2006.tb00682.x.

123 Seidler ZE, Wilson MJ, Toogood N, et al. Pilot evaluation of the Men in Mind training program for mental health practitioners. *Psychol Men Masc.* 2022;23(2):257-268. doi:10.1037/men0000390.

124 Rice S, Oliffe J, Seidler Z, et al. Gender norms and the mental health of boys and young men. *Lancet Public Health.* 2021;6(8):e541-e542. doi:10.1016/S2468-2667(21)00148-3.

125 University of British Columbia. Reducing male suicide. Accessed August 21, 2025. https://reducingmalesuicide.ubc.ca/.

MOVEMBER® INSTITUTE
OF MEN'S HEALTH

MUSTACHES LOVE RESEARCH