

Lagging Life Expectancy for Black Men: A Public Health Imperative

Black men's health disparities must be viewed within the larger context of public health, community wellness, and family formation. Healthy People 2020 recognizes both ecological and individual factors that determine health and wellness across the life span. Life expectancy summarizes the impact of risk across the life course.

Consider life expectancy by race (Black:White inequities) and gender from 1900 to 2011. Although it has improved for all race/ethnicity and gender groups for the past 111 years, Black men continue to have substantially lower life expectancy at birth than Black women and White women and men (Figure 1a).¹ In 1900, the estimated life expectancy for White men was 46.6 years; for non-White men it was 43.5 years; for White women it was 48.7 years, and for non-White women it was 33.5 years. **By 2011, the life expectancy for White men was 76.6 years; for Black men it was 72.2 years; for White women it was 81.1 years; and for Black women it was 78.2 years. For both genders, the relative difference in life expectancy declined from a high of 34% in 1900 to a low of 4% in 2011** (Figure 1b). Relative differences in life expectancy declined at a steady rate until 1960, then plateauing for males and females until 1990. The plateau in relative ratios for men probably reflects an increase in mortality from homicide and HIV for

young to middle-aged Black men. After 1990, the relative differences declined steadily for both men and women, reflecting annual increases in life expectancy (Figure 1b).

Post-1990 improvements in expectation of life at birth primarily reflect increases in survival after age 75 years. These improvements have been larger for females than for males, and for Whites compared with Blacks. There is a lag in increases in survival between the ages of 45 and 75 years for Blacks with the largest gap in survival for Black men. Increases in maximum life spans have been comparatively small. Life table survival analysis shows that improvements in life expectancy in young through middle age are close to their limits (with survival rates >90%). An examination of relative ratios in age-specific mortality rates for males reflects these race-specific changes. In 1960, relative ratios in age-specific mortality increased from birth to age 40 years (with Black male mortality rates from 40% to 230% higher than White male mortality rates) then declined to -10% at age 85 years (Black mortality rates were 10% lower at 85 years). In 2013, relative ratios remained relatively constant from birth to age 70 years (with Black male mortality rates about 40% higher than White male mortality rates) and then declined to 0% at age 85 years. Most of the improvement in life expectancy in the first half

of the 20th century was attributable to the reduction in both infant and childhood mortality and reductions in deaths from acute infectious diseases. Rates of decline were slower for Black men and women, resulting in larger relative ratios in life expectancy.

Life expectancy and other health outcomes are affected by exposures to a wide range of social, economic, and biological risk factors during critical periods of the life course. Early life exposures increase disease risk and have cumulative lifelong negative effects on the structure and function of organs, tissues, and body systems.² Some have labeled prenatal adverse exposures associated with poor growth in utero, low birth weight, or premature birth as "later life effect modifiers," and have linked them to coronary heart disease, hypertension, and insulin resistance. **Many historical, social, economic, physical, and biological risk factors shape the life course of Black men and contribute to their increased rates of premature morbidity and mortality. These include the role of the places and**

spaces where Black men and their families live, work, worship, and play; the risk that accompanies family formation in the Black community; and the increased individual social, economic, and behavioral risk that is associated with being Black in America.³⁻⁶

A PUBLIC HEALTH IMPERATIVE

The health and well-being of men is a public health priority and efforts to eliminate racial and ethnic inequities have often failed to include interventions to improve men's health. Black males continue to fare worse than Black women and White Americans in life expectancy, infant health outcomes, age- and cause-specific morbidity and mortality, insurance coverage, and access to adequate health care. These inequities have been prevalent for as long as routine data have been collected.

The importance of men's health has only recently been acknowledged, and men are increasingly being welcomed as an essential part of the family unit structure. The White House-sponsored Dialogue on Men's Health earlier this year brought together health care providers, practitioners, policymakers,

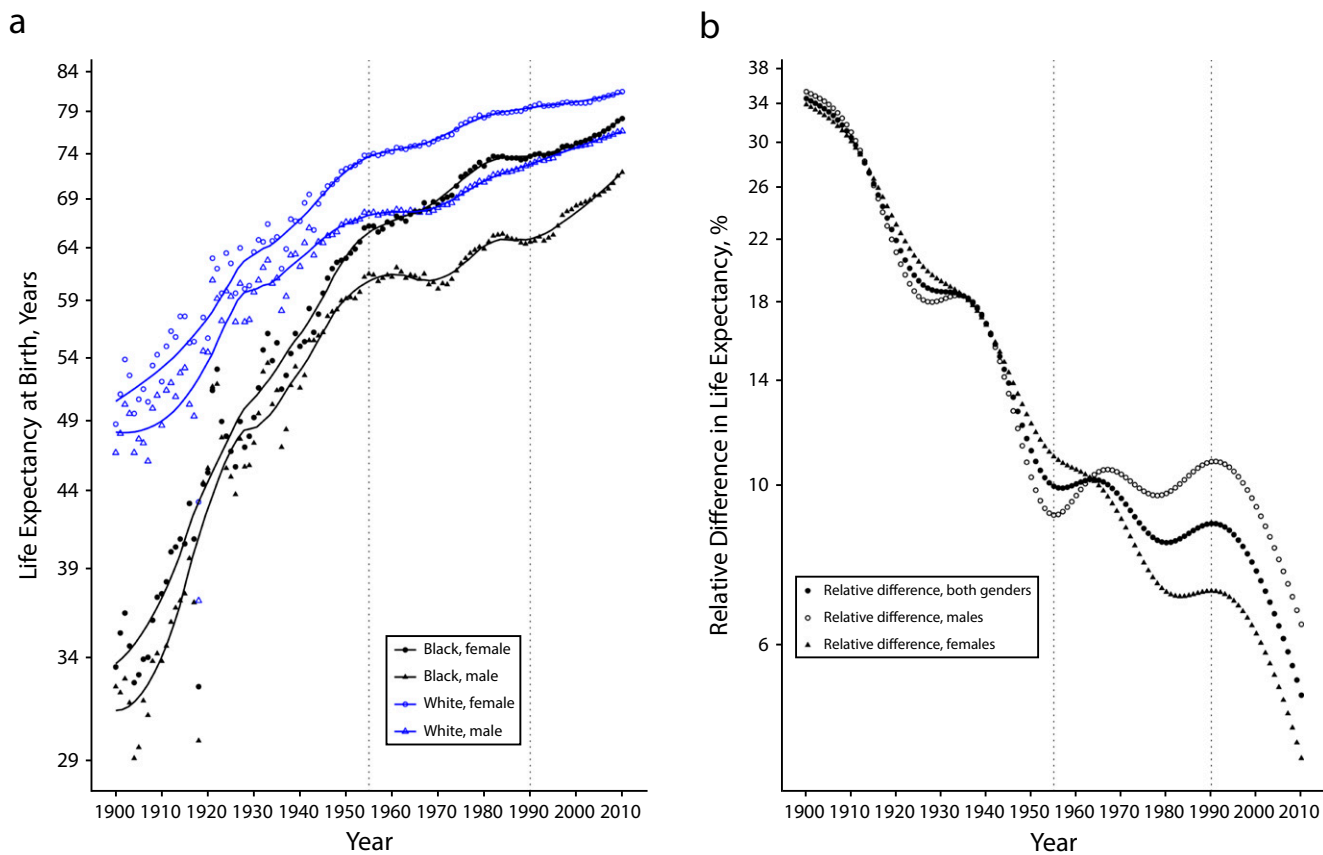
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Source. National Center for Health Statistics of the Centers for Disease Control and Prevention and, for 1900–1928, states that were included in the vital records registration system of the United States (12 states by 1900 and 46 states by 1928).

FIGURE 1—United States Life Expectancy (a) at Birth (in Years) by Race and Gender and (b) Relative Difference (%) Overall and by Gender: 1900–2011

researchers, and community organizers. Secretary Broderick Johnson, chair of the My Brother’s Keeper Task Force, and US Surgeon General Vivek Murthy spoke of a need to increase the understanding of contextual, institutional, and historical forces that shape life opportunities for boys and men of color, as well as the importance of men’s health.

MOVING FORWARD

Men play a significant role during family formation. Reproductive health and preconception care are therefore potential points of intervention for addressing the health care

needs of men and their families.

The Commission on Paternal Involvement in Pregnancy Outcomes—a transdisciplinary working group of clinicians and public health professionals convened in 2009—sought to raise public awareness about paternal involvement in pregnancy and family health by issuing 40 best and promising research, policy, and practice recommendations. These recommendations should be central

for reframing men’s health [and] should naturally include the basic components of preconception health (risk assessment, health promotion, clinical and psychosocial interventions) which can help identify challenges facing adolescents and

barriers confronting boys in the transition to manhood and in preparation for fatherhood.

Although men are important to maternal and child health, they do not play a significant role in current family health programs; they are less likely than women to receive preventive health services, have a regular source of care, or have health insurance. Instilling healthy habits and teaching young males about the importance of self-maintenance is key to improving the overall health of our nation. It is essential to provide boys and young men with the appropriate tools to maintain their own health and for them to find a healthy balance between health, work, and

family planning in preparing for fatherhood.

There are a number of conceptual frameworks that describe how the timing of social determinants and risk factors affect the health of men and their families. Future pathways of research success may depend on creating a men’s health cohort that uses advances in computing and wearable technologies to collect big data to build empirical knowledge with evidence-based strategies that address developmental disadvantages occurring in utero, with early life interventions to address the social determinants in childhood, in adolescence, and in early adulthood that can reduce illnesses in

middle and late life, including antecedent risk factors and subsequent health disparities. **AJPH**

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Beyond LARC: Advancing Reproductive Health to Include Men

The constant threats to Planned Parenthood and to legal and accessible abortion services compel us to try new avenues to expand reproductive health access and improve our approach to parenting. New family planning methods are aimed at closing the persistently large gap of “unmet need” for contraception. These new tools, together with expanded access to longstanding methods and vigorous advocacy to keep abortion legal, safe, and easily accessible, are clearly essential activities to support women’s control over their own reproduction, in particular the planning of pregnancies.

One class of technologies, long-acting reversible contraceptives (LARC), which includes implants and intrauterine devices, has been the subject of intense recent enthusiasm and promotion in the medical and lay press, and is specifically recommended for use as the “first line” of contraceptives for adolescents and young adults. Recent articles have addressed the limits of what technological advances alone, such as LARC, can accomplish—for example, whether “technology first” can adequately reduce health disparities or enhance reproductive health justice and equity.^{1,2} As Gubrium et al.¹ so

effectively argue, long-acting reversible contraception cannot be relied on to address larger social injustice issues. And, as eloquently laid out by Gomez et al.,² there is a need to carefully assess the impact of such technologies through the lens of true, woman-centered care and promotion of women’s agency and informed choice.

We are also concerned that the recent emphasis on LARC limits the public’s perception of the scope and the potential reach of family planning. First, regarding scope, contraception is only one of the several important roles a modern family planning center must play; and second, regarding reach, the absence of men from the discourse on LARC is a serious omission. In this editorial, the second issue is given most attention.

ENHANCING THE ROLE OF PARTNERS IN REPRODUCTION

Both research and programmatic evidence from multiple social sciences and health-related domains suggest that there are valuable gains to be made from efforts to enhance the role of partners in reproduction. Indeed, standard measures of “unmet need” for family

planning have recently been expanded to include men, an important first step in evaluating future activities to engage them actively in decision-making on parenting.³ Published data on the expressed need and experiences of reproductive health counseling to heterosexual couples, as well as limited experience from male-only clinic spaces are beginning to demonstrate the potential benefits of men’s participation—to their partners, families, and society. New models of male community health worker programs being piloted in US immigrant communities also support a clear role for men to spread reproductive health education and behavior change among male peers. More broadly, we have the impressive and encouraging global body of work in the gender and health domain, of projects to redefine masculinities—including men’s rejection of intimate partner

violence, embracement of new roles in evaluating childbearing options together with their partner, participation in pregnancy and childrearing, and reconceptualized notions of male strength and power that favor increased intimacy with partners and children.^{4,5} Recent vaginal microbicide trials demonstrate the value of applying gender transformative thinking, with an explicit programmatic focus on “building and strengthening partner relationships” to support use of women-initiated HIV prevention tools, while exploring in detail obstacles to men’s participation in such programs.⁶ In internationally partnered new models of sexuality education,⁷ mixed gender groups of young people are invited to think critically and collectively about how human rights, gender equality, and sexual health are linked, to promote and redefine models of friendship, love, support, and sexual intimacy. Furthermore, as we have witnessed, a strong wave of “affirmative consent” curricula now being introduced as early as the high school level is broadening the landscape of

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