Gender and health are also about boys and men

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Attention to the gendered dimensions of health has tended to focus on improving the disadvantages and vulnerability of girls and women. But to fully understand the ways that gender shapes how people live, work, and optimise health, more awareness is needed about the circumstances of men's lives that adversely affect their health. Men consistently experience shorter lifespans, greater threats to health and safety, and less access to health care than women.

Needed insight into gender is revealed in a new report from the American Psychological Association, which highlights the particular vulnerabilities of racial and sexual minority males who do not experience the same power and privilege typically afforded men in the USA.

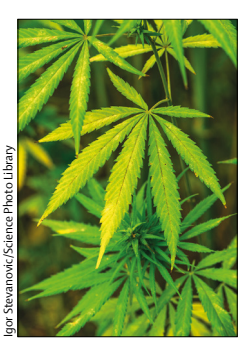
The report, published last month, argues that the systematic oppression experienced by these men has led to higher rates of trauma, substance use, depression, and violence. Boys and men of colour have worse health status but also are more likely to be poor or incarcerated, to have fewer educational and employment opportunities, and higher exposures to crime. Sexual minority men have higher rates of HIV, suicide, and mental health problems, but also more exposure to harassment, hate crime, and stigmatisation.

The report's explanations for the disparities are especially instructive. More so than lifestyle causes of risk, the report shows how rigid gender norms make these men vulnerable to poor health. For example, ideas and perceptions of masculinity—control, toughness—drive behaviour such that minority boys and men may suppress emotions when traumatised or hide symptoms of depression. Expectations of machismo lead to increased risk taking. For sexual minority men, their vulnerability to violence could be due to perpetrators' affirmation of hegemonic masculinity. In turn, masculinity norms that expect invincibility limit men's seeking of help and health care. Recommendations include building awareness of the structural determinants of men's health risks and more accessible health care for mental health and trauma. Above all, it reminds us that being gender blind benefits neither men nor women. ■ *The Lancet*

For the **American Psychological Association's report** see http://www.apa.org/pi/health-disparities/resources/race-sexuality-men.aspx

For more on **intersectionality and health** see **Comment** *Lancet* 2018; **391:** 2589–91

Cannabinoids: just like any other medication?



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More than 17 countries permit the medicinal use of cannabis, but the UK is not one of them. Cases of children with severe epilepsy who have seen benefit with cannabinoid derivatives from the cannabis plant but cannot access the medication have reignited the debate over medicinal cannabis. The UK's legislative polices and intense bureaucracy over individual licensing are a source of inertia for clinicians and distress for patients. Part of the problem is the confusion between medicinal cannabis using the whole cannabis plant and cannabinoid derivatives, of which there are over 100. The most commonly studied cannabinoid is cannabidiol—a non-psychoactive derivative, which differs from the psychoactive cannabinoid Δ-9-tetrahydrocannabinol (THC). Cannabis oil usually contains a high ratio of cannabidiol to THC.

Humankind's experience with cannabis has been long and relatively benign. Written evidence for medicinal uses of cannabis dates back to around 1700 BC. 3000 years later, William O'Shaughnessy studied the medicinal uses of *Cannabis indica* in the 1840s and the drug gained traction in modern medicine. *The Lancet* published a series of articles documenting the use of Indian hemp in conditions from dental operations to tetanus during this period. In the 1970s, preclinical epilepsy studies started exploring cannabinoids. Since 2015, one open-label study and two randomised controlled trials have shown a benefit of cannabidiol in treatment-resistant epilepsy and two complex forms of childhood epilepsy—Dravet and Lennox-Gastaut syndromes. In these three studies, adverse events were reported in 75–93% of participants. Conflicting legislature of psychoactive constituents and differing pharmaceutical formulations have made research into side-effects inconsistent. The evidence for cannabinoids in focal epilepsy, chronic pain, autism, and psychiatric disorders is preliminary and mixed.

Fundamentally, cannabinoids are like any other medication and should follow a regulatory pathway, based on clinical evidence, to licensing. In the interim, a risk balance approach is justified. In severe epilepsy, where a child might be on different medications with cognitive and physical side-effects and still having several seizures a day, cannabinoid derivatives should be available. ■ *The Lancet*

For more on **cannabinoids** see **Personal View** *Lancet Psychiatry* 2017; **4:** 643–48

For the **study on treatment-resistant epilepsy** see **Articles** *Lancet Neurol* 2016; **15:** 270–78

For the **study on Lennox-Gastaut syndrome** see **Articles** *Lancet* 2018; **391:** 1085–96