7. Health

World Health Organisation
Strategy for integrating gender analysis and actions into the work of WHO (extract), 2007

'In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognize that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ.

'In many societies, women have less access to health information, care, services and resources to protect their health. Gender norms also affect men's health by assigning them roles that promote risk-taking behaviour and cause them to neglect their health. Furthermore, gender interacts with race and other social stratifications, resulting in unequal benefits among various social groups and between women and men'.

The Council of the European Union
Conclusions on men and gender equality (extract)
30 November and 1 December 2006

The Council of the European Union:

'stresses that the recognition of the gender dimension in health is an essential part of EU health policies and that health promotion projects and services should be tailored, as appropriate, to women's or men's needs'.

Council of Europe
Recommendation CM/Rec(2008)1 of the Committee of Ministers to Member States on the inclusion of gender differences in health policy

The governments of Member States should:

- 'in the context of protection of human rights, make gender one of the priority areas of action in health through policies and strategies which address the specific health needs of men and women and that incorporate gender mainstreaming;
- 'promote gender equality in each sector and function of the health system including actions related to health care, health promotion and disease prevention in an equitable manner;
- 'consider issues related to the improvement of access and quality of health services as these relate to the specific and differing needs and situations of men and women;
- 'develop and disseminate gender sensitive knowledge that allows evidence-based interventions through systematic collection of appropriate sex-disaggregated data, promotion of relevant research studies and gender analysis;
- 'promote gender awareness and competency in the health sector and ensure balanced participation of women and men in the decision-making process; establish monitoring and evaluation frameworks on progress on gender mainstreaming in health policies'.

Introduction

This section is divided into the following categories:

Men, masculinities and health (page 84)

The policy context (page 86)

Gender Equality Duty and health (page 87)

The main problems with men's health (page 90)

Life expectancy and mortality (page 90)

Circulatory diseases (page 92)

Cancer (page 92)

Weight/obesity (page 93)

Mental health (page 93)

Sexual and reproductive health (page 94)

Risk-taking behaviours (page 96)

Use of health services (page 97)

Health information (page 100)

Recommendations (page 103)

Men, masculinities and health

If the health of men and boys is measured against the World Health Organisation's classic definition of health – *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'*[325] – it is immediately apparent that they are not doing well in many key respects. The most obvious and compelling problem with men's health is their life expectancy; average UK male life expectancy at birth, although steadily rising, still lags behind female life expectancy by four years.

Highlighting differences between men and women should not, however, obscure important variations between groups of men in terms of social class, age, sexual orientation, ethnicity and other demographic characteristics as well as geographic location. Comparisons between men and women must be used primarily as a basis for identifying outcomes that may be susceptible to improvement, and not to imply that the health of the sex that is 'doing better' requires no further improvement. It is very clear that there are major issues facing women's health – as well as men's – that need to be tackled. It must also be remembered that men often contribute directly to women's health problems, notably through violence and abuse.

Men's health problems are directly related to the social construction of masculinities. Boys and men are still socialised to be tough and strong, to appear in control and to take risks.[326] Many men neglect their health, and for some men – especially younger men – their 'masculinity' is characterised

325. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

326. Doyal L., *Sex, gender and health: the need for a new approach*, BMJ 2001;323:1061-3.

327. Hearn J., *Men and Gender Equality Policy*, in Varanka J. et al (eds) (2006) *Men and Gender Equality: Towards Progressive Policies*, Conference Report, Helsinki: Ministry of Social Affairs and Health

328. Patriarchy is a key analytical concept in feminist research and has been defined as *'the systematic domination of women by men and men by other men'*. See Chapman J. *The feminist approach*, in Marsh D, Stoker G, (eds.)(1995) *Theories and methods in political science.* London: Macmillan

by risk taking, an ignorance of their bodies and reluctance to seek medical intervention for suspected health problems.[327] It has been argued that patriarchy[328] not only harms women, but harms men's own health too; one study of 51 countries has suggested that there is a significant association between countries' levels of patriarchy (as indicated by female homicide rates) and men's higher mortality.[329]

Men often speak about their bodies as if they were machines and think about illness in terms of the malfunction or failure of a particular body part. Men expect their bodies to be capable of doing 'manly' things and not to be weak or vulnerable.[330] Many perceive health care as a 'fix-it' cure and use analogies such as going to the plumber to fix a leaking tap or a garage to get the car repaired. They often believe that their role is to 'tough out' illness for as long as possible rather than admit to what feels like a 'weakness'.

There are, without doubt, biological factors associated with specific men's health problems, such as disorders of the reproductive system (e.g. testicular cancer and prostate disease) and, to some extent, cardiovascular disease (linked to the absence in men of oestrogen, which has a protective effect). Black African and black Caribbean men have a much higher risk of developing prostate cancer, almost certainly for genetic reasons.[331] Biology also affects where men tend to store excess body fat – around their waists contributing to a higher risk of obesity-related diseases (this is a particular problem for South-Asian men[332]) – and the onset of baldness.[333]

It is clear, however, that it is the behaviour of men and boys that has a bigger impact than their biology on their health. If men's health problems were simply a result of biology, then there would be far fewer differences in key health outcomes – such as life expectancy – between men and women around the world. As it is, there is a four-year difference in life expectancy at birth between men and women in Sweden (men, 79 years; women, 83 years) and a 13-year difference in Russia (men, 59 years; women, 72 years).[334] Much of the difference in Russia is attributable to alcohol misuse by men as well as workplace and road traffic accidents, violence, smoking and a poor diet.[335] More positively, the extent of the impact of psychosocial factors on men's health means it is amenable to improvement through social and other policy measures.[336]

Masculinities almost certainly also impact on the way in which the health system views men. The Department of Health and the National Health Service are organisations which, at the highest levels, have historically been controlled mostly by men, but they have until very recently tended to ignore men's health issues. In so far as men have been considered, they have generally been viewed negatively.[337] Male risk-taking behaviour, and men's apparent unwillingness to take better care of their own health, led many to assume that any attempt to improve men's health was largely futile. Men in general have also often been seen as unreliable, irresponsible and difficult to work with. In particular, young men and black men have been seen as aggressive, and gay men have been held responsible for their sexual health problems. From this perspective, it is easy to believe that the finite resources that exist for healthcare should be allocated elsewhere.

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329. Stanistreet D., Bambra C., Scott-Samuel A., *Is patriarchy the source of men's higher mortality?*, Journal of Epidemiology and Community Health 2005;59:873-876

330. White A. (2001) *How men respond to illness,* Men's Health Journal 1(1):18-19

331. Ben-Shlomo Y. et al., *The Risk of Prostate Cancer amongst Black men in the United Kingdom: The PROCESS Cohort Study*, European Urology 2008; 53: 99-105

332. Dixit J., *Communicating the risks of obesity to South Asian men*, in White A. and Pettifer M. (eds.) (2007) *Hazardous Waist: Tackling male weight problems*, Oxford: Radcliffe

333. There is some evidence that the impact of hair loss is not insignificant for some men, affecting their self-esteem and even being a factor in depression) See M. Alfonso et al., *The psychosocial impact of hair loss among men: a multinational European study*, Current Medical Research and Opinion 2005 Nov, 21(11):1829-36

334. WHO data, http://www.who.int/countries/en/ (accessed 19 May 2008)

335. McKee M. and Shkolnikov V., *Understanding the toll of premature death among men in eastern Europe*, BMJ 2001, 323:1051-5

336. White A., *Men's health – what's it all about*, in Conrad D. and White A. (eds) (2007) *Men's Health: How to do it*, Oxford: Radcliffe

337. Men's Health Forum (2002) *Getting It Sorted: A New Policy for Men's Health.* A consultative document, London: MHF

It has, moreover, been observed that the nature of medical training – described by one author, himself a doctor, as 'the force-feeding of coping, survival, omnipotence, leadership and medical arrogance' – leads to consultations with male patients that are less than conducive to dealing with issues such as sexuality and personal relationships.[338] Men receive significantly less of a doctor's time in medical encounters than women and men are provided with fewer and briefer explanations. Although men are more likely to take risks with their health, they receive less advice about them.

The policy context

The emergence of men's health as an issue

Historically, there has been little interest in what is now understood by the term 'men's health'.[339] Until the 1990s, it was an issue almost completely overlooked by government, health policy-makers and practitioners, the media and, not least, by men themselves. Although there were, from the late-1960s onwards, significant and much-needed developments in women's health, pushed by an energetic grassroots women's movement, there was not only no comparable pressure to address men's health but also no awareness that an understanding of gender could contribute to an improvement in men's health as well as women's.

By the late-1990s, however, much had changed. The Labour Government elected in 1997 was committed to tackling health inequalities, and acknowledged that health was influenced by a range of social determinants as well as the behaviour of individuals. While the focus of attention was social class – and, to a lesser extent, ethnicity – brief references to gender as a health determinant began to appear in national policy documents as one of the issues requiring attention. Men's health specifically was rarely mentioned in policy but, less formally, some ministers and officials at the Department of Health began to acknowledge that it was a problem.

At a more popular level, interest in men's health issues was generated by the publication of an increasing number of glossy 'middle-shelf' men's magazines, notably *Men's Health* (launched in 1995). Like the other men's magazines, it was aimed mainly at a young professional consumer, but its coverage of a broad range of health and fitness issues is likely to have increased awareness of men's health more widely in the media, as well as among its readership.

The impact of these magazines has, nevertheless, been double-edged. As well as helping to 'normalise' health as an issue for men, they have simultaneously contributed to male anxieties about body image and 'performance', including at work and sexually. For example, one study of over 160 men aged 18-36 who were exposed to so-called 'lads' mags' suggested that, especially for single men, such exposure could increase preoccupation with attaining an 'ideal' male body.[340] The health coverage in men's magazines has also often sat uneasily alongside a celebration of dangerous risk-taking (especially in relation to alcohol consumption) and a view of women and women's bodies that is both sexualised and misogynistic.

Viagra became available on the NHS, albeit on a restricted basis, in 1999. This generated enormous media coverage of a major and exclusively men's health condition – erectile dysfunction – and, in turn, discussion of related issues, such as men's relationships with women, depression, heart disease, diabetes, and men's general reluctance to seek help from the doctors and other healthcare practitioners.

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338. Banks I., *No man's land: men, illness, and the NHS*, BMJ 2001, 323:1058-60

339. See *Getting It Sorted* for the MHF's definition of men's health.

340. D. Giles and J. Close, 'Exposure to "lad magazines" and drive for muscularity in dating and non-dating young men', *Personality and Individual Differences* 2008:44(7), 1610-1616

But men's health – or a comprehensive approach to gender and health – continued to be largely overlooked by government and the NHS well into the early 2000s. For instance, the various National Service Frameworks, which provide guidance on tackling major disease areas, did not acknowledge gender in any meaningful way, and neither did the various policy reports on tackling health inequalities. The Quality and Outcomes Framework (QOF) – a reward and incentive programme for GPs introduced in 2004 – also did nothing to encourage them to take account of gender in general or men's health in particular. QOF points (and therefore money) were linked to GPs achieving a target in relation to a range of specified conditions; however, these targets took – and still take – no account of gender differences, whether in terms of incidence or outcomes.

However, there were a few exceptions to this generally 'gender-insensitive' approach. The most significant of these was the Department of Health's 'Women's Mental Health Strategy' (2003) which very comprehensively highlighted the importance of gender in health policy and practice. This document not only defined gender and described its significance – it is *'fundamental to our sense of who we are, the roles we adopt, the way in which we experience and perceive others and in which they perceive us'* – it also stated that *'one aspect of ensuring that service planning and delivery is sensitive to gender is to recognise when there is a need for gender specific or single-sex services'*.[341]

Support for this sort of 'gender-sensitive' approach was expressed by many UK health organisations attending the first UK Gender and Health Summit held at the King's Fund in November 2003.[342] In the same month, the Equal Opportunities Commission published the report 'Promoting Gender Equality in Health'[343] which also made a strong case for 'gender mainstreaming' throughout health services.

There was also recognition of the need to improve men's health in two specific policy areas. The national suicide prevention policy focused attention on the need to tackle the problem in young men.[344] Published in 2002, this was the first Department of Health policy report to mention men in any significant detail. Men were highlighted too in the Department's policy for the development of pharmacy services, published in 2005. This noted that men under-use pharmacies, and that access might be improved *'if they are perceived to be more men friendly'*.[345]

Finally, medical training began, belatedly, to address men's health. In 2006, the Royal College of General Practitioners launched a new interactive short course, Men's Health in General Practice, to help GPs, practice nurses and other primary care professionals expand their knowledge and understanding of men's health needs and improve their consultation techniques. The Centre for Pharmacy Postgraduate Education (CPPE), which is funded by the Department of Health to provide continuing education for pharmacists in England, is currently preparing a similar educational programme.

The Gender Equality Duty and health

Men's health did not begin to shift more into focus at the national health policy level until the passage of the Equality Act 2006. The legislation effectively seeks to 'mainstream' gender in policy and service delivery, through the creation of a duty on public bodies to promote gender equality. The impact of the 'Gender Equality Duty' (see 'Men, boys and policy', page 34) on men's health, as well as women's, could potentially be enormous. The Men's Health Forum (MHF) has highlighted the types of issues the Duty requires the NHS to tackle; these include men's access to GP services, men's under-use of smoking-cessation and weight-management programmes, the lack of health information targeted at men and, above all, their lower life expectancy.

341. Department of Health (2003) *Mainstreaming Gender and Women's Mental Health: Implementation Guidance*, London: DH

342. O'Sullivan J.(ed.) (2005) *Improving the Health of Men and Women*, London: EOC, King's Fund, Women's Health, MHF, DH, EMHDF

343. Doyal L., Payne S., Cameron A. (2003) *Promoting gender equality in health*, School for Policy Studies, University of Bristol, Manchester: Equal Opportunities Commission

344. Department of Health (2002) *National Suicide Prevention Strategy for England*, DH, London

345. Department of Health (2005) *Choosing health through pharmacy: A programme for pharmaceutical public health 2005–2015*, London: DH

In recognition of the need to pay more attention to men's health, the Department of Health consulted the MHF on its guidance to the NHS on the new legislation. The published guidance included this significant statement:[346]

> *'It is vitally important that NHS organisations consider the different needs of women and men when developing policies and delivering services to the public…. [Gender] is a major factor in health care because of the vast differences in susceptibility to different conditions between men and women, and because of the different ways in which men and women access health services. Analysis of available data is necessary to discover who is using the service, and the levels of satisfaction of different services by men and women. Information may also highlight the fact that, for instance, disabled women, or men from a particular ethnic group, are dissatisfied with a particular aspect of a service, or do not use it. In this case, an organisation would need to analyse the reasons for this, and take steps to remedy the situation.*
>
> *'For instance, men in general do not access primary health care as often as women; they tend to wait until symptoms are serious or can no longer be ignored. This leads to late diagnosis, and poor health, and in the long run costs the health service more money. NHS organisations may consider methods of targeting men to encourage them to use primary health care services. For example where GP surgeries run regular clinics for women's health problems, similar clinics could be run for men, with a targeted leaflet drop to male patients outlining the advantages of regular health checks and early diagnosis of problems.*
>
> *'When developing health related programmes and activities, NHS organisations should consider the different ways in which men and women think about health, and how other factors, such as age, can affect these views…'.*

The MHF researched the impact of the Gender Equality Duty in its first few months of operation. It focused on the Gender Equality Schemes (GESs) developed by Primary Care Trusts (PCTs). PCTs are central NHS organisations. They assess local health needs, manage the range of primary care services (GPs, dentists, optometrists, pharmacists), commission secondary care services and control 80 per cent of the NHS budget. Their GESs should have been published by the end of April 2007 and they are required to set out how the requirements of the Gender Equality Duty will be met.

This research was completed in late July 2007 and showed that compliance with the new legislation was surprisingly and disappointingly poor. Over one-third of the 152 PCTs in England had failed to publish a GES at all. Of those that did, most failed to comply with the majority of requirements for a GES, as specified in the official code of practice. The emphasis of most GESs was also on internal administration and process, not on how to achieve equitable outcomes between men and women.

The Equality and Human Rights Commission (EHRC) responded to the MHF's findings by conducting its own enquiry into compliance by PCTs. The EHRC found that, by early March 2008, 27 PCTs were non-compliant in that they had not published a GES; it also concurred with the MHF's view that the vast majority of published schemes were inadequate in many key respects.

These findings serve to highlight a longstanding problem with men's health activity at the local level – it has overwhelmingly been patchy, short-term and inadequately funded. It has almost always been generated by the enthusiasm of an individual or a small group of practitioners and rarely part of a PCT's or other organisation's strategic programme of work. This has also meant that initiatives, even where they appear to have been successful, tend to have been poorly evaluated (or not even evaluated at all) and not written-up in health or other journals. The largest men's health project in

346. Department of Health (2001) *Creating a Gender Equality Scheme: A Practical Guide for the NHS*, London: DH

England – Bradford Health of Men, which was set up in 2002 as a Healthy Living Centre with a £1m five-year grant from the New Opportunities Fund and additional funding from local PCTs – is now winding down, without any assurances that the knowledge and expertise that it has succeeded in generating will become integrated into local policy and practice.

At a national level, however, more progress has been made. Since the introduction of the Gender Equality Duty there have been a number of significant government initiatives:

The Department of Health published a research study in 2008 by the Men's Health Forum and the School of Policy Studies at Bristol University into gender differences in access to health services – particularly in relation to cardiovascular disease, overweight and obesity, mental health, alcohol misuse, cancer and sexual health.[347]

The Department of Health has produced specific guidance for the NHS on creating a Gender Equality Scheme.[348]

The National Chlamydia Screening Programme has published a men's strategy (2007) which aims to drive up the numbers of young men tested for this sexually transmitted infection.[349]

The Government has announced an intention to introduce a national screening programme for men in their 60s at risk of abdominal aortic aneurysms. This is a condition overwhelmingly affecting men, in which – if undiagnosed and untreated – the aorta swells and eventually bursts; unsurprisingly, there is a very high mortality rate.

The Department of Health has established a National Cancer Equality Initiative Advisory Group whose members represent a wide range of equality issues (including men's health).

In 2008, the Department of Health appointed a senior-level gender equality 'champion', to help ensure that gender equality issues are mainstreamed in the Department's work.

In April 2009, the Men's Health Forum will become one of a small number of third-sector Department of Health Strategic Partner organisations. This is potentially of major significance for the profile of gender and health inequality issues at a national and local level.

It is unrealistic to expect that one piece of legislation will, at a stroke, transform health policy and services. Moreover, the Gender Equality Duty was introduced at a time when PCTs were undergoing a major structural reorganisation, when many parts of the NHS were in financial crisis despite the huge increase in public spending on health in recent years, and when staff morale was in many parts of the NHS very low.

While progress is likely to be slow, the new legislation does provide a major new tool to use in efforts to tackle men's health problems as well as women's. The health service can no longer ignore men's health or treat it simply as if it is an 'interesting' or even 'ethical' thing to do; it must now be addressed because there is a clear legal requirement to do so.

347. Wilkins D., Payne S., Granville G., Branney P. (2008) *The Gender and Access to Health Services Study*, Final Report, Men's Health Forum/University of Bristol, London: Department of Health

348. Department of Health (2007) *Creating a Gender Equality Scheme: A practical guide for the NHS*

349. National Chlamydia Screening Programme, *Men too…* (Health Protection Agency; London, 2007)

Men's Health Policy in Australia, New Zealand, Ireland and USA

The Australian Federal Government has recently announced that it will develop the country's first-ever national men's health policy.[350] The announcement focused on men's lower life expectancy (4.8 years); the much higher suicide rate in men; the high level of disease related to injuries; HIV/AIDs mortality; and the especially poor health of Indigenous men (average life expectancy, 59 years). There will also be a campaign to encourage men to see their GP for preventive health checks.

In New Zealand, the Government has launched a NZ$3m programme to run over the next year promoting greater awareness of men's health.[351] The funding will go into initiatives aimed at encouraging men to be more aware of their health and to access healthcare. Workplace clinics and improved health information are part of the package.

The Irish Government launched its national 'Policy for men's health and health promotion' in early 2009. This stems from a commitment made in the national Health Strategy, published in 2001.[352] A broad-based steering group was tasked with developing the policy; it has looked at evidence of best practice both nationally and internationally and consulted widely. **However, the Irish Government has stated that it currently has no resources with which to implement any of the report's recommendations.**

In the USA, the Men's Health Network and other groups have been lobbying Congress for the past 15 years to create a Federal Office of Men's Health.[353] In every congressional session since 2000, House and Senate members have unsuccessfully introduced legislation ('The Men's Health Act') to establish such an Office. It would be responsible for developing strategies, co-ordinating awareness and outreach activities, recommending public policies and taking other actions that would encourage men to engage in positive health behaviours.

The main problems with men's health

Life expectancy and mortality

Life expectancy at birth in the UK now stands at 77 years for males, compared to 81 years for females.[354] 'Healthy life expectancy' follows a similar pattern: males can expect to live 62.3 years free from a limiting long-standing illness or a disability, and females 63.9 years.[355]

There are wide variations in life expectancy amongst different groups of men, especially by social class. In the period 2002-2005, males in the professional class (1) had a life expectancy at birth of 80 years compared to 72.7 years for men in the manual unskilled class (5).[356] Although life expectancy for men in all social groups has improved over the past 30 years, the relative difference has remained broadly unchanged.

350. See www.health.gov.au/menshealthpolicy for more information (accessed 6 July 2008)

351. See http://www.beehive.govt.nz/release/3+million+funding+new+men per cente2 per cent80 per cent99s+health+programme (accessed 29 July 2008)

352. Department of Health and Children (2001) *Quality and Fairness: A Health System for You*. Health Strategy, Dublin: The Stationery Office

353. Feinberg S., Lewis H.A. (2008) *Men's Health: A Report on Gender, Racial and Ethnic Health Disparities in Cambridge*, Cambridge, Massachusetts: Cambridge Public Health Department

354. See http://www.statistics.gov.uk/CCI/nugget.asp?ID=168 (accessed 29 July 2008)

355. Office for National Statistics (2008) Social Trends 38, Basingstoke: National Statistics

356. See http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=8460 (accessed 4 August 2008)

Social class variations can also be highlighted by comparing the data for different geographic areas: life expectancy for men in relatively-deprived central Glasgow is just 70.5 years,[357] for example, compared to 82 years in affluent Kensington and Chelsea in London.[358] There can also be wide variations in life expectancy within just a few kilometres: within the London borough of Camden, life expectancy at birth for males ranges from 70 years in St Pancras ward to 84 years in Hampstead ward.[359]

These social inequalities are also reflected in mortality rates. Although rates for men aged 25-64 have fallen in all social class groups since 1930, they have fallen disproportionately more in the better-off groups. In fact, mortality rates are similar today in unskilled groups to those for professional groups in 1930. By contrast, mortality rates in professional groups have fallen substantially, and are now almost three times lower than for unskilled groups.[360]

There are also likely to be inequalities in life expectancy related to ethnicity, but the evidence is inconclusive because ethnicity is not recorded on death certificates. However, there is compelling evidence that male Gypsies and Travellers have particularly high mortality rates, with one study suggesting that average life expectancy may be as low as 48 years.[361]

Canadian research has suggested that gay men have a lower life expectancy than heterosexual men, but the evidence is very limited and may in any case have changed now that HIV/AIDS mortality in gay men has declined.[362] A review of the health inequalities experienced by lesbian, gay and bisexual (LGB) people in the UK does not mention life expectancy directly, but does comment that *'the health of many LGB people is affected by social exclusion, starting in youth and continuing through adulthood, resulting in a negative, cumulative effect across the life-course… people who are socially integrated live longer, whereas socially isolated people are at risk of earlier death.'*[363]

There is evidence that married men have lower mortality rates than unmarried, divorced or widowed men, although this is a complex issue to analyse.[364] A range of factors may be involved. For example, it may be that marriage protects individuals by generally providing them with healthier lifestyles, but it may also be the case that healthy people are more likely to marry or remarry than those with health problems. For married men, the more positive outcomes are likely to be linked to the care provided by their spouses; research shows that older men who live without women are likely to lack the protective support experienced by partnered men.[365] The suicide rate is known to be much lower among married men and there is also data suggesting that, after the age structure of the population has been taken into account, men who are married or cohabiting are most likely to report 'good' general health.[366] Bereaved men are at greater risk of death than women, particularly during the first 12 months following bereavement. Suicide rates and depression are also significantly higher in bereaved men.[367]

357. See http://www.gro-scotland.gov.uk/statistics/council-areas-map/glasgow-city.html (accessed 29 July 2008)

358. Mayor of London (2008) *Living Well in London: The Mayor's Draft Health Inequalities Strategy for London*, London: Greater London Authority

359. Ibid.

360. West Midlands Public Health Observatory data. See http://www.wmpho.org.uk/phlearn/pdf/MPHMM8.pdf (accessed 29 July 2008)

361. Tavares M. (2001) *Gypsies and Travellers in Leeds: Making a Difference. An Exploratory Study on the Health Needs of Gypsies and Travellers*, Leeds: Travellers Health Partnership

362. Hogg R.S. et al., *Gay life expectancy revisited*, Journal of Epidemiology 2001;30:1499

363. Scott S.D. et al. (2004) *Sexual Exclusion, Homophobia and health inequalities: A review of health inequalities and social exclusion experienced by lesbian, gay and bisexual people*, London: UK Gay Men's Health Network

364. Government Actuary's Department data, accessed at http://www.gad.gov.uk/Demography_Data/Marital_status_projections/2003/mortality_assumptions.asp (18 June 2008)

365. Davidson K., Daly T., Arber S. (2003) *Exploring the worlds of older men*, in Arber S., Davidson K., Ginn J., Gender and Ageing: changing roles and relationships, Maidenhead: OUP/McGraw Hill

366. Matheson J., Summerfield C. (eds.) (2001) *Social Focus on Men*, London: The Stationery Office

367. Allen J. (2008) *Older People and Wellbeing*, London: IPPR

Circulatory diseases

Circulatory diseases (which include heart disease and stroke) are the most common cause of death among males in the UK. In 2006, age-standardised death rates for circulatory diseases were 2,462 per million for males and 1,559 per million for females;[368] however, death rates have declined significantly over the past 30 years, particularly among men (down from 6,936 per million males in 1971). Nevertheless, men have higher coronary heart disease (CHD) mortality rates compared with women in all age groups, and men on average develop CHD 10 to 15 years before women.[369] In all age groups, there are more male deaths due to CHD, with the widest gap in the ages 45-54, where there are 4.5 times as many male deaths as female.[370] The risk of heart disease is particularly high among working-class men.[371] Men and women often experience different symptoms for CHD, with the 'typical' symptoms being more often experienced by men. This may mean that women are less likely to recognise symptoms in themselves, and tend to seek help at a later stage. South-Asian men living in the UK (Indians, Bangladeshis, Pakistanis and Sri Lankans) have a higher premature death rate from CHD than the general male population.[372] Data from the early 1990s show that the death rate for men in these groups was 46 per cent higher than average. Premature death rates from CHD for men born in the Caribbean and West Africa were much lower than average – around half the average rate for men.

Men born in South Asia also have a premature death rate from stroke which, in the 1990s, was 55 per cent higher than average for men. For those born in West Africa and the Caribbean, premature death rates for stroke were even higher. For men born in West Africa, the rate was nearly three times higher; for men born in the Caribbean, it was 68 per cent higher.

Despite these differences, there is very little national policy that takes gender differences into account.[373]

Cancer

Cancer is the second most common cause of death among males in the UK. In 2006, death rates for males were 2,201 per million and for females, 1,569 per million.[374] The incidence of prostate cancer among men and breast cancer among women has risen considerably over the past ten years, and these are the most commonly diagnosed cancers for men and women respectively. For the ten commonest cancers which affect both men and women (excluding breast cancer, which is rare in men), age-standardised mortality rates are in every case higher in men.[375] The biggest difference in mortality between men and women is for bladder cancer, for which male age-standardised rates are three times higher.

In the past, there has been little consideration of the need for gender sensitivity in cancer services, but the NHS *Cancer Reform Strategy* (Department of Health, 2007) has highlighted the need for a better understanding of the issue: *'the reasons for the differences in mortality rates between men and women are not fully understood. In some cancers, such as lung cancer and oesophageal cancer, differences in smoking prevalence play a large part. In some other cancers, it may be due to later presentation by men. In melanoma for example, the incidence is higher in women, possibly because*

368. Office for National Statistics (2008) Social Trends 38, Basingstoke: National Statistics

369. Fodor J.,Tzerovska R. (2004) *Coronary heart disease: is gender important?*, Journal of Men's Health and Gender, 1(1):32-37

370. See http://www.heartstats.org/datapage.asp?id=713 (accessed 29 July 2008)

371. White C. et al. (2008), *Social inequalities in male mortality for selected causes of death by the National Statistics Socio-economic Classification, England and Wales, 2001-3*, Health Services Quarterly 38:19-32

372. See http://www.heartstats.org/datapage.asp?id=737 (accessed 29 July 2008)

373. Wilkins D., Payne S., Granville G., Branney P. (2008) *The Gender and Access to Health Services Study, Final Report*, Men's Health Forum/University of Bristol, London: Department of Health

374. Office for National Statistics (2008) Social Trends 38 Basingstoke: National Statistics

375. NHS (2007) Cancer Reform Strategy, London: Department of Health

of the greater over exposure to sunlight, but death rates are higher in men, perhaps due to presentation at a more advanced stage.' The Strategy suggests that research is needed in this area.

Survival varies by type of cancer and, for each cancer, by a number of factors including sex, age and socio-economic status. Black African and black Caribbean men are three times more likely than white men to develop prostate cancer,[376] and men with this cancer generally report a significantly worse experience of their care than patients with other common cancers.[377]

For the majority of cancers, a higher proportion of women than men survive for at least five years after diagnosis.[378] An analysis of data for patients diagnosed with cancer in 2000-2002 found that the relative survival rate for men was 47 per cent compared to 56 per cent for women.[379] The rates for England specifically were 45 per cent for men and 53 per cent for women; for Scotland, where outcomes were worst out of all the UK countries, the five-year relative survival rates for men and women were 40 per cent and 48 per cent respectively.

Weight/obesity

Men are more likely than women to be overweight.[380] Women and men are currently equally likely to be obese; however, there is good evidence that, by 2015, 36 per cent of men are likely to be obese compared with 28 per cent of women. By 2025, only 13 per cent of men will have healthy body mass index (BMI) compared with around one-quarter of women.[381] Being overweight or obese creates a much higher risk of developing a wide range of diseases, not least cardiovascular disease and diabetes.

Self-perception of weight is also important. Research shows that women are more likely to report themselves as overweight, even when they are not, and to think that they are heavier than they are; men on the other hand are likely to think themselves lighter than they really are, even when overweight. Women also describe their ideal weight in terms of a lower BMI than men's perceptions of ideal weight, and men are less concerned with being overweight. A NOP survey, for example, found 42 per cent of men compared with 27 per cent of women reported that being overweight 'wouldn't bother me at all'.[382]

There are no gender-specific national targets in relation to overweight and obesity, and very little consideration of gender in the relevant national strategies.[383]

Mental health

Sex differences in susceptibility to common mental health problems like depression are the subject of considerable debate. Although more women are diagnosed with depression, this may be because men are much less likely to seek help for the condition, or even because there may be a different symptomatology for men that is not yet widely understood by healthcare professionals.[384] In any

376. Ben-Shlomo Y. et al., op cit.

377. House of Commons Committee of Public Accounts (2006) Department of Health: *Tackling cancer: improving the patient journey* Nineteenth Report of Session 2005-6, London: The Stationery Office

378. National Statistics Online, Cancer statistics, 18 December 2007

379. Verdecchia A. (2007) 'Recent cancer survival in Europe: a 2000-02 period analysis of EUROCARE-4 data' 8(9):784-96.

380. Office for National Statistics (2008) Social Trends 38, Basingstoke: National Statistics

381. McPherson K. et al. (2007) *Tackling Obesities: Future Choices – Modelling Future Trends in Obesity and the Impact on Health.* 2nd Edition, London: Department of Innovation Universities and Skills

382. Men's Health Forum (2005) *Hazardous Waist? Tackling the epidemic of excess weight in men*, London: MHF

383. Wilkins D., Payne S., Granville G., Branney P. (2008) *The Gender and Access to Health Services Study, Final Report*, Men's Health Forum/University of Bristol, London: Department of Health

384. See Kilmartin C., *Depression in men: communication, diagnosis and therapy*, Journal of Men's Health and Gender, Lancet Oncology 2005.62 Winkler D., Edda P., Kasper S., *Gender-specific symptoms of depression and anger attacks*, Journal of Men's Health and Gender 2006

event, an examination of some of the broader indicators of mental distress – such as the misuse of drugs and alcohol or 'going missing' – suggests that many men who may have no formal diagnosis of a mental health problem may nevertheless be struggling to cope.[385]

There is a clear difference in the suicide rates between men and women.[386] Until 1988, men aged 65 and over had the highest suicide rates; in 1986 the suicide rate among this group peaked at 26.3 per 100,000 population and then fell, to 13.0 per 100,000 in 2006. In contrast, suicide rates for younger men rose over the period, in particular for those aged 25-44, for whom the suicide rate almost doubled from 13.6 per 100,000 in 1971 to a peak of 26.9 per 100,000 in 1998. The suicide rate among men in this age group has since declined, but in 2006 remained the highest of all age groups and of both sexes, at 21.3 per 100,000. In 2006, the age-standardised rate for all men aged 15 and over in the UK was 17.4 per 100,000, three times that of women, at 5.3 per 100,000.

Recent evidence strongly suggests that suicide is also closely linked to income and social class – the higher the level of deprivation, the higher the suicide rate.[387] Data for England and Wales from 1999-2003 show the suicide rate for men aged over 15 in the most deprived areas was more than twice the rate of those in the least deprived areas.[388] There is evidence that young gay men in particular are more likely than heterosexual young men to attempt suicide and probably also to die. Homophobic bullying appears to be a significant factor.[389]

Men from African and Caribbean backgrounds are over-represented in mental health services.[390] They tend to come to the attention of services via the police and the criminal justice system, and are more likely to experience controlling responses from services. Black men are often unaware of sources of help, and fear that contact with services will lead to a loss of status. Black males find themselves in situations that place them at greater risk of mental health problems, such as exclusion from schools, social deprivation, crime and drug cultures and racial victimisation. Racism is clearly an important explanation for the poor mental health of this group.

Research studies of ethnicity and mental illness have tended to focus on treatment rates, mainly in clinical settings.[391] These studies show that black and minority ethnic men are more likely to receive a diagnosis of mental illness than their white British counterparts. However, the patterns of ethnic inequality are diverse. For example, African Caribbean men and, in particular, black British-born men are more likely to be given a diagnosis of schizophrenia than the general population. Men from Indian and Chinese ethnic groups, on the other hand, are less likely to be admitted to mental health services.

Sexual and reproductive health

Men's sexual and reproductive health is poor and in many ways becoming poorer. Prostate disease (both benign and malignant) is becoming more common: up to 2.5 million men in the UK are now believed to be affected by Benign Prostatic Hypertrophy (BPH) and this number is expected to increase by 50 per cent by 2025;[392] prostate cancer represents one-quarter of all new cases of cancer diagnosed in men (35,000 new cases were diagnosed in 2004).[393] Many men are unaware

385. Men's Health Forum (2006) *Mind Your Head: Men, boys and mental well-being*, London: MHF

386. Office for National Statistics (2008) Social Trends 38, Basingstoke: National Statistics

387. Platt S. et al. (2007) *The Epidemiology of Suicide in Scotland 1989-2004: An examination of temporal trends and risk factors at national and local levels*, Edinburgh: Scottish Executive

388. Office for National Statistics (2008) Social Trends 38, Basingstoke: National Statistics

389. Scott S.D. (ibid.)

390. Keating F. (2007) *African and Caribbean men and mental health*, London: Race Equality Foundation

391. See http://www.menshealthforum.org.uk/userpage1.cfm?item_id=2168 (accessed 29 July 2008)

392. McNicholas T. (1999) *Management of Symptomatic BPH in the UK: Who Is Treated and How?*, European Urology 36: 33-39

393. See http://info.cancerresearchuk.org/cancerstats/types/prostate/incidence/?a=5441 (accessed 29 July 2008)

of the symptoms of prostate disease (often believing that 'waterworks' problems are a consequence of old age rather than an underlying condition), and as a result suffer unnecessarily by not seeking medical advice.[394] The incidence of testicular cancer is also steadily rising[395] and this may be linked to a variety of other reproductive health problems that are also becoming more common in males, including infertility, undescended testicles and hypospadias (a congenital condition where the urethra does not open at the tip of the penis).[396]

With the exception of gonorrhea, incidence rates of all sexually transmitted infections (STIs) are rising, with the increase being greater in women than men.[397] There were over 224,000 new diagnoses of STIs in men at Genito-Urinary Medicine (GUM) clinics in the UK in 2006, up from about 137,000 in 1997. Although the infection rates are rising for both heterosexual and gay/bisexual men, the Health Protection Agency reports particularly high levels of infections in men who have sex with men (MSM).[398] In 2006, there were an estimated 2,700 new HIV diagnoses in MSM and an estimated 5.4 per cent of MSM aged 15-44 are infected with HIV.

The estimated number of adults (aged 15-59) living with HIV (both diagnosed and undiagnosed) in the UK was 69,400 in 2006. Of these, 30,100 (43 per cent) were MSM and 14,700 (21 per cent) were heterosexual men. Of the heterosexual men, 8,900 (61 per cent) were African-born and 5,800 (39 per cent) were non-African-born.

The incidence among MSM of most STIs increased still further in 2006, so that, over the previous five years, gonorrhoea diagnoses increased by 25 per cent, genital warts by 21 per cent and genital herpes by 15 per cent. Following a 117 per cent increase between 2002 and 2006, infectious syphilis incidence in MSM stayed high in 2006, and most cases were in the non-HIV-infected.

The rising rates of STIs highlight the failure of sexual health promotion and treatment services to work effectively with men, especially MSM. The Gay Men's Health Network has identified gaps relating to HIV education in schools and to tackling the issues that impact on the ability to adopt healthy behaviours, such as accessible health resources, personal skills and motivation.[399]

According to a large, recent Office of National Statistics survey of contraception and sexual health,[400] more than half of men (57 per cent) reported making no changes to their behaviour as a result of what they had heard about HIV/AIDS and other STIs. However, 39 per cent of men said they had increased their use of condoms. Seven per cent said they had fewer 'one-night stands' and just three per cent had a test for STIs when they changed partners.

Sexual dysfunctions (such as erectile problems and premature ejaculation) continue to affect large numbers of men. Some 2.3 million men in the UK are believed to be affected by erectile dysfunction alone. It is a distressing condition in its own right, damaging self-esteem, causing anxiety and depression and affecting relationships. It can also be an indicator of underlying (and often undiagnosed) health problems such as diabetes or cardiovascular disease. Indeed, there is emerging evidence that erectile dysfunction can 'predict' many cases of cardiovascular disease,[401] creating a 'window' of perhaps three years during which time accurate diagnosis and treatment can only be helpful.

394. NHS (2004) *Making Progress on Prostate Cancer*, London: Department of Health

395. See http://info.cancerresearchuk.org/cancerstats/types/testis/incidence/ (accessed 29 July 2008)

396. Aschim E. L. et al. (2004) *Risk factors for hypospadias in Norwegian boys – association with testicular dysgenesis syndrome?*, International Journal of Andrology 27(4):213-221

397. Wilkins D., Payne S., Granville G., Branney P. (2008) *The Gender and Access to Health Services Study, Final Report*, Men's Health Forum/University of Bristol, London: Department of Health

398. Health Protection Agency (2007) *Testing Times, HIV and other Sexually Transmitted Infections in the United Kingdom*, London: HPA

399. Scott S.D. (ibid.)

400. Lader D. (2007) *Contraception and Sexual Health 2006/7*, Omnibus Survey Report No 33, Newport: ONS

401. Solomon H. et al., *Erectile dysfunction and the cardiovascular patient: endothelial dysfunction is the common denominator*, Heart, March 2003, 89(3): 251-253

Despite greatly increased levels of public frankness about sex in recent decades, men are often unable to obtain the information they require in order to improve their sexual and reproductive health. Many men frequently delay seeking help when symptoms appear and struggle to achieve sexual fulfilment and the sense of well-being that can derive from rewarding sexual relationships.

Recent research published by Brook suggests that young men generally feel under-informed about where to go for sexual health services and advice.[402] They are almost certainly less knowledgeable than their female peers; only around half of all young men aged 11-15 years are aware of their local sexual health services compared to three-quarters of women of the same age. As many as one-third say they did not visit a clinic before having sex for the first time because they did know where it was.

Young men also seem either to be unclear about what sexual health services can provide, or to have a limited view. A belief that services are set up primarily to treat illness and provide contraception is widespread, meaning that young men do not see them as potential providers of advice or support. Many young men still appear to believe 'the umbrella myth' – that they will be subject to an examination in which a small umbrella-shaped device is inserted in their urethra, opened and withdrawn – and this deters them from seeking help.

The Brook report comments that data on ethnicity are not very robust and, although some individual services achieve a high representation of young men from ethnic minorities, the specific issues which relate to the use of sexual health services by young men from black and ethnic minorities are not well understood.

> 'Gender is considered frequently in sexual health policy in the sense that many services are for one sex or the other, but there is less consideration of the link between gender and help-seeking behaviour. The National Chlamydia Screening Programme has pioneered a strategy for increasing the take-up of services by men – currently the only strategy of its kind in any area of health provision'.
>
> Wilkins D., Payne S., Granville G., Branney P. (2008) *The Gender and Access to Health Services Study, Final Report*, Men's Health Forum/University of Bristol, London: Department of Health

Risk-taking behaviours

An important part of the explanation for men's poor health is the risks many take with their health. Risk-taking is closely linked to men's sense of what it means to be male and what helps to differentiate men from women. For example, drinking is regarded by many young men as an important element of their social lives and a measure of masculinity. In one study, young men's comments included 'you've got to be a lad' and they emphasised the importance of 'keeping pace' with their peers when drinking.[403]

Men, especially young men, are far more likely than women to drink heavily. In 2006, 40 per cent of men and 33 per cent of women in Great Britain reported exceeding the recommended amount of alcohol on at least one day during the previous week.[404] Although binge drinking among young women is increasing at a faster rate, men aged 25-44 were the most likely to binge drink (defined as the consumption of twice the recommended daily amount). In 2006, 31 per cent had done so on at least one day in the previous week compared with seven per cent of men aged 65 and over.

402. Brook (2007) *Boys, young men and sexual health services: a summary of a review of the academic literature*, Accessed at: http://www.brook.org.uk/uploads/File/lit per cent20review per cent20briefing per cent20final.doc (13 March 2008)

403. Harnett R. et al (2000) *Alcohol in transition: Towards a model of young men's drinking styles, Journal of Youth Studies*, 3, 61–77

404. Office for National Statistics (2008) Social Trends 38, Basingstoke: National Statistics

Death rates from alcohol-related causes are much higher among men than women, and the gap between the sexes has widened in recent years. In 2006, the male death rate was 18.3 per 100,000, more than twice the rate of 8.8 per 100,000 for women. The alcohol-related death rates among men increased in all age groups between 1991 and 2006, and in 2006 were highest among those aged 55-74, at 44.6 per 100,000. The alcohol-related death rate for men living in the five per cent most-deprived areas was more than five times higher than the rate for those living in the five per cent least-deprived areas.

According to the 'Gender Access in Health Services' report:[405] *'Policy tends to see the consequences of unsafe drinking as different for men and women; men become violent or take unwise risks, women may become more vulnerable to abuse or attack. It is possible that women feel more stigmatised by alcohol-related problems and this may influence their response to services – at the same time, women are more likely to use some services than men, despite men's greater level of problems.'* It concludes that national alcohol policy takes little account of the differences between men and women.

Men are also more are more likely to smoke cigarettes, albeit by a much smaller margin.[406] There is some evidence that gay men are more likely than heterosexual men to smoke, drink alcohol and misuse drugs, but further research is needed in this area.[407] Women's diets tend to be healthier than those of men – women consume more fruit and vegetables and less red meat, fat and salt than men – although the differences are not especially large and, overall, the diet of both sexes falls short of nutritional guidelines.[408]

Men are much more likely to be injured or killed by an accident, especially on the roads. In Great Britain in 2006, three times as many male road-users as female were killed and twice as many seriously injured.[409] Male casualties made up 58 per cent of all casualties but 76 per cent of those killed. The sex differences in traffic accidents can only partly be explained by the fact that men are more likely to drive cars and to drive longer distances. There is evidence that men are more likely to drive dangerously and aggressively.[410] Male drivers under 30 years old have the highest incidence of failing a breath test after being involved in a personal injury road accident. The failure rate for women was only about one-third of that for male drivers, a difference that cannot be accounted for by the slightly lower rates of testing for female drivers.

Use of health services

Men are much less likely than women to use primary health care services. Overall, men in Great Britain visit their GP four times a year compared to six times for women. The difference in usage is most marked for the 16-44 age group – women of this age are twice as likely to use services as men. According to National Statistics analysis, the higher consultation rates by females is evident in all age groups except pre-school children, and is distributed across a wide range of illnesses in addition to the obvious needs of women to consult for contraceptive and pregnancy care.[411] There is a similar pattern for dental check-ups: women are much more likely than men to seek regular dental check-ups, and younger men are one of the groups least likely to seek regular check-ups.[412]

405. Wilkins D., Payne S., Granville G., Branney P. (2008) *The Gender and Access to Health Services Study, Final Report*, Men's Health Forum/University of Bristol, London: Department of Health

406. Office for National Statistics (Ibid.)

407. Scott S.D. et al., (ibid.)

408. See http://www.food.gov.uk/multimedia/pdfs/ndns5full.pdf (accessed 15 May 2008).

409. Department for Transport et al. (2007) *Road Casualties: Great Britain 2006*, London: The Stationary Office

410. The Social Issues Research Centre (2004) 'Sex differences in driving and insurance risk: An analysis of the social and psychological differences between men and women that are relevant to their driving behaviour', Oxford: SIRC

411. Bajekal M. et al. (2006) *Focus on Health*, Basingstoke: National Statistics/Palgrave Macmillan

412. National Statistics (2000) *Adult Dental Health Survey: Oral Health in the United Kingdom* 1998, London: The Stationary Office

Men who are economically inactive are more likely to consult their GP than those who are working, with 19 per cent of men in this group having consulted their GP in the last two weeks compared with eight per cent of those in employment.[413] There are also important differences in access by black and minority ethnic men. Black Caribbean men had a higher consultation rate, and Bangladeshi men were twice as likely to have contact with a GP, than men in the general population. This increased with age, with the highest consultation rate (seven per year) found in Bangladeshi men over 75 years.

Many men appear to have more negative attitudes towards emotional expression, and this helps to explain their under-use of mental health services.[414] This is partly a result of their perceptions of their own role – but it also reflects many men's experience that being emotionally expressive and/or displaying vulnerability may often not be well received by others. Gender differences in help-seeking behaviour in relation to mental health problems start early, with male teenagers reporting less understanding of mental health, more stigma associated with mental illness and less willingness to use mental health services. A survey of people aged 14-16 found that only 52 per cent of boys talked to their friends about their feelings more than once a month, compared to 82 per cent of girls.[415]

A relatively small proportion of men visit family planning clinics: in 2006-2007, about 1.1 million women attended compared to 117,000 men.[416] There is also evidence that men, especially young men, generally do not use community pharmacies as a source of advice and information about health.[417]

Men are much less likely to take part in mainstream health improvement programmes. Despite the high levels of weight problems in men, in the recent 'Counterweight' GP-based project in the UK only one-quarter of participants were male, while the pilot of one programme delivered in partnership with a commercial slimming organisation had a participation rate by men of 12 per cent.[418] Similarly, the vast majority of those signing up to a community pharmacy initiative to deliver weight- management services were women, with just 15 per cent of users being men. There are also clear and similar sex differences in participation in NHS smoking cessation programmes as well as the Expert Patient Programme and cancer support groups.

There is good evidence too that men make much less use than women of community-based services generally. Older men, for example, typically do not feel that organisations run specifically for their age group are appropriate for their needs, except perhaps as a last resort.[419] They tend to avoid organisations where the membership (and staffing) are dominated by women, and consider that attendance at a day centre suggests that they have 'given up'. Another significant barrier is ineffective referral policies; where older men are referred, whether by social services, GPs or PCT staff, they are more likely to attend.[420]

Men's lower usage of primary care services is reflected in a range of qualitative work that strongly suggests that men are frequently reluctant to seek help until they are in pain or convinced that they have a serious problem. One large study of men aged 25-35 found that men generally preferred to keep their health worries to themselves, and delayed going to the doctor for as long as possible.[421]

413. Bajekal M. et al.(ibid.)

414. Branney P. and White A. (2008), *Big boys don't cry: depression and men*, Advances in Psychiatric Treatment (14)256-262

415. See http://www.samaritans.org/pdf/F1EmotionalHealth.pdf (accessed 4 August 2008)

416. See http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/contraception/nhs-contraceptive-services-england:-2006-07 (accessed 29 July 2008)

417. PAGB and Reader's Digest (2005) *A Picture of Health: a survey of the nation's approach to everyday health and well-being*, London: PAGB & Readers Digest; Pawson R., Tilley N. (1997) *Realistic Evaluation*, London: SAGE; Community Pharmacy Research Consortium (1999) *The Public's Use of Pharmacies as a Primary Health Care Resource*, London: Royal Pharmaceutical Society of Great Britain

418. Men's Health Forum (2005) *Hazardous Waist? Tackling the epidemic of excess weight in men*, London: MHF

419. Davidson K., Arber S., 'Older men's health: a life course issue', *Men's Health Journal* 2003(2), 3:72-75

420. Ruxton S. (2006) *Working with Older Men*, London: Age Concern

421. Sharpe S., 'Attitudes and beliefs of men and their health', *Men's Health Journal* 2002(1), 4:118-120

The most frequent reasons given included that they did not want to waste the doctor's time, they were deterred by GP appointments systems, and that work or family responsibilities meant they had no time to deal with minor illnesses. Many men also considered it 'wussy' to talk about health problems and felt embarrassed to see a doctor about 'below the belt' problems.

For younger men especially, lack of familiarity with the health system may also be a factor. Young women tend to use health services routinely – for contraception, cervical cancer screening (after the age of 25), pregnancy, childbirth and their children's health – whereas men are not expected to use most services until they are actually ill.

Full-time working and long working hours have also been an important barrier for many men.[422] It is practically difficult for a man to attend a health service which is open only or mostly during the 'normal' working day if he is at work at the same time. Many men will, of course, have started work, or be commuting to it, during the critical morning 'window' when appointments can be made with a GP (see section on 'Work', page 45). There is also evidence that men may be deterred by a perception that primary care services are aimed mainly at women and children and feel like 'feminised' spaces.

Recent Danish research has examined the potential impact of men's lower contact rate with GPs and suggests that, because men present later than women with severe symptoms, it may be linked to higher hospitalisation and mortality rates.[423] This finding is consistent with UK and Europe-wide data on malignant melanoma which shows (as stated above) that while women are more likely to develop this type of cancer, men are more likely to die from it. The most plausible explanation is that men tend to present when the cancer is more advanced and therefore harder to treat. However, the reasons for men's apparently poor use of health services – and the consequences of this for health outcomes – are not yet well-understood and this area requires further investigation and research.

The UK Government has recently pushed GPs into extending their opening hours and this may make it easier for men to access services. There is also an intention to create different points of access to primary care, including sports centres/stadia, pharmacies and walk-in centres, and to explore the potential for delivering more health services via workplaces; again, these developments, if implemented effectively, have the potential to improve male access (see section on 'Work', page 45). It would also be useful to consider the potential role of other 'non-health' agencies that men may be in contact with, for example in the fields of criminal justice, housing, social care and post-school education, as well as those offering general advice. These services could, at the very least, provide their male users with information on health and refer them into the health system where appropriate.

'Evidence shows that men are less likely to access primary care networks than women. In order to ensure that services and information are reaching men, consideration could be given to providing information through workplaces, pubs, clubs and shops popular with men.

'Consideration should be given to tailoring appointment times so that both men and women can access the service easily. For instance, a surgery that only offers appointments between 9 and 5 would make it very difficult for those who work full time (men are more than twice as likely to be in full time work).'

Department of Health (2007) *Creating a Gender Equality Scheme: A Practical Guide for the NHS*

422. See http://www.menshealthforum.org.uk/userpage1.cfm?item_id=1731 (accessed 29 July 2008)

423. Juel K., Christensen K., *Are men seeking medical advice too late? Contacts to general practitioners and hospital admissions in Denmark 2005*, Journal of Public Health 2008 30(1):111-3

Health information

Health information has, until recently, largely been provided to patients and the public on a 'one-size-fits-all' basis. Some 60,000 organisations are believed to be producing healthcare information but only a handful has produced health information aimed specifically at men. Even fewer have produced information for men on issues that are not sex-specific, such as prostate cancer, or on sexual health for gay men. The vast majority of health information does not therefore take account of the different ways in which men think about their bodies and health issues. Against this background, it is perhaps unsurprising that there is evidence of significant differences in the health literacy of men and women.[424]

However, there have been some recent developments which suggest that male-targeted health information could have a positive impact. The Men's Health Forum (MHF) runs a health information website (www.malehealth.co.uk) specifically aimed at men. The site now receives over 140,000 'unique visitors' (i.e. different visitors) a month and the average 'stickiness' (i.e. length of visit) exceeds five minutes, a significant length of time in cyberspace. It is difficult to measure the site's impact, but surveys of visitors suggest they are more likely to make lifestyle changes and to visit a doctor if necessary. In addition, the MHF has developed health information in the format of car repair and computer maintenance manuals and these have been well-received by health professionals as well as male 'consumers'.

The NHS has recently begun to develop a more gendered approach to health information: for example, the NHS's 'Choices' website (www.nhs.uk) now guides visitors to separate sections designed specifically for men and women, and there have been occasional magazines targeted at a male audience (*Fit* for young men and *Prime* for men aged over 40).

The development of health information that is targeted at men in general – and at specific groups of men in particular (e.g. older men, younger men, gay/bisexual men, black and minority ethnic men) – would be in line with recent national policy developments on a more patient-centred health system and current government interest in 'social marketing' approaches to health. However, there is currently no strategic approach in this area.

424. See, for example, von Wagner C. et al., *Functional health literacy and health-promoting behaviour in a national sample of British adults*, Journal of Epidemiology and Community Health 2007, 61:1086-1090. This found that men were twice as likely as women to have inadequate health literacy. See also, National Center for Educational Statistics (2006) *The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy*

'Knowsley Pitstop'

In 2003, Knowsley Primary Care Trust and Knowsley Council decided to take a social marketing approach to improving men's health, targeting older men, initially aged 50-65 years, as it as at this age that the early signs of long-term or life threatening conditions commonly begin to emerge and may be more effectively tackled through treatment, management and/or lifestyle change if identified early.

Focus-group work revealed that men of this age are interested in their health, but that a special effort to engage with them and remove barriers is necessary and that any campaign should be hard-hitting, humorous and not blaming of men. A two-pronged approach was taken to raising awareness ('Endangered Species – It's never too late to get healthier') and calling men to action ('Don't ignore the warning signs – Get a FREE health check').

Humorous, risqué 'road signs' got the message noticed; there was advertising on buses and local radio as well as in local newspapers. Community networks, such as social club stewards, were of critical importance. A 'Knowsley Man' health information booklet was produced in partnership with the Men's Health Forum, and a Pitstop 'web portal' to the Forum's website www.malehealth.co.uk was established.

Beer mats, urinal and toilet cubicle posters, stickers, pens, stress toys and car air-fresheners targeted 50 – 65 year olds on their own 'turf' – in pubs, social clubs and bookmakers. Humour was used to break down men's 'internal barriers' and to help get men discussing health. A comedy play toured local venues. An ex-Everton FC captain fronted the PR.

At the health checks, information was given in parking ticket, driving licence and AA-card style formats. Point-of-sale boards and Pitstop uniforms for staff were also developed. Checks included a lifestyle questionnaire, blood pressure, lung function, body mass index and others.

Follow-up research in June 2005 showed that awareness of men's health campaigns had increased and 57 per cent of local men were now aware that male life expectancy is shorter than female. Over 3,000 local men had health checks and 85 per cent of the men who were followed up after a health check reported lifestyle changes. Follow-up work continued with GPs and pharmacists to improve core services for men.

Good practice: international experience

The World Health Organisation has analysed data from 58 evaluation studies of interventions with men and boys in a range of health and health-related issues, including sexual and reproductive health, fatherhood, gender-based violence and programmes engaging men in improving maternal and child health.[425] Of the 58 studies, 24 (41 per cent) were from North America with smaller numbers from Latin America and the Caribbean, Europe, Sub-Saharan Africa, the Middle East and North Africa, and Asia and the Pacific.

The review found that well-designed programmes with men and boys showed compelling evidence of changes in behaviour and attitudes. Overall, 29 per cent of the 58 programmes were assessed as effective in leading to changes in attitudes or behaviour using the definition previously cited, 38 per cent as promising and 33 per cent as unclear. Programmes rated as being 'gender-transformative' had a higher rate of effectiveness. These were programmes with men and boys that included deliberate discussions of gender and masculinity and made clear efforts to transform gender norms.

Integrated programmes and programmes within community outreach, mobilization and mass-media campaigns also showed more effectiveness in producing behaviour change. This highlights the importance of reaching beyond the individual level to the social context – including relationships, social institutions, gatekeepers and community leaders.

The report concluded: *'In sum the behaviour and attitudes of men and boys that have often been considered unchangeable can be changed and lead to better health outcomes for men, their partners, their families and their children'.*

However, the report also observed that relatively few programmes with men and boys go beyond the pilot stage or a short-term timeframe.

425. Barker G., et al. (2007) *Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions*, Geneva: World Health Organisation/Instituto Promundo

Recommendations

A range of actions are needed to improve men's health. It is important, however, that these are taken within the context of achieving gender equality. This should help to ensure that there are also parallel improvements in women's health and that the two sexes are not pitched against each other in a competition for resources.

Health policy and practice needs to take greater account of the differences between men (e.g. in relation to class, age, ethnicity, sexual orientation, disability) in order to tackle men's health problems effectively. To facilitate this, there is a clear need for further research in this field as well as more consistent and more widespread professional training on gender and health issues.

Although the Department of Health has made significant steps towards addressing men's health issues in national policy, there is still an inconsistent approach across policy areas and gender is not yet fully integrated into the Department's work on health inequalities. All national health policy must specifically address men's health within the context of the Gender Equality Duty (except where obviously inappropriate).

Key national policy areas which are in particular need of review to take the issues facing men more fully into account include mental health, and cardiovascular disease and obesity, building on the findings of the 'Gender and Access to Health Services' study.[426]

Local implementation of the Gender Equality Duty has been poor to date. Primary Care Trusts in particular appear to have a limited understanding of gender and health issues and how to take effective action. Local health organisations require greater levels of support as well as a tougher regulatory regime to ensure compliance. PCT Gender Equality Schemes must include specific objectives in relation to improved services for men and/or improved health outcomes for men.

Action is needed to improve men's use of primary health services. This requires long-term initiatives – such as improved health education in schools – as well as more immediate changes to the opening hours, location, marketing and ambience of services. A national strategy is needed to help achieve this. The Quality Outcomes Framework should be reviewed to take account of gender differences.

There is a clear need for a much greater variety of male-targeted health information (using all appropriate media). The Department of Health, the NHS and other statutory organisations must make a strategic commitment to achieve this, underpinned by more research and evaluation.

The NHS needs to find more imaginative ways of consulting men about its policies and services; this is a requirement of the Gender Equality Duty.

There must be a strategic commitment by the Department of Health, the National Institute for Health and Clinical Excellence (NICE), Strategic Health Authorities, PCTs and others to address men's health and gender in data collection and analysis, research and the evidence-base for public health improvement.

There needs to be more integrated policy and practice between health and non-health sector (e.g. workplaces, trade unions, sports stadia, prisons, faith organisations) in order to engage a much wider group of men.

426. Wilkins D., Payne S., Granville G., Branney P. (2008) *The Gender and Access to Health Services Study, Final Report*, Men's Health Forum/University of Bristol, London: Department of Health