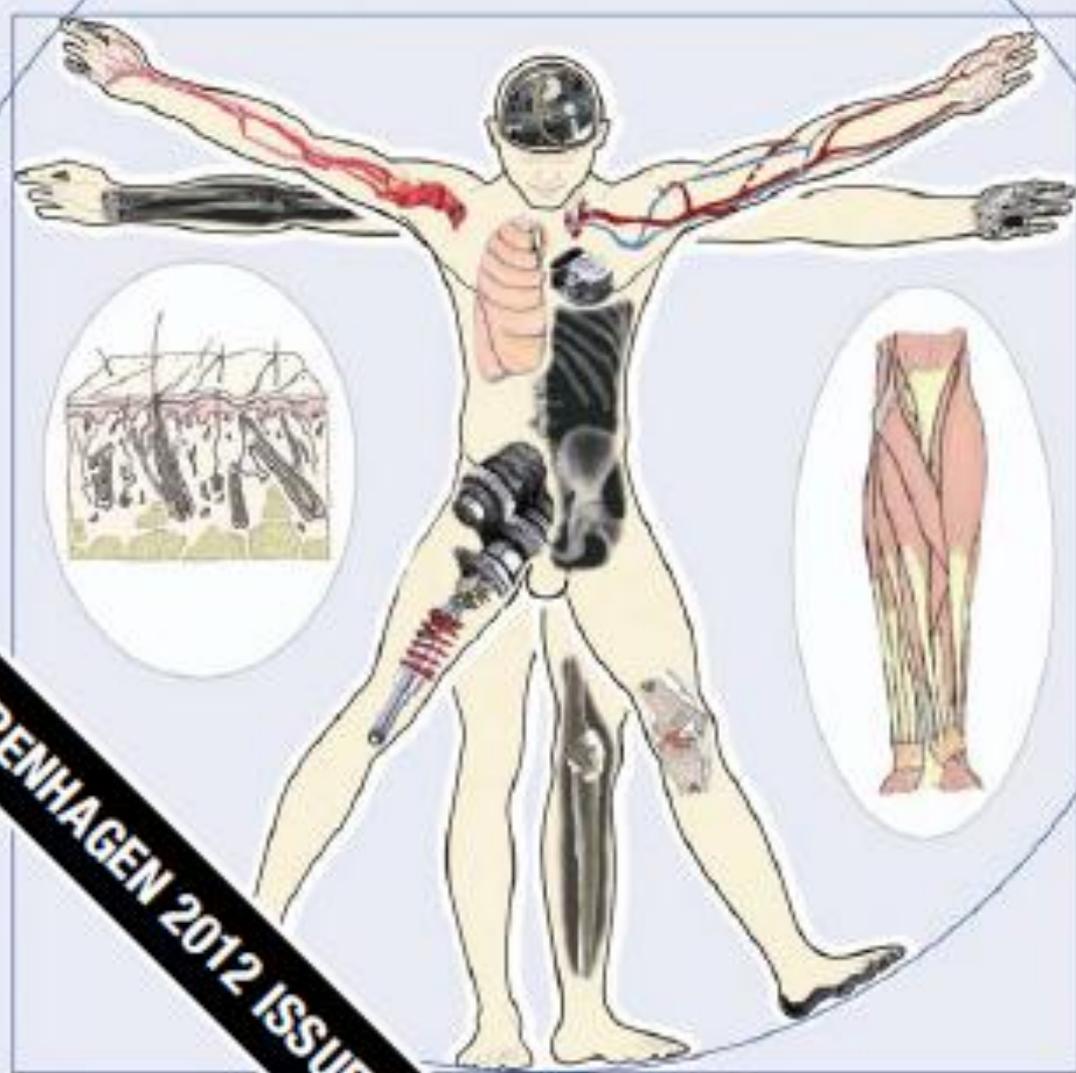


EUROPEAN



MEN'S HEALTH FORUM

RESPONSE TO THE EC REPORT ON THE STATE OF MEN'S HEALTH IN EUROPE



THE COPENHAGEN 2012 ISSUE

European Men's Health Forum and Men's Health Society, Denmark presents:
Recommendations for actions to Main Points and Summaries from
"The State of Men's Health in Europe – Extended Report" 2011
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**European Men's Health Forum and
Danish Men's Health Society presents**

Recommendations for actions to "The State of Men's Health in Europe – Extended Report" 2011



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Selskab for Mænds Sundhed
Men's Health Society

Copenhagen Conference 2012 on

"Gender and Health through Life"

**With support and participation from
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OF THE COUNCIL OF THE
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Ministeriet
for Ligestilling
og Kirke

June 14 – June 15 2012

Copenhagen University Hospital, Rigshospitalet

Introduction

By European Men's Health Forum & Men's Health Society, Denmark

For the first time the EU has put a focus on men's health. This has been done with the publication of the EU Commission's seminal report "The State of Men's Health in Europe Extended Report".

The report is written, reviewed and discussed by scholars from more than 15 European countries. The report is a milestone in clarifying how important gender is in the health of the population.

The report provides an overview of the state of men's health across the 34 European countries. The report shows that there is a high level of premature morbidity and mortality in men. This has implications not just for the men, but for their families, for society, and for all those concerned with health and social welfare.

The report shows that, for every cause of death, men are dying younger and in greater numbers in every age group and in every European country, with most of men's higher occurrence of diseases and early death being preventable. This publication is a critically important step towards informing strategies to prevent men's premature morbidity and mortality.

For every chapter in the report, we have reproduced the Main Points and Summaries followed by a list of recommendations for actions in each area to improve men's health and reduce men's premature diseases and deaths. These recommendations have been proposed and discussed in different occasions among which are meetings in EMHF, at the Leeds Metropolitan University, in Gastein at the European Health Forum and more. Our goal is that everybody at the "Copenhagen Conference on Gender and Health Through Life" will engage in developing and proposing further recommendations for this important area.

◆ **General Recommendations for Actions**

- Recognition of men's physical and mental health as an area of public health concern. Gender mainstreaming should be expanded to have a more explicit focus on men.
- Inclusion of men's health within the decision making processes relating to the impact on men's health of the social determinants of health
- Recognition of the difference between sex and gender with regard to men's health as well as women's health.
- The establishment of a research agenda that can identify:
 - The causes of male specific diseases and those conditions where men seem most vulnerable
 - The role of gender and male socialisation processes on health behaviour
 - Barriers to men's use of health services
 - How best to communicate with men with regard to their health needs
- The promotion of men's health should not be at the expense of women's health and should not pose a threat to the resources currently utilised tackling the specific health and wellbeing needs of women
- Involve politicians on an on-going basis in increasing the policy spotlight on men's health and in working towards solution-oriented outcomes in addressing men's health. There is an urgent need to increase awareness at government level within member states and in the EU of the breadth of issues impacting on men's health
- The importance of education and environment in influencing men's health
- The importance of focusing on prevention.

The Male Population

Main points

- There is an increasing longevity of much of the male population, but this is coupled with a decline in the birth rate.
- If the current projections for the changing male population are correct there will be a reduction of nearly 24 million working age men (aged 15-64 years) across the EU27 by 2060 and an increase in the number of men over 65 by some 32 million.
- Young men are living at home for longer and deferring the age of marriage.
- Boys and girls are in the education system for longer, but boys seem to be missing out on a full educational experience, with more leaving school prematurely and fewer entering tertiary or adult education.
- Patterns of work are changing, with higher unemployment levels than women and being less likely to have a job for life.
- Early migration and asylum seekers are predominately male, with a greater degree of migration occurring within Europe, reducing the male population in the home countries.
- Men in vulnerable positions such as Migrants / Asylum seekers, Prisoners, the homeless or the disabled are all facing challenges to their health and well-being.

Summary

The emerging demographic picture will have a marked impact on men over the coming decades, with implications for how men live, are educated, and work. An expanding older population will put an increased strain on resources at a time when the younger population is diminished in number. Changing patterns of work and fewer jobs for men is occurring at a time when European policy is striving to retain more men at work for a greater proportion of their lives. The message that we need a highly qualified workforce still seems to be missing a large proportion of men, with relatively few entering into tertiary education or taking up adult education opportunities. More men are living at home for longer before getting married and family size is reducing with children being born later in married life. For many men there is the prospect of divorce and the health challenges that this brings.

The movement of men across borders through emigration, or asylum seeking may be plugging some of the demographic gaps in the younger population for some countries, but internal migration within Europe has a negative effect on the workforce in the home countries. It also brings with it challenges in

how these young men will be enabled to manage their health and wellbeing in their host country as they tend to be working and living in poor conditions. There are other groups of men who also face particular health challenges, which include those who are in prison, the homeless and men with disabilities.

◆ **Recommendations for Actions**

1. Monitoring of the effects of the post industrial society on the health and wellbeing of men
2. Improvement in the guidance and support given to boys and men with regard to the benefits of secondary, tertiary and adult education
3. Need for targeted strategies for men at different stages of the life course, from different socio-economic background
4. Focus on the reaching out to those men separated from mainstream society through being unemployed, homeless, having migrant status or through imprisonment.
5. Research to explore the health and wellbeing needs of the older population of men

Lifestyle & Preventable Risk Factors

Main points

- Poor lifestyles and preventable risk factors are still some of the principal causes of premature death and morbidity in men, with over 50% of premature deaths being avoidable.
- There are strong links between the socioeconomic and educational background of men and their available health choices, which impact on their wellbeing.
- A gender element exists with regards to men's lifestyle choices, with social pressure increasing the likelihood of adopting risky behaviour.
- There has been a steady reduction in smoking across Europe – but the levels are still highest amongst men in lower socioeconomic groups and in the Eastern European countries.
- Alcohol consumption remains high in men, but differences are most noticeable for drunkenness and binge drinking.
- Illicit drug use varies across Europe, but men tend to have greater use of cannabis, ecstasy and steroids, with more drug related deaths in men.
- Though men have higher levels of activity than women generally, there are too few men taking sufficient exercise for health maintenance.
- Men tend to have less nutritiously balanced diets, with above the recommended levels of dietary cholesterol and saturated fatty acids and lower levels of polyunsaturated fat, carbohydrate, and fibre. Higher than advised salt and other mineral levels adds to the negative health consequences of men's diets.
- Obesity is increasing across Europe and the male form of overweight with central fat deposition increases the risk of many health problems [with links to cardio-vascular disease, cancer and diabetes].
- Men tend to accumulate fat at a faster rate than women, becoming more overweight at an earlier age.
- It is difficult to make international comparisons relating to Sexually Transmitted Infections.
- Programmes that target young men regarding screening for STI's are proving successful.
- Men tend to have a lower age of sexual initiation, have more partners, with condom use being greater in young men and those with higher levels of education.

Summary

The way men live their lives has a major effect on their overall health and wellbeing. From childhood onwards the lifestyles that many men develop are building up problems for their future, whether it's smoking, excess alcohol intake, illicit drug use, poor diet or limited physical activity the effect is seen in their high rates of premature death and chronic morbidity.

Young men feel they are living invulnerable lives, able to eat, drink and take risks without fear of the consequences; sometimes the reality is immediate, through the sudden death of alcoholic poisoning, or it may be cumulative effect as in the rising incidence of ischemic heart disease or cancer in their early adult years. The risks men face are not only the consequence of the life choices they take, there are anatomical and physiological, social and environmental, and service provision factors that can compound the problems. An instance of this relates to the health problems men have when they are overweight, which are a complex blend of the availability of the right food, a socialisation process of boys with regard to their body size and their diet, an increasing sedentary lifestyle coupled with the male form of obesity comprising central (or visceral) fat deposition increasing the risk of the metabolic syndrome and the fat related cancers. This is then linked to the tendency for weight-loss health promotion and services being focused onto women.

There is difficulty in agreeing the extent of sexually transmitted diseases, but it is apparent that the number of cases is increasing. However the targeting of men with regard to Chlamydia is showing that if the screening is done appropriately then men will engage. Getting men to use condoms is more effective in the young. Understanding men's lifestyles is a significant factor in the development of health strategy aimed at supporting men to lead less damaging lives.

◆ Recommendations for Actions

1. Provide an increased focus on preventative and health promotion programmes that have a specific focus on men, and that specifically target those subpopulations of men who are most in need (young men, lower socio-economic group men, ethnic minority men).
2. Consult with men and those working with men in the community, voluntary and statutory sectors, to design preventative and health promotion programmes targeting men.
3. Increase the focus on workplace health promotion initiatives that specifically target men

4. Devise gender-competent health information and health promotion literature and disseminate it through media that are appropriate for men.
5. Provide dedicated men's health websites that provide reputable and accessible health information for men that include links to existing sources of information and support.
6. Develop gender-specific social marketing campaigns that specifically target the health and risk behaviours of young men.

Accessing Health Services

Main Points

- Infrequent use of and late presentation to health services are associated with men experiencing higher levels of potentially preventable health problems and having reduced treatment options.
- The overall rate of admission to hospital is higher for men than for women for all of the principal diseases and health problems.
- Men are also less likely than women to engage in routine or preventative health checks.
- Men's poorer knowledge/awareness of health points towards the need for targeted health information to be delivered to men.
- Men's preference for the internet as an alternative to mainstream medical services can create the problem of missed diagnosis and the possibility of accessing potentially dangerous counterfeit drugs.

Summary

Men's usage of health services has been long recognised as a possible contributing factor in their high rate of premature morbidity and mortality. There is evidence that some men use primary health services less frequently and are more likely to need hospitalisation for the principal causes of disease. There is also evidence that men do not use preventative services at the same level as women, which may be due to the availability of services only being available during the working day so inaccessible to many men. Men have higher levels of usage of the internet for health advice and are more likely to buy drugs through this route (and therefore more vulnerable through missed diagnosis and the rise of counterfeit drugs). Conversely men tend to show no difference to women with regard to presenting with symptoms of illness. Where services have been set up in ways that make access easier, then men have used them and many have been shown to have high levels of hidden problems, both physical and emotional.

Against a background of higher premature death rates among men for nearly the whole range of non-gender specific disease and illness, there is an urgent need for more targeted measures that enable boys and men to recognise their health risks and to take increased responsibility for managing their own health.

There is a need for the provision of training for GP's and other healthcare professionals on the gendered aspects of health and illness and, in particular, on best practice in engaging men with health services. There also needs to

be an increased focus on how health services can be configured to be more successful at targeting men.

◆ **Recommendations for Actions**

1. Develop specific health education initiatives that enable men to make more informed decisions about seeking help in a timely fashion for health conditions that pose a serious threat to their health.
2. Develop 'male-friendly' primary care services that provide flexible opening hours and that have the capacity to be offered in more accessible community and workplace settings.
3. Adopt more stringent regulatory and legislative measures to counteract the sale of counterfeit drugs through the Internet.
4. Provide increased resources for dedicated men's health Helplines.
5. Develop specialised academic programmes on men's health and integrate modules on gender and men's health into the training syllabi of all health and allied health courses.
6. Develop training protocols and short training courses in the area of men's health, targeting existing service providers in the health, allied health and community sectors.
7. Provide support and information for men in the workplace (on health and better lifestyles) through Trade Unions, Employers and NGOs.
8. Bring health professionals to the workplace for conducting check-ups
9. Promote the notion of men as co-deciders of their own health and care
10. Acknowledge the reluctance of some men to really look after themselves – because of other priorities, embarrassment and stigma, or the perception of being emasculated
11. Recognise the importance of using familiar and traditional environments trusted by men to promote health – e.g sports organisations, etc.
12. Ensure health services actively reach out to men
13. Make testing / screening 'routine' and build it into men's lives, from their perspectives
14. Ensure that men recognise signs and symptoms of illness and act on them, with the family acting as a 'team'

Health Status

Main points

- Men generally identify themselves as having better health than women, although this may not accurately reflect their actual level of health and wellbeing.
- Life expectancy is lower for men across all the EU Member States, ranging from 66.3 years for men in Latvia (77.6 yrs for women) to 80 years for men in Iceland (82.2 yrs for women).
- There are more variations found between men's life expectancy between different countries and regions than between men and women's life expectancy.
- Men have nearly double the potential years of life lost as compared to women, with large differences also evident between the countries.
- For the EU27 it can be seen that the rate of death is higher for men across all age ranges, with 24% higher rate in the 0-14 year age range, 236% higher in the 15-44 age range, 210% higher in the 45-64 age range and a 50% higher rate of death in the over 65 age range
- The rate of premature death in men still far exceeds that for women, and is evident across the majority of disease states.
- Over 630,000 male deaths occur in working age men (15-64 years) as compared to 300,000 women.
- Infant mortality tends to be higher in boys.
- Cardiovascular disease is still the biggest cause of premature death, but this is rapidly being replaced by cancer.

Summary

Men report better health than women and have lower levels of self reported chronic morbidity, but their life expectancy remains lower across all the countries. The gap between male life expectancy across different countries and regions is more marked than that between males and females, suggesting that men are more vulnerable to social circumstances. The biggest challenge facing men with regard to the mortality figures is in relation to their higher levels of premature death, with over 2.5 times more young men (aged 15-44 years) dying than young women across EU27. These deaths are also seen across nearly the whole spectrum of those health conditions that could affect men and women equally as they are not sex-specific.

The burden of death appears to differ across the countries with those in Eastern Europe having higher rates of death as a result of cardiovascular

disease, whereas the predominated cause of deaths in the West are due to cancer.

◆ **Recommendations for Actions**

1. Health data should routinely be broken down by age and sex
2. Develop action plans to tackle men's high rates of premature mortality
3. The working age male population should be monitored to assess the extent of preventable deaths.
4. Research should explore men's increased vulnerability to those conditions that should affect men and women equally

Cardio-Vascular Disease

Main points

- Since the 1970's in Europe there have been marked reductions in cardiovascular morbidity and mortality. Nevertheless, Cardio-Vascular Disease (CVD) is still one of the biggest risks to men's health. In the older population it is increasingly the principal cause of death.
- Whilst CVD accounts for a mortality rate of 36% of all deaths for men, the differences across Europe are marked ranging from 61% of total male deaths in Bulgaria to just 25% in France.
- The Balkan and Baltic regions have significantly higher mortality levels from CVD than the other European countries.
- Ischemic Heart Disease, (IHD) is responsible for 360,000 deaths among men in the EU27, nearly 15% of all mortality.
- Cerebro-Vascular Disease (stroke) constitutes 8% of all male deaths or nearly 200,000 lives lost.
- Educational attainment levels have a direct impact on the risk of dying from Cardiovascular disease.
- Smoking remains the single most preventable cause for poor cardiovascular health.

Summary

Although there have been great improvements in cardiovascular health, marked differences exist between different parts of the EU. In some countries cardiovascular disease (CVD) accounts for half of all premature male deaths. In the most vulnerable regions, such as the Baltic States, CVD premature mortality is almost 6 times higher than in those countries with the lowest risk rates such as Switzerland, Iceland and Italy. These inequalities are found not just at the national level: a significant degree of social stratification with regard to CVD is also seen within countries across Europe. A prime example of this is found in Polish young adult males (15-44) for who, at the beginning of the 21st century, the risk of dying from cardiovascular diseases was some six times higher for those with primary education than for those with university education. The historical trend of low IHD mortality in the Mediterranean region is today much less apparent with Greece having one of the highest rates in Western Europe. Stroke accounts for 200,000 deaths among men in Europe but as with IHD, the Balkan region, Bulgaria, Former Yugoslav Republic of Macedonia and Romania have the highest rates of stroke mortality.

Educational attainment has a direct impact on the risk of CVD mortality, up to six times higher for those without a University education. Smoking of tobacco is the single most preventable cause for poor cardiovascular health.

One of the most important challenges in vascular disease control in Europe is the huge gap between Eastern and Western Member States of the EU. As the single most controllable cause of this gap, cardiovascular diseases are one of the most important areas in which the European Union that can achieve significant results in equalising the health of Europeans. Targeted action in the form of special programmes of activity within these countries would hasten the process of health transformation in the Eastern part of the EU29.

A further challenge in the management of cardiovascular disease across all the Member States of the European Union is the inequality in access to appropriate health services determined by socioeconomic factors.

◆ **Recommendations for Actions**

1. Introduce gender sensitive National cardio-vascular strategies – including vascular checks coupled with appropriate counselling and follow-up for all men over the age of 50 years.
2. Prioritise efforts to curb smoking and excessive alcohol consumption (including pricing) across Europe.
3. Introduce legislation directed at the causes of cardio-vascular disease including, for example, the salt and fat content in food.

Cancer

Main points

- Cancer kills around 700,000 men in the EU27 each year which accounts for a 1/3 of all male deaths, with premature mortality affecting some 198,000 males under the age of 65 years.
- Men develop and die sooner from those cancers that should affect men and women equally.
- Tobacco is the largest single preventive cause of cancer death among men across Europe.
- Male cancer patterns are changing, lung cancer is declining but prostate cancer has become the most diagnosed among European males affecting around a million men.
- Lung cancer is on the decrease but will remain a major cause of premature mortality while tobacco products remain so freely available.
- Colorectal cancer is a leading cause of cancer death in Europe and requires population-based screening.
- Stomach cancer has steadily decreased in the last two decades although it is still one of the most leading cancers.
- Testicular cancer, despite effective treatment, still remains the first cause of cancer death among young males (20-35 years).
- Not all countries have a cancer plan that addresses how men's risk of cancer will be tackled.

Summary

Male cancer patterns are changing with a reduction in deaths as a result of stomach cancer and now lung cancer, but with an increase in cases of prostate cancer. Marked differences exist between countries in relation to the male burden of cancer. Men generally have a higher incidence rate for those cancers that should affect men and women equally and a higher rate of premature death. The gender differences are also evident with respect to survival rates, which are generally improving but still poorer in men.

The reasons for men's higher risk of developing and dying of cancer are multifactorial but tobacco remains the largest source of exposure to carcinogenic substances for men. Tobacco causes numerous localised and systemic cancers (lung cancer, oral cancer, pharyngeal cancer, laryngeal cancer, oesophageal cancer, pancreatic cancer, kidney cancer, urinary bladder cancer, leukemia, etc). Tobacco is still the largest single preventive cause of cancer death among men across Europe.

◆ Recommendations for Actions

1. National Cancer plans should make specific recommendations with regard to monitoring and reporting on male cancer patterns, to male cancer susceptibility and lower rates of survival and to lower male cancer literacy
2. Screening needs to be better understood and targeted – for example, bowel cancer needs to be started at an earlier age for men and effort has to be made to ensure more men present for screening while research is needed into the development of an effective screen for prostate cancer.
3. Prioritise earlier cancer screening, with more aggressive treatment (biological difference between women and men)

Accidents, Injuries and Violence

Main points

- Throughout the EU, there is a clear and consistent pattern of higher mortality rates among males compared to females from accident and violence-related injuries.
- There are considerable differences between countries with male mortality rates from accident and violence related injuries being particularly high in Eastern Europe.
- Accidents account for the biggest proportion of deaths within this classification group (some 36,000 male deaths in EU27) with death rates from road traffic accidents being 3 times higher in males than in females. Men account for 95 % of fatal workplace accidents.
- Homicide accounts for 5,500 deaths annually in the EU27 with the rate of homicide being twice as high for males as for females.
- Road injuries are the principal cause of accidental fatality.
- The economic costs associated with accidents in the EU are estimated at over € 15 billion a year.
- Whilst the vast majority of both victims and perpetrators of violence are male, females are much more likely to be victims of intimate partner violence (IPV).

Summary

Men's accidents, injuries and violence are a major public health problem within the EU. Male risk taking, the effect of male anti-social behaviour, male work and play activities and the management of mental and emotional conflict are all implicated in the higher rates seen in men. With the exception of sexual violence (for which 90% of victims are women) 72% of interpersonal violence victims and perpetrators are men. Homicide accounting for over 5,500 deaths each year also rises exponentially in young males after the age of 15 and peaks again in the 80 plus age group.

In light of the large intercountry variations in mortality rates from injury, it seems prudent that policy lessons and tried and tested preventive programmes established in low mortality countries could be used as a blueprint for good practice initiatives for countries with higher injury mortality rates. If all countries matched those with the lowest mortality rates, half of the lives lost to road traffic injuries and 9 out of 10 of those lost to drowning, poisoning, burns and falls could be saved each year. With men being vastly overrepresented in the

injury statistics, such reductions would be particularly significant in reducing mortality and morbidity rates among men.

◆ **Recommendations for Actions**

1. Adopt the policy lessons and tried and tested preventive programmes established in countries with low mortality rates for accidents and injury as a blueprint for more co-ordinated and multisectoral action in those countries with high accident and Injury mortality rates.
2. Provide an increased focus on research that seeks to unravel the underlying factors associated with accident and injury, particularly in regions with high mortality rates, and that support a strong evidence-based approach to injury prevention.
3. Develop more stringent mechanisms for collating and tracking accident and injury data that are consistent between member states, and that lead to an increased focus on alignment of leadership, infrastructure and capacity building directed at reducing accident and Injury rates.
4. Provide increased resources towards the enforcement of regulatory and legislative measures targeted at accident and injury prevention
5. Provide at both an EU and member state level an increased focus on violence prevention, addressing the root causes of violence and developing a better understanding of the structural and cultural conditions that help to foster lives free of violence.
6. Provide increased intervention programmes for male perpetrators of domestic violence and ensure that male victims of domestic violence have appropriate access to information, support services and counselling services.
7. Health and Safety at Work is an EU competence – use it more

Mental Health

Main points

- Men's depression and other mental health problems are underdetected and under treated in all European countries. This is due to men's difficulty in seeking help, health services' limited capacity to reach out to men, and men's different presentation of symptoms to women with higher levels of substance abuse and challenging behaviours.
- More than three times as many men as women commit suicide and the difference increases to up to five times among the elderly. The higher suicide rates in men are linked to undiagnosed mental health problems.
- Men can suffer from post natal depression which is a scarcely recognised problem, but one that can have a marked effect on families.
- Sex differences between EU countries regarding incidence, occurrence and admission to treatment for bipolar disease are evident, but difficult to explain.
- Schizophrenia onset is earlier in men than women, with men having poorer long term outcomes, longer inpatient stays and extended periods of impaired functioning.

Summary

Mental ill-health in European men is under-diagnosed and under-treated. Many men seem to find it challenging to seek help when it comes to mental or emotional health problems. It may be difficult for health professionals themselves as well as individual men to identify changes in health behaviour as signs of mental disturbances. There is a lack of adequate assessment tools suitable to diagnose men's symptoms, and a lack of suitable ways of referral for gender specific treatment. Mental and behavioural disorders due to the misuse of alcohol are one of the most disturbing problems of men's mental health. The deaths of men and women as a result of mental & behavioural disorders due to alcohol show a significant gender difference with three to four times more men dying than women.

There has been a 15% increase in the number of suicides in the last decade. Eight Member States are amongst the fifteen countries with the highest male suicide rates in the world, with large differences seen between the highest and lowest countries. In order to address mental health issues more effectively in men, there is a need to address gendered patterns in the upbringing of boys, and to improve our understanding of gendered dimensions to mental health disorders, mental health service delivery and in the behaviours of men themselves. One very important change that has emerged is in relation to

more contemporary approaches to fatherhood. Greater numbers of men attending the births of their children and participating in caring may enhance men's awareness of their own and their family's mental and emotional well being. This may also sensitise men to be more aware of their own mental health and to seek help more promptly.

◆ **Recommendations for Actions**

1. Develop the techniques to detect the 50% of male depression that remains undiagnosed and to treat it. Research into the symptoms of male depression in men leading to screening instruments for men especially those in vulnerable groups such as older or single men
2. Develop methods for referral and treatment models better suited for men.
3. Prevent much more of men's suicides – especially older men's suicides. This must be done by detecting men's depressions earlier and to a much greater extent and by developing programs for identifying men with mental problems. One important way to reach this is by educating GPs and other health professionals in home and institution services
4. Acknowledge that parenthood is a massive transition for men, and acknowledge that around 7-10 percent of all new fathers suffer from Post-Partum Depression
5. Explore men's self-esteem linked to their mental health – power, control and transference

Problems of the Male Reproductive System

Main points

- There is a lack of patient focused research into men's experiences of reproductive health problems.
- There appears to be a gap between men's needs for treatment or advice in relation to sexual health and the capacity of health services to meet these needs. This gap is a result of men's under-use of health services and an apparent reluctance of many health care professionals to address men's sexual health.
- Erectile dysfunction is a common condition that can cause great distress to sufferers, but it is also an important early warning of cardio-vascular disease and other health problems.
- The Lower Urinary Tract Symptoms (LUTS) cause significant problems for a large proportion of the older generation of men across Europe.
- Late onset hypogonadism has been found to have a biological basis for about 2 % of men.

Summary

The problems encountered by men with regard to the male reproductive system are often wrongly associated with the ageing process. Early diagnosis of the causes of erectile dysfunction can uncover serious health concerns as well as allowing restoration of a normal sex life. The lower urinary tract symptoms (LUTS) are associated with a number of conditions, such as Benign Prostatic Hyperplasia and Prostatitis, which cause significant discomfort for the affected individual. Though these are significant illnesses for the older man there remain few treatment options available. Over 40 % of cases of infertility are due to male problems.

◆ Recommendations for Actions

1. Improved communication with men on the signs and symptoms of male reproductive disorders to help differentiate between normal ageing and problems and to recognise the importance of early diagnosis
2. Expand research opportunities to explore male reproductive disorders
3. Improve access to men for diagnosis and treatment of erectile dysfunction

Communicable Diseases

Main points

- Men have a higher risk of dying prematurely from the major infections as a result of reduced immunity and their greater likelihood of either having a lifestyle or social circumstances that makes them more susceptible.
- Tuberculosis was in decline, but it is increasing in sub-populations of men. Drug-resistant strains hamper the management (and containment) of this disease.
- It is difficult to make international comparisons relating to Sexually Transmitted Infections.
- Across Europe there are about 2 HIV cases for every 1 case in women, and 3 AIDS cases to every 1 case in women, with differing patterns of incidence rates across Europe, with a ratio of 5:1 male to female deaths.
- Viral Hepatitis affects more men than women by a ratio of about 4:1.

Summary

Communicable diseases have significantly been reduced in Europe over the last two decades for both men and women, but the gender differences in morbidity and mortality between countries and within the EU are still very significant. The accession countries, particularly those of Eastern Europe and the former soviet block are struggling with higher rates of communicable diseases particularly among men. Across the lifespan deaths from Pneumonia are higher in men and boys until the over 80 age bracket, which accounts for 77% of female deaths and 55.4% male deaths. Tuberculosis continues to be a public health risk with 18 European States in the WHO 'high-priority' category. Mortality from HIV and AIDS has seen a general decrease across EU27 with a larger decrease in Males but there are still 3 new AIDS cases in men to every one case in women.

◆ Recommendations for Actions

1. Improve reporting of communicable disease states with standardisation of data collection – specifically age-range – and Inclusion of sex breakdown in all data
2. Improve tracking of men infected with TB
3. Improve health conditions in prisons to ensure minimal transfer of infection and rapid effective treatment.

Dental and oral health

Main points

- Dental and oral ill-health are causes of many systemic diseases as well as being the source of marked discomfort to the individual.
- Dental caries and missing teeth are a bigger problem for women than men.
- Periodontal disease affects a significant proportion of the population and has a greater prevalence in men
- The older generations are more at risk, but obese young men are emerging as another at risk group.
- Strong links are evident between periodontal disease and cardio-vascular disease.

Summary

Women tend to have more problems with regards to dentition but men have the greatest need with regard to poor periodontal health, which, apart from being a cause of considerable pain and discomfort, is associated with cardiovascular disease and increasingly with metabolic syndrome in men. It is ironic that although men are less likely to use preventative dental services women have a higher incidence of dental caries.

The causes of periodontal disease are closely associated with risky male health behaviour but though this was once seen mainly as a problem of the older men it is now being increasingly seen in the young, especially those who are obese.

Whilst there are variations across the EU with regards to consultation with a dentist by educational level, periodontal disease can be prevented through changes in lifestyle behaviours. Improved oral care is a precursor to reducing the incidence of systemic diseases across the world and early health promoting strategies aimed at men would seem to hold great worth.

◆ Recommendations for Actions

1. Improve surveillance of men's oral health problems
2. Include gender specific information in the Oral Health report
3. Develop better health strategies on how to improve men's oral health

Other Health Conditions Affecting Men

Main points

- Type 2 diabetes is increasing in men as a result of obesity. The death rate in men is twice that of women in those under the age of 65 years, and across Europe men have higher admission rates for diabetes.
- Obese diabetics have a 40-60% higher risk of cardiovascular mortality.
- Across Europe there are higher levels of chronic lower respiratory diseases in men than women. Around 4% of all male deaths result from this condition, which is mainly caused by smoking.
- Osteoporosis is traditionally seen as a problem of older women. There are however problems of low bone density in young male athletes, men with specific health problems and hereditary factors. A growing number of men develop the condition as a result of hormone ablation therapy for prostate cancer.

Summary

The mortality data for diabetes masks the true extent of its influence on the overall health of the population as it is the fourth leading cause of death in the EU.

Type II diabetes, once only seen in adults, is being diagnosed in younger populations and is associated with obesity. With the link between male form of central obesity and the metabolic syndrome and other health conditions this is a major cause of premature death as a result of cardiovascular disease. With chronic lower respiratory diseases it is noticeable that the Eastern European countries have a lower percentage of total deaths despite having higher levels of smoking than Western Europe. This may be explained by higher mortality levels of cardiovascular disease in Eastern Europe. Osteoporosis once seen as a problem for post menopausal women is also prevalent in men.

◆ Recommendations for Actions

1. Routine checking of blood glucose in men to identify undiagnosed diseases – especially those who are overweight or obese.

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**Recommendations from the
GENDER AND HEALTH THROUGH LIFE
Conference, Copenhagen, June 13th -15th, 2012**

Recommendations are from presenters and participants in the conference. These are not all verbatim. The list is possibly incomplete. Some are taken from presenters slides, others were written directly by the participants on paper whilst at the conference and then transcribed, others were noted by Prof. Ian, Banks, Susan Barber, Veronica Wray, EMHF(Main conference), and Nicola Beddington, European Patient's Forum, (Round Table on Cancer).

No	Recommendation	Target audience
1	“A more focused approach to the physical and mental health of younger men needs to be balanced with one that also faces the health challenges of an ageing male population. The diversity of factors contributing to men’s poorer health requires measures that not only recognise any gender equality issues, but also highlight a more fundamental concern with equity. This relates to the right of all men - irrespective of social, cultural, political or ethnic differences - to live long and fulfilling lives.” White et al., 2011, Europe’s men need their own health strategy. British Medical Journal 343:d7397	1,3
2	2020 Health for Growth <ul style="list-style-type: none"> • Focus on productivity and competitiveness • Economic viability of the European Union • Men’s Health as an asset and an investment Prof Alan White	1,3
3	“In policy, practice, and research there is a pressing need to examine the “problems” with men’s health and to tackle the underlying causes as well as the symptoms. This demands appropriate intersectoral and intergovernmental responses at both EU and national levels.” White et al., 2011, Europe’s men need their own health strategy. British Medical Journal 343:d7397	1,3
4	In Denmark: Health check for all at the age of 50 The municipalities should be obligated to assist workplaces Focus on exercising during work hours Targeted information about health towards men, unskilled and short term educated	3, 4

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	<p>3F'S GOALS FOR THE FUTURE Jane Korczak, United Federation of Danish Workers</p>	
5	<p>HPV Programme – An Action Plan</p> <ul style="list-style-type: none"> Extend HPV vaccine to boys. Ensure proper national and local strategies are in place. Link local health promotion and school health education programmes more effectively. Use a wider range of professionals to promote and deliver the programme -including pharmacists and health trainers. Incorporate more of the programme into school lessons. Recognise the need to get girls and boys fully on board before the vaccination programme begins and allow them to influence their parents. Encourage family health literacy approaches in schools using teachers as well as health professionals as mentors. Develop peer education programmes. <p>Increasing the research commitment.</p> <ul style="list-style-type: none"> Advocating change where necessary with decision makers. Providing effective health education and health programmes in schools and the work place. Increasing health literacy levels. Promoting a life course approach to health, culture and personal responsibility. Pursuing and supporting appropriate behaviour change. <p>Dr Selwyn Hodge, Chair, Royal Society for Public Health, UK</p>	<p>1,3 1,3, 19 1,3 14 21,22,5 14 14 14 14 3, 12, 13 14, 4 14 1,3,14 21</p>
6	<p>Mental health policies and programmes should incorporate an understanding of gender issues</p> <ul style="list-style-type: none"> • Gender-based barriers to accessing mental health care need to be addressed in programme planning. • A public health approach to improve primary prevention, and address risk factors, many of which are gender-specific, is needed • If gender discrimination, gender-based violence and gender-role stereotyping underlies at least some part of the distress, then these need to be addressed through legislation and specific policies, programmes and interventions. • Training for building health providers' capacity to identify and to treat mental disorders in primary health care services needs to integrate a gender analysis. • Provision of community-based care for chronic mental disorders should be organized to ensure that facilities meet the specific needs of women and men, and that the burden of caring does not fall disproportionately on women <p>Marif Bravo-Ortiz, Mental Health Europe, University La Paz</p>	<p>10 10 21 1,3, 5, 12, 13 5,10 10</p>
7	<p>Communication and exchange of useful information, advocacy strategies, entry points to different levels of political arena –for</p>	<p>23</p>

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	<p>coordinated and complimentary actions („many drops of water make a hole in a rock“)</p> <p>Strengthen partnership between civil society and academic institutions: firsthand knowledge of the most pressing research needs, users and disseminators, tuned to health problems and SDOH neglected or emerging, connected to hard-to-reach groups</p> <p>Many health promotion strategies aim at reducing risky behaviours, such as smoking, while ignoring the material, social and psychological conditions within which the targeted behaviours take place. There is a strong association between smoking prevalence, material hardship, low SES, stressful work or life. Gender roles and linked health-related behaviours in many strategies led to focusing on behavioural change at the individual level (eg. Different specific stress coping strategies for both genders to be learnt instead of taking up risky behaviour)</p> <ul style="list-style-type: none"> •However, the individual level is not enough and on a longer run generic strategies aimed at population and macroeconomics level are needed, eg. Smoking bans, plain packaging •Another good practice is monitoring and collecting gender aggregated data to inform planning, implementation and evaluation of gender health promotion and disease prevention programmes <p>It is never too early to prevent and tackle chronic diseases. Healthy practices, health capital and resilience to diseases begin in infancy or even <i>in utero</i>. Lifecourse approach would not only benefit patients who already developed a disease but mainly protect healthy people from early on from developing it in the first place.</p> <ul style="list-style-type: none"> •Early years development and interventions/prevention in this crucial period are of 20-80 ration cost effective, build up resilience and health capital, literacy, empowerment <p>Dorota Sienkiewicz, EPHA</p>	<p>1,3, 23, 24, 11, 19</p> <p>1, 3, 21</p> <p>24, 1, 3, 11</p> <p>1,3,14,23, 22, 21</p>
8	<p>EPF calls on the EU institutions to ensure that the revision of the clinical trial directive address this issue: beyond the question of ethics- effectiveness and safety of medicines is at stake</p> <p>EPF calls for comprehensive strategy on information to patients at EU level that encompass health literacy</p> <p>- Health Professionals need to be aware of how gender</p>	<p>2, 3, 19</p> <p>3</p> <p>5</p> <p>5</p>

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	<p>influences health outcomes and health seeking behaviours.</p> <ul style="list-style-type: none"> - They also need to be trained in communicating more effectively with patients from both gender. - need for further availability of sex disaggregated data - Continuing Professional Development <ul style="list-style-type: none"> • EPF has formulated recommendations on meaningful patient involvement as part of the Value + project which takes into account diversity issue- we call on Member States and EU institutions to implement them. <p>Susana Palkonen, EPF</p>	<p>24 5 3</p>
9	Don't neglect politics (needs to be linked to some of the other recommendations)	
10	Don't neglect conventional sources of information and early diagnosis even with innovation	
11	Involve men and women in the approach to developing a gendered health policy	1, 3, 4, 9, 10, 19, 21, 22, 23, 24
12	Secure consensus amongst traditional and non-traditional partner health organizations	1, 3, 4, 9, 10, 19, 21, 22, 23, 24
13	Develop an international men's health strategy that incorporates a gender approach to policy <ul style="list-style-type: none"> - Engage WHO, European CDC/US CDC 	25, 1, 3, 23, 21, 9, 1, 2, 3, 4, and then 12, 13
14	Host a joint summit engaging policymakers from US, UK, and Europe around gender and health	25, 26, 27, 28, 29
15	Pharmacies should be used for public health info as research suggests that men use pharmacies more than they use any other health professional environment.	22
16	Communication should be on the agenda of all healthcare professional curriculum.	5
17	It is critically important to consider how gender intersects with the other social determinants of health	1, 3
18	Need to target 'high risk' populations of men and women Greater understanding of the complexities of attitudinal and behaviour formation.	21, 18,
19	Develop health information and strategies to increase health	25, 26, 27,

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	literacy through means that ask different types, classes, cultures and age groups what they know and what they need to know and what they need to access good health and health services.	28, 29, 21, 22, 9
20	Link health strategies to increased effort to close inequalities gaps across social class, gender and ethnic background.	1, 3, 12, 13
21	Tackle problem of access to primary care – needs to be made simpler and quicker to improve early diagnosis	6, 9
22	Gender in all policies and working together across NGOs and other stakeholders	1, 3,
23	Implement VALUE+ recommendations on patient – male and female – involvement on projects , research , policy practice	1, 3, 11
24	Ensure that health policies are based on a gender analysis of sex disaggregated data that address women's and men's health issues in relation to their socioeconomic status.	1, 3
25	Need to raise awareness about inequalities in incidence of ill health, survival and death between women and men and in particular include this in doctor's training, and in health policy	21, 1, 3, 5
26	Men delay preventative action. Evidence shows that a significant reason for this is that they find it hard to lose time from work. Recommend that work-places plan health promotion awareness campaigns, and health information campaigns using materials that are targeted differently at women and men. Reach out to people who may consider themselves healthy – point out the lifestyle related risk factors for major diseases likely to affect them at some point in their lives if no preventative action taken.	4, 7, 21,
27	Women around the world should be targeted and trained to become IT literate. This should be planned to enable even those women living in countries where health information and possibly health services are scarce, to access internet based information and services.	15
28	Women are living longer than men in most European countries and they live for longer periods as dependents, and with chronic diseases. They are very affected by loneliness and depression. Men live less-long and are most likely to commit suicide. Promote policies which enable older women to maintain quality of life and remain independent.	1, 3
29	Recommend that all people do much more physical activity. 30 minutes per day is not enough! Doing enough physical exercise will postpone disease. Raise awareness that a	Problematic as much of the available

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	sedentary lifestyle is the most dangerous thing and responsible for many aspects of ill-health.	research out says that less than 30 min per day would do it. Needs further thought.
30	Need for services contextualised in men's experience. Use men's experience to get them to talk about their health and health experiences and to give them opportunities to explore how to best look after their health.	1, 3, 9, 10, 11, 14
31	Promote education that enables boys in particular to explore their emotions and challenge peer group pressure to close emotions down or frown upon boys who attempt to be more open to this.	14
32	Find out what sorts of public health services would best suit men.	21, 11
33	When planning services and policies bear in mind both gender differences, and class differences. For example, people at the top end of the class structure fare much better than those as the bottom.	1, 3
34	Stress the importance of health education in schools and availability of information, and the central role of communication to meet the different propensities of boys and girls to promote good health	14
35	Monitor the impact of austerity measures currently being taken across the European Union and how these affect the health of men and women.	1, 3 with the input, where possible, of 26-29 and 23 – and then 12, 13
36	There is little research carried out on men's health. We need to find out from men's perspective why it is that men's health gets so bad when austerity bites.	11
37	There is a very significant link for mental illness being a risk factor for suicide. Mental health issues should be more considered as part of anti-suicide strategies than they currently are. (In Denmark – possibly elsewhere?)	1, 3, 10

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38	In Denmark we need a better understanding of at risk groups, and we need a plan of how to reach and treat them, a governing body to analyse what's happening among different risk groups and make recommendations about what to do. (Reco about research needed) Lesbian, bi and gay people are at much higher risk of suicide than others, they should be included in at risk groups, and included in strategic and operational planning as above	3, 10
39	In Spain research shows that there are peaks in suicide rates when unemployment figures climb, and troughs in suicide are positively correlated with improvements in health services. (Sort out the unemployment issue).	3, 12, 13
40	Women talk about what's bothering them, their mental health issues, they seek help in primary care and access services in secondary care more than men. Men are much more likely to take their own lives and die from preventable diseases earlier than women. Men delay until symptoms, and/or their coping mechanisms reach crisis point. Find ways of reaching out to men that they will take up at a much earlier stage to help to prevent suicides among them.	10
41	Find ways of including this understanding in the training of people who are lawyers or who work in the area of law; health planning; training of health professionals; police. (See slide – a public health approach to preventing mental health disorders).	5
42	Denmark is the only country that recognises that men get post-partum depression. Should this be a recommendation for other countries?	3
43	Men need appropriately targeted services connected to their mental health, encouraging them to seek help and take up services.	10
44	The way I see it the approach to tackle men's health should be taken in two ways@ Vertical: meaning involvement of politics, engagement of politicians in preparing the EU and national strategies about how to deal with the problem. Horizontal: different actions in the society, in the micro environment: through sport activities (the Premier Health Programme is great). I think also the associations of patients	1, 3, 16, 17, 12, 13

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	had can be of great support. In Slovenia, different associations organise a lot of different activities for general awareness. If there could be an organisation for men's health, it could do the same. There should be a wide campaign. `Men – wake up!' Ksenja Tratnik, Slovenia	
45	We are currently developing a project – “Norm Stormerne” with the municipality of Copenhagen to address bullying and discrimination against LGBT youth and children. At this conference I have realised how beneficial our “norm critical” approach (as opposed to a “tolerance pedagogic approach”) will be for all genders, sexual orientations, ethnic groups, minorities of all kinds... In confirms that our work is important – not only for the equity in health for LGBT citizens but to all and everybody! Ole Moller Markussen, Anthropologist, Aids-fondet, Denmark ole@aidsfondet.dk	14
46	Take gender also into consideration as some of the basic criteria for designing health-care policies and provisions for good continence care. Children's, men, women, pregnant women, older people, people with dementia, diabetes, MS etc. Person centred assessment and care, for good continence care. Nichole Huige, SCA.	1, 3, 9
	Include motivation and recruitment in research ?	
47	Include hands-on experience for practitioners working directly with men in health promotion and disease prevention.	5
48	Plan conference after men's health week so practitioners can attend (they are busy carrying our men's health week).	26, 27, 28,29
49	Being a high school teacher in sports I will make a 5-10 minute session – work-out 2-3 times a week and try explaining why this is a good idea but also give the children and teachers feel the difference	14
50	In high-school sports I will make the students focus on gender differences on health, and make them focus on what they can do, any how they can recognise that they are doing good or bad.	14
51	I myself will learn more about health literacy and see how aesthetic learning (cesterisk learning” in Danish) can contribute to make people understand, evaluate and change	

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	their health behaviour.	
52	Engage in structured and context sensitive training of healthcare professionals on all levels in communication with patients/ people of any kind/sex/background. If the professionals knows more about and knows how to communicate they can easier tailor information and engage in cooperation with the patient in a constructive way. Thank you for a really great conference. Annegretke Bielsen (Communications person) ann@ucu.dk	5
53	Development of a new diagnostic scale to diagnose men's depression and a new diagnostic scale to diagnose post natal depression among men. Kind regards Lennie Toxny, University College, Nordern Jutland, Dept of Midwifery.	10,11,24
54	Invest in developing / giving comprehensive sexuality education in schools – leads to change in gender stereotyping and leads to precondition for health issues and concerns.	14
55	When it comes to gender and health always take into consideration that different gender identity or different sexuality stresses health problems even further and it covers up this 10 percent of any population	1, 3,9
56	More funding to establish/ research best practice principles for the promotion of men;s health followed up by sufficient resources to implement such evidenced based interventions	11, 1, 3, 12, 13
57	Highlight more clearly the fact that when so many men of working die across Europe “families, women and children go into poverty”. Politics might ??	14 influencing 1 & 3? 12, 13?
58	More qualitative research – a life course approach, exploring men's narratives of health and wellbeing.	11, 1, 3
59	Implementing initiatives based around educating the youth in schools highlighting health, wellbeing that is gender specific.	14
60	Gender issues in health should be a part of all health professional education.	5
61	National health policies must reflect known differences in gender and social determinants, in order to put especially the health of men and the working class in front.	3
62	Research: rights and responsibility approaches to be developed.	11

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63	Research: implementation studies (tools) – qualitative studies on men’s perspectives. Men meet primarily women in the health sector and women carry out and plan health promotion care and rehabilitation.	11
	ROUND TABLE ON CANCER – part of the Copenhagen Conference	
Ca1	<p>Importance of information that will really encourage people to seek help: e.g. UK bowel screening programme Results of which suggested that there was a clear gender difference in take-up. Women submitted samples far more readily than men. Information should be gender sensitive and age sensitive and take on board psychosocial factors</p> <p>Example that people become more pessimistic as they age and men have a tendency to become fatalistic</p> <p>Information should take on board people’s fear of both diagnosis and prognosis. Gender differences in terms of how men and women respond to and use information plus their individual gender barriers...were stressed Men , in general, tend to like statistics , facts, practical info Women , in general, tend to like info that points them towards peer support and the social dimension of chronic disease The importance of information and support programmes being as user-friendly as possible was stressed – many are perceived as ‘inconvenient, troublesome’</p>	3, 9, 18, 23, 27, 29
Ca2	The importance of consulting young people appropriately on the information that works for them was emphasised strongly	29, 27, 3, 23 (in each country – eg., the Youth Cancer Trust in the UK)
Ca3	The importance of research was stressed, not only in terms of developing and targeting materials but also evaluating their impact	11, 29, 27
Ca4	It was highlighted that there are important cultural and	3, 9, 18, 23

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	environmental factors that also influence access to info Example Muslim women accessing info from internet cafes.	– in each country
Ca5	The use of accessible (plain – not doctor-speak) languages and formats was discussed, and that this should be reflected in the patient doctor relationship (particularly the need to reach undergraduates with better / more communication training).	5, 9, 18, 23, 27, 29
Ca6	Health literacy: It was acknowledged that health literacy is defined in many different ways; Very important to stress profound differences in boys' and girls' psychological development. Health literacy is not necessarily about reading skills – Shakespeare example There is a need for early intervention on health literacy particularly among boys – (there is a lot of research around differences between girls/boys left-hand/right-hand brain functions and the need for boys to have special support in actually understanding health info). Health literacy encompasses knowledge, understanding, ability to navigate, evaluate , critique and to take appropriate action. 'The imperative to act' was underlined several times The role and potential of education systems / curricula in enhancing health literacy was stressed. It was highlighted that progressive work on information in the cancer fields could be replicated in other disease areas.	14, 11, 21
Ca7	The issue of adaptation versus targeting was addressed The same materials can be ' branded ' and targeted in many different ways BUT there will remain a need for targeted information to specific constituencies, in particular environments The role of the work place was stressed in particular.	27, 29, 4, 7, 22, 23
Ca8	The importance of a holistic approach to health information that will really influence behaviour and choice – lessons could be learned from the corporate world's advertising strategies – particularly using children to target their parents (Stop Smoking campaigns – where children ask their parents to stop because they need them 'alive').	27, 29, 4, 7, 22, 23, 3, 9, 21
Ca9	Meaningful information sharing and dialogue requires appropriate	5, 14

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	<p>training and CPD of health professionals that integrates the gender dimension BUT the key challenge is encouraging and mobilising people to go to the doctor sooner rather than later. (In addition there is a need for medical staff to be better trained in communication skills – so better undergraduate/CPD training needed).</p>	
Ca10	<p>The need to access different info during the patient journey was stressed</p> <p>Info needs at the point of diagnosis clearly different from long-term info needs. Research has been done into patient's initial diagnoses. In diabetes - patients and doctors were asked after the initial diagnosis what had been said. The difference in what doctors had said and what the patient had understood were staggeringly different! Which suggests that more time, more understanding (the patient is often in shock) should be given. Medics need to provide an opportunity for more follow-up info. an appointment to discuss further. And give the patient plain, understandable health info).</p> <p>Innovative work is required on information and how it should be best conveyed – not a 'one size fits all approach.'</p> <p>It would be useful to have an analysis of existing materials and explore the implications of the presence, or absence of a gender dimension – we need to substantiate our arguments but also use the evidence base that already exists</p>	<p>27, 29, 11, 6, 8, 10, 24, 23</p>
Ca11	<p>Screening programmes tend not to be fit for purpose, they are seen as invasive, and reinforcing vulnerability among women because procedures can be intrusive and perceived to undermine dignity and self esteem.</p>	
Ca12	<p>Research into a reliable, uncontroversial and effective national prostate screening service should be a number one priority. Prostate cancer has become the most diagnosed cancer among European males affecting around a million men.</p>	<p>11, 27, 29, 3, 1</p>
Ca13	<p>Men want reliable, clear, easy to understand information about prostate cancer produced using language that they relate to and understand. They also want information and services that recognise survival of cancer as part of a journey in which they often still require support to navigate and come to terms with what has happened to them and to help them to understand the after effects of treatment and how to make as good a recovery as possible.</p>	<p>27, 29, 3, 8, 9, 6, 22, 28, 23</p>

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Ca14	National Cancer Plans should prioritise cancer awareness and health information about all stages of the journey, prevention, earlier detection, diagnosis, survival. This should be done with full input and feedback on early drafts from men and organisations that represent them. They should steer the look, feel, and content and type of the information and how it can be accessed by them. This should be done in partnership with healthcare services that have a remit to run effective awareness raising initiatives.	3, 9, 27, 23, 29, 21
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Key to target audiences

1. European Commission – Health Services Directorate
3. Individual Governments/ country specific
4. Trade Unions
5. Providers of training for different medical professions, and other professions (educators, legislators etc).
6. GP's / Primary Health Care Organisations
7. Employers
8. Hospital based services – Secondary Health Care Organisations
9. Planners of health services
10. Planners/providers of mental health services
11. Research funders
12. MP's
13. MEP's
14. School teachers – especially PE, health and those who can address bullying, talk/teach about gender
15. Educators in IT
16. Sports organisations
17. Leisure Centres
18. Organisations representing/supporting different groups: e.g., LGBT, ethnic minorities; younger people, women
19. Pharmaceutical organisations
20. Practitioners and organisers of Men's Health Week in different countries
21. Public health practitioners/organisations
22. Pharmacists
23. Patient focused organisations, NGO's, health network
24. Academics
25. International (not European) health focused organisations
26. European Men's Health Forum EMHF
27. European Cancer Patient Coalition ECPC
28. European Patients Forum EPF
29. European Cancer Organisation ECCO

