

MEN'S HEALTH **around the world**

**A review of policy and progress
across 11 countries**

Edited by David Wilkins and Erick Savoye

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Erick Savoye

Director of EMHF

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Introduction

David Wilkins

Is the health of men important?

This may seem like a rather fundamental question to ask at the beginning of a review of policy and progress in male health across eleven countries. On one level, the answer is bound to be “yes”. Of course the health of every individual man everywhere in the world matters to him and to the people who care about him. The evidence about whether men’s health is important to politicians and health planners however, is rather less convincing. Campaigners for better male health from three continents report in this paper that, despite enormous progress in public health and the sophistication of modern treatment approaches, men consistently suffer more serious illness than women and die at an earlier age.

Does the very consistency of these patterns suggest though, that poorer health in men is inevitable. Is it a simple matter of biology?

In fact, the biological arguments are much less important than they first appear. There is very significant variation in male/female comparative mortality rates between one country and another. Female life expectancy in the Russian Federation is more than 13 years greater than male life expectancy; in the Netherlands the difference is only a little over four years. Biology alone cannot explain this. The scientific consensus tends to be that inherent differences between men and women are at most only partly responsible for the discrepancies in morbidity and mortality rates¹.

Comparing male health with female health is crucial to our debate because it brings into focus those factors that are different for men. But if we put male/female comparisons to one side for a moment, it can be seen that male life expectancy also varies considerably between different groups of men *within* as well as *between* countries. Indeed male life expectancy varies within even very small geographical areas. In England for example, it is often pointed out that for each station east from central London on the city’s underground railway system, male life expectancy falls by nearly a year; a man born in the affluent heart of the city, in Westminster, can expect almost to reach the age of 79; a man born a few miles away in Canning Town in East London will not live to see 73. Similar variations in mortality rates can be seen within cities and between regions throughout the world.

We can easily see therefore that both the sex-comparative data and the data that compares groups of men suggest that non-biological factors are extremely important determinants of male mortality and morbidity. Since non-biological factors are not fixed - that is to say that they are capable of change in response to external intervention - it is consequently safe to conclude that vast and untold numbers of men around the world are dying earlier than they need. Given the political will to address this issue, both sexes could enjoy better health and a longer life even while the differences in outcome between men and women are being tackled.

But don't most of the authors writing in this report also acknowledge that men take less effective care of their personal health? That men tend to use health services less frequently? That men are believed to delay seeking help until later in the development of symptoms? Doesn't that make it men's own fault that their health is often so poor, regardless of where in the world they live?

It is certainly true that men, by and large, tend to be less knowledgeable about personal health than women and that they are less likely to seek help from medical practitioners. It is also true that men take more "health risks" than women, whether those are direct physical risks such as working in more dangerous professions or driving at higher speeds, or "lifestyle" risks like being more likely to drink alcohol to excess or to eat a less healthy diet. It is remarkable indeed, how entirely consistently these patterns of behaviour are reported by the authors in this paper, despite their describing countries with wide social and cultural differences.

Does this mean though, that men *deserve* poorer health and an earlier death?

Surely not.

If poorer use of services was an underlying cause of poorer health in a particular minority ethnic community, the political consensus in most countries covered in this report would be that the existing services were failing that community. Most nations with a developed understanding of health inequalities accept that health systems sometimes need to take account of differences between population groups in order to achieve fairer outcomes. There is no logical reason why gender differences in health outcome should not be treated in the same way.

If this is so obvious, why do our authors - from countries as culturally varied and geographically distant from each other as Malaysia and Denmark, New Zealand and Canada - report similar difficulties in persuading governments to pay particular attention to the health of men?

One reason is the one we have just considered - the idea that the problem lies with men themselves. This may lead to the regrettable political view that it is up to men to change, not services. This is a fallacious argument that fails to acknowledge men's poorer health as the inequality that it is. Furthermore, as our authors report, cultural pressures and social expectations make help-seeking very difficult for men all over the world. If men are to change, we must accept that whole societies must change. Some may argue that would be desirable - but the only realistic view to take is that change on that scale is not going to happen in the foreseeable future.

Another reason is the sheer familiarity of the differences between the sexes. Politicians and clinicians may have simply become so used to men dying sooner than women that they have ceased to wonder why it happens. This perception may be reinforced by the fact that – as we have seen – there are some potential biological explanations for some of the differences. This may lead people to regard men’s greater burden of premature disease and death as “natural”.

Finally, there is the persistence of the view that gender inequalities only affect women.

It should be made clear at this point that there are no negative views about women or women’s organisations to be found in this report. Nowhere does anyone take issue with the view that women are seriously disadvantaged in many areas of life in many countries. Several authors indeed, acknowledge a debt to women’s organisations, who have led the way on social change in recent decades. Unfortunately however, the widespread association of the very word “gender” solely with the concerns of women is extremely unhelpful. The chapter on “Gender Equity” in *Closing the gap in a generation*², the World Health Organisation’s important recent report on the need for worldwide action to address health inequalities, does not contain a single sentence about male health. The opening paragraph illustrates the point very effectively:

Gender inequities are pervasive in all societies. Gender biases in power, resources, entitlements, norms and values and in the organization of services are unfair. They are also ineffective and inefficient. Gender inequities damage the health of millions of girls and women

What progress is being made?

The following definition of a male health issue has been proposed:

A male health issue is one that arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or necessitates male-specific actions to achieve improvements in health or well-being at either individual or population level³.

This definition acknowledges that there are more factors at play than the biological; that the health of men and boys cannot be divorced either from prevailing notions of masculinity or from the influences of the wider world of (for example) work or relationships. By stressing however, that one of the defining characteristics of a male health issue is that “male-specific” actions are needed to bring about an improvement, the definition also recognises the crucial point that services will need to differ by gender in their design and content. In other words, that the onus is on policy-makers to take the initiative if they are serious about improving male health.

This report contains some examples of countries where governments have taken exactly this kind of positive action. At the same time it contains a greater number of examples of countries where non-governmental organisations are still pressing their political leaders to begin to tackle the issue. In the absence of a political response, these non-governmental organisations are themselves often delivering programmes that target men's poorer health.

Although some of our authors are frustrated at the lack of progress, it is nonetheless positive that the issue is being discussed, at least to some extent, in all the countries described in this report. Of course this is to be expected; the eleven countries featured are all known to have activist organisations campaigning for change. It is entirely possible that there has been good - or even greater - progress in other countries but that this has not come to the attention of the editors. It is perhaps more likely however, that the majority of the world's nations have not yet begun to consider strategies to improve the health of men.

Where there has been sufficient progress to have resulted in government activity, that activity tends to fall into one of two categories.

The first is politically-led activity directly intended to improve male health by the development of dedicated policy and/or investment in health programmes targeted at men. Very strong examples of this can be seen in the reports from Australia and Ireland. Ireland has recently seen the publication of what is believed to be the world's first national policy intended to improve the health of men. Australia has a long track record of activity on men's health both at the level of community activism and at the level of government (both national and regional). It is not surprising therefore that progress there has been good. At time of writing, Australia is also developing a national policy for men's health and has appointed a group of "Men's Health Ambassadors" to inform government thinking and galvanise public opinion.

Initiatives at this level are very much to be welcomed and are a tribute to the campaigning work of men's health organisations as well as to the foresight of the governments concerned. A problem with actions of this kind though is that they may be vulnerable to political change which has the potential to bring them to an end before they can become fully established. A clear example of this can be seen in the report from New Zealand where, in 2008, as a consequence of a change of government, the demise of a dedicated investment programme occurred within just a few months of its announcement.

The second category of progress has been in those countries where an emphasis on gender equality in social policy overall has opened the door to arguments that men's poorer health outcomes should be addressed within this context. Examples of progress here include England & Wales, Scotland and Norway. This route is probably available in a good number of other nations too - at least in theory. The difficulty lies in shifting the obstructive public and political view that we have already described - the idea that "gender inequality" is a problem that affects only women. It can be difficult to instigate a constructive debate on this issue and even more so

to achieve a workable understanding. The argument runs the risk of alienating politicians who adhere to the view that men can never be seen as disadvantaged. It may also be perceived as diminishing the importance of those aspects of life where women do suffer discrimination and discrimination. In fact, an emphasis on gender-sensitivity in health and healthcare provision has the potential greatly to benefit both sexes.

Highlighting progress in the countries mentioned above should not be taken to imply that there has been no progress in others. Canada, for example, has identified gender equity as one of the primary goals of health policy and has established a research institute specifically to explore the relationship between gender and health. In the USA significant political influence has been achieved at both state and national level, and the Men's Health Network has an important co-ordinating role. In Malaysia, a broad commitment has been given by government to work towards a national policy on men's health, and programmes of activity have been initiated by both government and the voluntary sector. In Denmark and Switzerland, government initiatives in specific areas of provision (e.g. support for fathers) have taken account of the health needs of men. All of the countries in this report organise activities during International Men's Health Week in June each year – a common thread that links activists around the world.

The final chapter in this report gives an overview of the situation across the European Union, particularly from the point of view of political activity at the European Commission. This chapter helpfully unravels the complex range of health policy and guidance at EU level and picks out the areas that are most relevant for understanding the potential for more concerted action to improve the health of men and boys. The European Men's Health Forum (EMHF) supports a network of activist organisations including some in countries not covered by this report. One of the most influential initiatives of the EMHF has been the Vienna Declaration on the Health of Men and Boys⁴. The Declaration was launched in 2005 and now has over 500 key signatories from 48 countries.

The Declaration calls on "the EU, national governments, providers of health services and other relevant bodies" to:

- Recognise men's health as a distinct and important issue
- Develop a better understanding of men's attitudes to health
- Invest in "male sensitive" approaches to providing healthcare
- Initiate work on health for boys and young men in school and community settings
- Develop co-ordinated health and social policies that promote men's health.

Although the international debate has moved on since the Declaration was published, these ideas still have very significant weight. It is interesting and encouraging to note the unanimity of the authors in this report in continuing to endorse them as the potential building blocks of policy - despite the political and cultural diversity of the countries they describe. This augurs well for the future development of a "movement" for men's health that has international authority.

It remains only for me to encourage readers to look at all the chapters in this report. The strength of this paper is in the diversity of the contributions. We have used the same format for each chapter so that it should be possible to make direct comparison between countries in relation to:

- The current state of men's health
- The response of government
- The authors' sense of what the future holds

Please bear in mind incidentally, that not all the authors have English as their first language. The particular gratitude of the editors is expressed to those authors who had to contend not only with the tight word limit but also with the difficulties of translation.

Information about the authors is given at the end of each chapter as are the web addresses of national men's health organisations where those exist. It is hoped that this report will form the beginning of a historical record and – apart from its general interest – will be of particular use to colleagues hoping to develop activism on men's health in countries where none presently exists.

References

1. Gjonca A, Tomassini C, Toson B, Smallwood S. Sex differences in morality, a comparison of the UK and other developed countries. Health Statistics Quarterly No. 26. London: National Statistics; 2005.
2. Commission on Social Determinants of Health. Closing the gap in a generation. Geneva: World Health Organisation; 2008
3. Wilkins D and Baker P. Getting It Sorted: a policy programme for men's health. London: Men's Health Forum; 2003.
4. See: www.emhf.org/index.cfm/item_id/305

Men's health in Australia

Anthony Brown and John Macdonald

The current state of men's health in Australia

The popular image of the bronzed Aussie springs to mind when people talk about Australian men. Fit and healthy, a man who likes to work and play hard, and who perhaps drinks too much with his "mates" (close friends).

Like most stereotypes there is some truth in this image, Australian men are not, however, an homogenous group. As famed as Australia is for its sportsmen, it is also the home of the largest gay and lesbian parade and party in the world (the Sydney Gay and Lesbian Mardi Gras), over 25% of the population were born in another country, and up to 5% of the population are Indigenous Australians.

The recently released discussion papers for the National Men's Health Policy make the situation of men's health clear¹:

While overall there has been an increase in life expectancy for all Australians over the past century, rates of mortality among men are still higher than mortality among women, and have not improved to the same degree as mortality among women.

At all ages men experience higher mortality rates than women in suicide, accidents and injury. As men age they have higher mortality rates than women for cancers, diabetes mellitus, and diseases of the circulatory system. For men the highest proportion of total disease burden attributed to determinants of health in 2003 were tobacco smoking (9.6%), high blood pressure (7.8%), overweight/obesity (7.7%), high blood cholesterol (6.6%), physical inactivity (6.4%) and alcohol (3.8%).

Aboriginal and Torres Strait Islander men have by far the worse health outcomes of any sub-population in Australian. Aboriginal and Torres Strait Islander men have a life expectancy of almost 20 years less than non-Indigenous men. More than half (53%) of the deaths of Indigenous men were of men aged less than 50 years, compared to non-Indigenous Australian men most of whom (75%) die at more than 65 years of age¹.



Members of the Richmond Men's Shed, with NSW Minister for Fair Trading, Linda Burnie and Anthony Brown at the Richmond Men's Shed, Richmond, NSW Australia.

The Richmond Men's Shed is the 'classic' Australian men's shed where men, mostly retired men, come together and share skills and knowledge around metal and/or wood work. This shed has a focus on bicycle repair and recycling.

Photo courtesy of the Hawkesbury Gazette, Richmond, NSW, Australia".

The response of the Australian government

Australia is a Federation of 6 states and 2 territories. In addition to the National (Commonwealth) government, each state and territory has its own government and parliament; giving Australia a total of 9 Ministers for Health and 9 Health Departments. In general, the Commonwealth Government sets overall health policy and funds the states and territories. The states and territories in turn are responsible for providing direct health services (such as hospitals and community health). The Commonwealth provides funding to General Practitioners under the Medicare scheme. There is also a strong private health care sector of hospitals and clinics paralleling the public system.

National Men's Health Policy

In 1999 the then Commonwealth Minister for Health announced a men's health policy. This policy never eventuated, due mainly to a change of government. This may have been for the best, for the conventional wisdom and overwhelming attitudes to men's health at the time attributed men's poor health to men – “men don't go to the doctor” they say – “that's men's problem”. “Men drink too much, don't exercise enough. Are too violent” . . . etc. Given the growth internationally of the importance of the social determinants of different populations' health status, behaviour and needs, and the call for evidence- based policies, such negative stereotyping has no legitimacy at all.

In the last decade there has been a lot of talk about “masculinity” as the major problem facing men's health. This approach has allowed us as a country to turn our attention away from social, economic and political issues which can and do affect men's health. It also hampers our efforts to support men positively, whether boys at school, young fathers struggling to work for their families, gay men seeking their rightful place, separated dads, immigrant men trying to find a new identity here, older men facing retirement. One of the success stories of men's health in Australia has been the Sheds Movement² – at its best a grass-root movement, building on men's strengths and offering

them social support. Government policy should support and not control this type of community movement.

Policies are only words but they influence the way we think about boys' and men's health and what services we do or do not provide for them. The state of Indigenous men's health is worst of all in Australia; their life expectancy is in the mid fifties, to our shame as a nation, and although non-Indigenous men do not face the same challenges as Aboriginal men, their state of health illustrates well that health is embedded in the social circumstances of all our lives, not just in “masculinity”. Five men a day kill themselves in our country and one woman. Men die several years younger than women. Men benefit less from doctors' services and from community health services than do women. As an Australian psychologist famously said, when questioning the those who explained men not using a help line as being due to their “masculinity”: “If I have a party and people don't come, shouldn't I be asking: what is wrong with the party? Not what is wrong with those who don't come?” This perspective should lead us to think differently and plan differently for men's health, indeed to make health services more *men friendly*.

During International Men's Health Week in 2008, the Commonwealth Minister for Health, Nicola Roxon, announced that the Australian Government would develop a National Men's Health Policy. The discussion paper that followed this announcement indicated a significant move forward from the discourse of ten years ago. The discussion paper highlights the importance of the social determinants of health, how we need to understand the context of men's lives if we ever hope to improve their health, as well as a commitment to ‘male friendly’ health services³. This is not only an acknowledgement that barriers exist for men in accessing health services (it is not just a case of “men not taking care of themselves”); it is also an acknowledgement of those many health and community services in Australia who for years have been attracting men, in some cases having to turn men away because they are oversubscribed.

Being “men friendly” means taking a “strength-based approach” to working with men and boys⁴.

Such services deliver effective care to men by:

- using positive and appropriate language when working with men
- creating an respectful environment
- ensuring a model of service provision that meets men’s needs and ways of communicating

Australian commentators have also called for policy development that takes into account men’s existing and knowledge of health⁵ and health seeking behaviours⁶.

As part of the announcement of a National Men’s Health Policy, the Minister also announced the appointment of Men’s Health Ambassadors, to promote the policy process and to feed back suggestions and ideas to government. The second author of this paper is one such ambassador.

Consultations for the National Men’s Health Policy are currently being held around Australia. With at least 2 taking place in each state and territory, including a national Men’s health Summit in Canberra on 18 March 2009. Policy discussion papers and information about the consultations can be downloaded from: www.health.gov.au/menshealthpolicy

Senate Select Committee into Men’s Health

In November 2008 the Australian Senate formed a Select Committee to enquire into the state of men’s health in Australia and to look at levels of funding and support offered by Australian governments. This process is separate to the development of the National Men’s Health Policy as described above. At date of writing the enquiry is still accepting written submissions, and hearings are expected to be held around the country before the tabling of their Select Committee’s report by 30 May 2009.

More information on the Senate Select Committee, including copies of already received submissions, can be obtained from: www.aph.gov.au/Senate/committee/menshealth_ctte/index.htm

New South Wales Policy

In 1999 New South Wales (NSW) became the first, and to date only, Australian state or territory to adapt a men’s health policy. The authors have not been able to locate men’s health policy anywhere in the world that pre-dates *Moving Forward in Men’s Health*.

At a time when the Commonwealth and other commentators were focusing on masculinity and “men behaving badly” as way to explain men’s health, *Moving Forward in Men’s Health* developed a framework for working with men that was ahead of its time. The policy affirmed the importance of men’s health as an issue and committed the NSW Government to improving men’s health and to target those men in the community who are most in need. It recognised both the importance of the social determinants of men’s health and need to develop partnerships with government and non-Government agencies outside of health services⁷.

The policy has five Key Focus Areas⁸:

- Making Health Services More Accessible and Appropriate to Men
- Developing Supportive and Health Environments
- Improving Collaboration and Coordination of Services
- Research and Information
- Workforce Development and Training

The policy allowed NSW Health to increase the range and scope of services to men. It attempted to put structures in place to ensure the success of each Key Focus Area, including the appointment of Men’s Health Officers in each local Area Health Service and the establishment of the Men’s Health Information and Resource Centre, University of Western Sydney.

While there were many projects initiated from *Moving Forward in Men’s Health*, they are mostly isolated services started and continued with the good will and passion of local individuals. The policy alone was not able to secure an integrated, permanent structure for the planning and delivery of men’s health projects in NSW.

In December 2008 NSW Health released a discussion paper on creating an Action Plan on Men's Health in NSW⁹. The aim of the action plan is to ensure that consideration of men's and boys' health issues are incorporated into the planning and delivery of all health services across the state.

The Men's Health Action Plan is based on three principles:

- Equity in health outcomes;
- A focus on health needs of men across the life course; and
- A focus on health promotion and prevention.

In February 2009 a consultation was convened by MHIRC in partnership with NSW Health, with key men's health organisations. NSW Health is considering the outcomes of this consultation, together with individual submissions received. The final NSW Men's Health Action Plan is expected to be released mid 2009, hopefully during International Men's Health Week in June.

The future for male health in Australia

Despite the commitment to the social determinants of men's and boys' health spelled out in the Commonwealth Government's discussion papers, there appears to be a growing emphasis on behaviourism, a "men behaving badly" approach to men's health. Current government priorities of reducing smoking, unhealthy drinking and obesity risk overshadowing the social determinants of health. There is a risk that men will be targeted in these campaigns without an attempt to understand the social and economic factors linked to these behaviours. There is a danger that the men's health policy will sink into somewhat reductionist health education strategy, rather than attempting to understand and change the underlying social factors behind these behaviours. This despite another document of the government released this year¹⁰ which acknowledges:

Some groups have increased risk of disease because of social, cultural socio-economic or other factors e.g. from place of residence, economic resources, employment status, skills, lower levels of education language, cultural barriers and lifestyles. These factors can

Following on from these principles are five key priorities that aim to promote:

- More accessible and appropriate health care for men
- More cancer awareness, less cancer
- Less obesity, less smoking, less risky drinking and less unsafe sex
- Better mental health and wellbeing
- Better prepared, more involved fathers

make it hard to make changes or adhere to advice on diet, smoking, drinking and other lifestyle behaviours. For instance, some people can find it hard to adopt a healthy diet because it can be more expensive than one based on foods that are high in fat, sugar and salt

A successful men's health policy must be evidence based, with a broader focus than just "masculinity" and "men behaving badly". It needs to understand the socially constructed differences between men and women, and the impact this has on health, but to go beyond that to understanding of men's and boy's social needs and how these impact on health¹¹.

Improvements in men's health have for too long been dependent on the passion and drive of isolated individuals. A men's health policy, for any level of government, will only succeed if there are accompanying resources, money and a dedicated infrastructure.

Australia has indeed been at the forefront of many initiatives in men's health. It remains to be seen if the positive steps made so far can be sustained.

Addendum: The Australian Senate Select Committee on Men's Health has just released its report which can be downloaded from www.aph.gov.au/senate/committee/menshealth_ctte/report/index.htm

About the authors

Australasian Men's Health Forum (AMHF) is the peak body for men's and boys' health in Australia. AMHF recognises and advocates for the broad spectrum of male health and wellbeing, including the areas of medicine, allied health, health promotion, research, psychology, as well as the broad range of social, economic and cultural influences that determine the health of men and boys. AMHF also convenes the bi-annual National Men's Health Conference and National Aboriginal and Torres Strait Islander Male Health Convention, as well as co-ordinating International Men's Health Week in Australia. Since its inception in 2001 AMHF has been advocating for an Australian Men's Health Policy.

Men's Health Information and Resource Centre (MHIRC) was founded in 1999 as a recommendation of Moving Forward in Men's Health, the NSW Men's Health Policy. MHIRC is a research and policy centre that focuses on the social determinants of men's health; with particular interest in the health of marginalised men. MHIRC conducted the first longitudinal study into men's health in Australia and has research interests in the health and social needs of Aboriginal men, separated fathers, prisoners, frail older men and retired men. MHIRC also convenes the NSW Health Men's Health Officers network.

Anthony Brown is the Project Officer at MHIRC. He has worked closely with the NSW Health Department with their review of Moving Forward in Men's Health. He is also a PhD student investigating retired men's health.

John Macdonald is Foundation Professor of Primary Health at the University of Western Sydney, as well as Co-Director of the Men's Health Information and Resource Centre. He is also the President of the AMHF. In February 2009 Prof. Macdonald was appointed one of the Australian National Men's Health Ambassadors, by the Commonwealth Minister of Health, to promote the development of the Australian Men's Health Policy. He is the author of several books on Primary Health Care (PHC), as well as numerous articles and book chapters on PHC and men's health.

Men's Health Australia: www.menshealthaustralia.net

References

1. Department of Health and Ageing. Developing a Men's Health Policy for Australia: Executive Summary. Canberra: Department of Health and Ageing; 2008. Available from: www.health.gov.au/internet/main/publishing.nsf/Content/phd-mens-policy
2. See: www.mensheds.com.au
3. Department of Health and Ageing. Developing a Men's Health Policy for Australia: Setting the scene. Canberra: Department of Health and Ageing; 2008. Available from: www.health.gov.au/internet/main/publishing.nsf/Content/phd-mens-policy
4. King, A., Sweeny, S., and Fletcher, R. A Checklist for Organisations Working with Men. *Developing Practice*, 2004. 11: p. 55-66.
5. Smith, J.A. Addressing men's health policy concerns in Australia: what can be done? *Australia and New Zealand Health Policy*, 2007, 4(20).
6. Smith, J.A., Braunack-Mayer, A., and Wittert, G. What do we know about men's help-seeking and health service use? *Medical Journal of Australia*, 2006, 184(2): p. 81-83.
7. Kakakios, M. Men's Health - The Way Forward. *NSW Public Health Bulletin*, 2001, 12(12): p. 315-317.
8. NSW Health Department. *Moving Forward in Men's Health*. Sydney: NSW Health Department; 2001 [p. 40].
9. NSW Health Department, *DRAFT NSW Men's Health Action Plan 2009-2012*. 2008.
10. Department of Health and Ageing, *Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government 2008* [cited 2008 13 March] Available from: [www.health.gov.au/internet/main/publishing.nsf/Content/D66FEE14F736A789CA2574E3001783C0/\\$File/DiscussionPaper.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/D66FEE14F736A789CA2574E3001783C0/$File/DiscussionPaper.pdf)
11. Macdonald, J.J., 2006. Shifting paradigms: a social determinants approach to solving problems in men's health policy and practice. *Medical Journal of Australia*, 185(8): p. 456-458.

Men's health in Canada

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The current state of men's health in Canada

Canada is the second largest country in the world, and comprises 10 provinces and 3 territories. Historically, there are three main cultural groups in Canada: First Nations & Inuit (about 2% of the population), Francophones (about 20% of the population concentrated mostly in Quebec Province) and Anglophones. However, Canada is truly a multicultural nation, with a large degree of racial and ethnic diversity throughout the country. Responsibility for the health of Canadians is split between two federal agencies (Health Canada and the Public Health Agency of Canada) and the provinces. The roles of the two federal agencies are focused mostly on health prevention and treatment issues that affect all Canadians. The provinces are responsible for the delivery of primary, secondary, and tertiary health care services. Given that each province has a slightly different approach to health care, there are important discrepancies between them, especially in their approaches to topics such as men's health.

In Canada, the 1990s was characterised by a contentious period of restructuring state social provisions, marked particularly by issues of gender¹. This state and social policy re-structuring has rejuvenated debates about the role of state policy vis-à-vis the market and traditional welfare state provisions. Equity and gender pervade these debates, as evolving definitions of femininities and

masculinities shift the policy terrain around health as a field of equitable social citizenship. In this broad context, men's health as a field of research and study is still relatively nascent in Canada. Yet, it is increasingly important to gain a clearer picture of how gender, specifically masculinity, intersects with constructions of the 'healthy male citizen', under the directives of neo-liberal health and state welfare policies that seek to intervene on the behalf of men and their health careers.

In general, men's health is a neglected political and policy topic in much of Canada. For the most part, governments have ignored men's health as a specific issue. When men's health concerns are addressed, it tends to be driven by city or regional health authorities because of local concerns (as opposed to provincial or federal policies). Some local, community-based organizations have been created in the past. The Toronto Men's Health Network is perhaps the most notable, being based in Canada's largest and most ethnically diverse city. Established in 1999, it disbanded in approximately 2007 due to an inability to achieve enough funding to support itself and the projects it wished to conduct. A similar attempt to create a Canadian Men's Health Network has been stalled since 2005².

A summary of men's health statistics in Canada reveals on-going gaps in current health policy initiatives, and also highlights the continued need for analyses and health policy that can address the complex intersections of men's health across class, culture, socio-economic status, immigration, and visible minority status:

- Canadian men lead in 14 of the 15 primary causes of death, including cancer and heart disease³.
- Men with the same social disadvantages as women experience poorer health outcomes in relation to mortality, disability, chronic illness, and injury rates⁴.
- Controlling for the greater life expectancy of women, men are 39% more likely to die from diabetes, 84% from arterial diseases, 78% from heart disease⁵.
- Men are 29% more likely to be diagnosed with cancer and 52% more likely to die as a result^{6,7}.
- Men are twice as likely to die from unintentional injuries and 7 times from HIV⁵.
- The cancer most likely to kill men between the ages of 15 and 30 is testicular cancer, but most physicians don't talk to boys about testicular self-examination⁷.
- 4 out of 5 suicides among young people in Canada are committed by men, despite men's lower reported rates of depression⁶.
- First Nation men living on reserves die an average of 5 yrs younger than those living off reserve; 8.9 yrs younger than Canadian men in general⁸.
- The life expectancy of gay men is 20 to 30 yrs shorter than that of heterosexual men⁹.

The response of the Canadian government

Yet, lack of a specific political and policy focus on men's health does not imply a complete lack of any and all activity. Canada has identified gender equity as one of the primary goals of health policy. In 1995, the "Federal Plan for Gender Equality"¹⁰ was designed as a means to advance gender equality within the Canadian context. One of the primary ways successive governments have addressed the gender divide in rates of morbidity and mortality between men and women is via research initiatives. Health Canada and the Canadian Institutes for Health Research (CIHR) implemented gender and sex based analysis (GBA) guidelines to encourage researchers to formally describe the effects of gender and sex on health and illness^{11,12}. The primary goal of GBA in Canada is to positively impact the health outcomes and quality of care received by boys and girls, men and women, by developing gender-sensitive health promotion programs, procedures and practices¹³.

Additionally, CIHR established the Institute of Gender and Health to focus on developing empirical foundations about the connections between gender and sex, health and illness, and thereby improve population-health outcomes¹⁴. Initially, these plans were developed to enhance inclusiveness for researching women's health issues. However, as gender based research efforts advance, there has been more attention paid to the health consequences of male gender roles among men who are members of dominant and marginalized groups¹⁵.

Some Provincial governments have developed education campaigns to increase the awareness of specific men's health issues. Men's mental health issues have received attention due men's high suicide rates (e.g., Government of Nova Scotia – Men/ Depression: <https://gov.ns.ca/health/mhs/depression/men.asp>) and attention has been paid to providing information about men's

exercise and diet (www.ottawa.ca/residents/health/adults/mens_health_en.html#P23_1687) and Health Canada offers an online resource detailing various men's health issues (www.hc-sc.gc.ca/hl-vs/jfy-spv/men-hommes-eng.php). In Quebec, interest in men's health began in the late 1970s when a small group, named HomInfo, created a journal about men's issues. In the 1990s, specific interest emerged around suicide prevention, domestic violence and drug and alcohol abuse^{16,17,18,19} and between 1999-2001, a suicide prevention campaign, "demander de l'aide, c'est fort" (it is strong to ask for help), focused on men. Meanwhile, the provincial Ministry of Health and Social Services commissioned a large scale analysis of men's health²⁰. This paralleled a similar study on women's health and recruited a task force that reported to the government in 2004²¹. Despite this interest in men's health in Quebec, except the newly funded research team "Masculinités & Société", there is no specific men's health group or men's health program, and most recommendations from Rondeau et al.'s report have not been enacted.

The focus on the biological differences between men and women have manifested most often as sex-specific cancers of the reproductive systems (i.e., cervical, prostate, breast, testicular). There has been pressure, for example, to increase rates of screening for prostate cancer, despite the scientific debate about the efficacy of such screening²². As such, screening programs have not engaged governmental policy support but remain a focus of community-based men's health interest groups, including the Canadian Prostate Cancer Network, which aims to increase public awareness and availability of prostate cancer screening (www.cpcn.org/).

In Canada, as elsewhere, efforts to increase awareness and access to men's health services has lacked the focused direction and momentum found in the women's health movement in the 1970s and 1980s. Approaches to address men's health have therefore tended to develop as an adjunct to wider gender initiatives that originally had the health of women as the main focus, or in a piecemeal way where enthusiastic individuals in practice and policy settings have driven the issue forward. Furthermore, the development of male specific health policies remains controversial and efforts must be undertaken to ensure that campaigns for men's and women's health are not drawn into a competing victims discourse with one another as they lobby for limited monies from health care budgets²³.



"You have to be strong to ask for help" a poster to help prevent suicide.

The future for male health in Canada

Canada has a long-standing history of being a leader in the field of public health and health promotion research, policy and practice. The fact that it is the birthplace of "The Ottawa Charter for Health Promotion" is evidence of that. It is all the more surprising therefore that the specific issue of promoting men's health has remained almost silent within this national context. Patterns of male mortality and morbidity are similar to other developed countries with comparable socio-economic profiles that have not remained silent about this issue.

A recent CIHR-IGH commitment to funding specific boys' and men's health research is timely and will hopefully remain a priority within future funding competitions. Thought needs to be given to how promoting men's health might be handled at a policy level. The current commitment to GBA suggests that Canada favours a 'gender mainstreaming' approach. Yet, presently, there seems to be only small pockets of application of GBA to assure gender sensitive health service provision in addressing men's health. As implied earlier, it is possible that such a policy approach is constrained in

implementation within neo-liberal political structures (see also²⁴). In this context, it seems likely that reviewing how GBA is implemented, and developing a 'Men's Health Strategy' that compliments the current 'Women's Health Strategy', would be a positive step forward.

Others countries have recognized the challenges for practitioners trying to develop men's health services work where there is a limited evidence base or where access to existing evidence is restricted. It would be useful therefore to emulate models developed elsewhere that enable practitioners to share resources and experiences and that can and do act to influence policy making to promote the health of men. Men's Health Forums and Networks have been established in other countries, often with government support, to serve such a purpose. A vital next step for coordinating and guiding research, policy and practice in men's health across Canada would be Federal Government support for the development of a Men's Health Forum/Network that can work alongside some of the strong women's health organizations in the country.

References

1. O'Connor, J. S. Orloff, A.S. Shaver, S. States. *Markets, Families: Gender, Liberalism and Social Policy in Australia, Canada, Great Britain and the United States*. Cambridge: Cambridge University Press. 1999
2. Long, D. *Building on Our Strengths: A New Vision for Men's Health in Canada*. Report on a National Survey to Establish a Canadian Men's Health Network. The Kings University College, Edmonton, Alberta. 2005
3. Statistics Canada. *Selected leading causes of death by sex*. Statistics Canada. Ottawa, ON. 2005. www40.statcan.ca/l01/cst01/health36.htm
4. Schofield, T., Connell, R., Walker, L., Wood, J. & Butland, D. *Understanding men's health and illness: A gender-relations approach to policy, research, and practice*. *Journal of American College Health*, 2000, 48: 247-256.
5. Toronto Men's Health Network. [n.d.]. *The killers*. Retrieved February 14, 2007, from: www.menshealthnetwork.ca/why/killers.asp
6. Canadian Health Network. 2004. *The truth about men's health*. Retrieved February 14, 2007, from www.canadian-health-network.ca
7. Underwood, N. *The truth about men's health*. Canadian Health Network: Toronto, ON. 2004
8. Frohlich K. L., Ross, N., & Richmond, C. *Health disparities in Canada today: Some evidence and a theoretical framework*. *Health Policy*, 2006, 79: 132-143
9. Jalbert, Y. *Gay health: Current knowledge and future directions*. Ottawa: Health Canada. 1999
10. *Status of Women Canada. Setting the stage for the next century: the federal plan for gender equality*. Ottawa: Status of Women Canada; 1995.
11. Canadian Institutes of Health Research. *Gender and sex-based analysis in health research: a guide for CIHR researchers and reviewers*. 2007. Retrieved 01-02-2009 from www.cihr-irsc.gc.ca/e/32019.html.
12. Health Canada. *Health Canada's gender-based analysis policy*. Ottawa: Minister of Public Works and Government Services Canada; 2000.
13. Health Canada. *Exploring concepts of gender and health*. Ottawa: Minister of Public Health Works and Government Services Canada; 2003.

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14. Glouberman, S., & Millar, J. Evolution of the determinants of health, health policy, and health information systems in Canada. *American Journal of Public Health*, 2003, 93(3): 388-392.
15. Spitzer, D. L. Engendering health disparities. *Canadian Journal of Public Health*, 2005, 96(Suppl 2): S78-S96.
16. Dulac, G. Les demandes d'aide des hommes. Montréal : Centre d'études appliquées sur la famille, École de service social, Université McGill; 1997.
17. Dulac, G. & Groulx, J. Intervenir auprès des clientèles masculines. Théories & pratiques québécoises. Montréal : Centre d'études appliquées sur la famille, École de service social, Université McGill. 1999
18. Dulac, G. Aider les hommes...aussi. Montréal : vlb. 2001
19. Turcotte, D., Dulac, G., Lindsay, J, Rondeau, G. & Dufour, S. La demande d'aide des hommes en difficulté : trois profils de trajectoire. *Intervention*, 2002, 116: 37-51
20. Tremblay, G., Cloutier, R., Antil, T., Bergeron, M.-È. & Lapointe-Goupil, R. La Santé. Des hommes au Québec. Québec : Publications du Québec – MSSS & ISQ; 2005.
21. Rondeau, G. et al. Les hommes : s'ouvrir à leurs réalités et répondre à leurs besoins. Rapport du Comité de travail en matière de prévention et d'aide aux hommes. Québec : MSSS. 2004.
22. Concato, J., Wells, C. K., Horwitz, R. I. et al. The effectiveness of screening for prostate cancer. *Archives of Internal Medicine*, 2006, 166: 38-43.
23. Doyal, L. Sex, gender, and health: the need for a new approach. *BMJ*, 2001, 323: 1061-1063.
24. Williams, R. Robertson, S. Hewison, A. Masculinity, 'men's health' and policy: the contradictions in public health. *Critical Public Health* In Press.

Men's health in Denmark

Svend Aage Madsen PhD

The current state of male health in Denmark

Although Denmark is a welfare society and a country with high standards in health and gender equality, life expectancy for Danish men is among the lowest in the European Union (EU) at 78.3 years. Danish men are number sixteen of twenty.

Smoking among Danish men seems to be the most important factor behind this. Historically and culturally the attitudes to all kind of health and especially men's health has been very laissez-faire and against any kind of restrictions in Denmark. Furthermore Danish men have lower all-cancer survival than countries with similar national expenditure on health. The 5-year survival rate for prostate cancer among Danish men is only 47% compared with 75% in Europe as a whole.



When you look at healthy life years at 50 years of age for the same 25 European countries however, Denmark is in first place with 23.6 years.

When it comes to men's use of health care system it has been established that Danish men fall significantly behind women in using GPs and other primary healthcare services. Danish men hospital patients seem to want the disease and health services to take up only a small part of their daily life and identity yet they occupy most of the beds in hospitals. This point to a need for developing a better understanding of gender differences in patients' health psychologies. The development of more 'male-sensitive' health services should be a central issue in the education of health professionals in Denmark.

These issues have been some of the most important in recent years - and these are some of the issues that the Danish Men's Health Society has worked with during these years, especially during the national Men's Health Week (MHW), which is the most important yearly activity.

Presentation of the 2005 Men's Health Prize; a well established activity of the Danish Men's Health Week.

The theme of the week was men and sexuality. The prize was given by Else Smidt (right), head of prevention at the National Board of Health to Kristian Ditlev Jensen (left) for his famous autobiography about sexually abused boys.

Danish MHW focuses on themes, and in previous years Danish MHW has covered:

- Men's health in general (2003)
- Men's health and physical condition (2004)
- Mens' sexual health (2005)
- Men's mental well-being (2006)
- Male sensitive communication and education in health settings (2007)
- Men's health and the workplace (2008)
- Men and cancer (2009)

The main objective of MHW is to raise awareness about specific issues affecting men, and to improve the health and well being of boys and men. Health services have been slow to recognise particular issues affecting men in relation to health. These issues include men's increased risk of developing poor health because of risk-taking lifestyles; delay in diagnosis due to men's late presentation to health services; and men's reluctance to take appropriate care of themselves and to access support services once diagnosed.

During MHW there are plenty of opportunities for organisations and charities to join in as active partners by organising local events, providing information packs

and by reviews or press coverage in local magazines. The co-ordination group provides a framework for the week and the activities.

The following organisations have been part of the organisation group through the years: the Danish National Board of Health; the Ministry for Equalities; Danish Nurses Organisation; United Federation of Danish Workers; the Danish Metalworkers' Union; the Danish Healthy Cities (municipalities and counties) Network; the Danish Mental Health Fund; the Copenhagen University Hospital Rigshospitalet; PROPA (the Prostate Cancer Patient Organisation); the Danish Cancer Society; the Danish Family Planning Association; the Confederation of Danish Industry; and Men's Health Society Denmark. Several local and other organisations also support MHW.

Support for the week has been expressed by the Danish minister of Health, the Danish minister of Equalities, the Director-General of the Danish National Board of Health and Chief Medical Officer, and several members of Parliament.



This book 'Know Your Body, Man!' written by five health specialists who are also members of the Danish Men's Health Society was the number one bestseller in Denmark for several weeks when it was published in 2006.

The response of the Danish government

Although support has been expressed by leading politicians, even the Minister of Health has addressed and supported Men's Health Week in Denmark, no special initiatives or health regulations or laws have been established in order to take special action related to men's health. The reason for this is more lack of interest and conservatism among health professionals than resistance from politicians. This is very much due to a refusal to accept gender as an important issue in health politics among medical staff.

However there are areas showing progress in men's health. This is especially related to the laws and regulations and health services for men as fathers. In that matter there has been a positive development, and it seems that men's participation in at the birth, parental leave (many places there are two to three months parental leave with full salary for men), and caring for their small children has a positive impact on men's health

and health behaviours. This is probably due to the fact that men will have more contact with and get more accustomed to making use of health services. Furthermore the men's taking active part in childcare seems to prevent divorces and it has been established that divorce is a threat to several aspects of a man's health. Finally it seems that being engaged in parenthood also increases a man's taking care of his health and wellbeing.

The future for male health in Denmark

What we would like to see happen is the development of a much bigger awareness on men's health in public, political, and health opinion. This seems to be the way to make changes in men's health behaviours and in health services for men. With the inclusion of The Danish Healthy Cities Network, which is a network of municipalities and counties, in the group of organisations behind Men's Health Week there are very good prospects for changes in the development of health promotion policies and activities in municipalities and counties and in promoting public health.

This might have an important impact on the lifestyle of Danish men, which is in imperative need of improvement in several areas, especially in the areas of smoking, alcohol drinking, and physical activity.

An important way to achieve the goals of better circumstances for men's health is the educational programmes of all health professionals. There is a need to include all kind of gender aspects, and not the least men's health issues. There is progress in this area with well established educational programmes for both GPs and nurses, while hospital physicians have not yet shown any interest in such education.

Besides this there is an urgent need for improving the cancer prevention, detection, and treatment for men in Denmark. In this area there are no positive developments for the time being but it is hoped that the Men's Health Week 2009 in Denmark, which has 'Men and Cancer' as focus will have a positive influence on that.

About the author

Men's Health Society, Denmark is a multidisciplinary organisation dedicated to the field of men's health in all its aspects. The society was founded in 2003 in connection with the first Men's Health Week in Denmark, and Men's Health Week continues to be an important and highly prioritised activity. Through the Men's Health Weeks the Danish Men's Health Society collaborates with all kinds of national and local health organisations and authorities in the health areas. These co-operations contribute to the dissemination of knowledge on men's health issues in different health spheres and around the country. Men's Health Society, Denmark is engaged in the Nordic Network on Men's Health and in organising the Nordic Men's Health Conferences. Men's Health Society, Denmark is also a member of the European Men's Health Forum.

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Men's health in England & Wales

David Wilkins

The current state of male health in England & Wales

To some extent the history of progress in male health in England & Wales is also the history of the Men's Health Forum (MHF), the group founded by the Royal College of Nursing in 1994 to campaign for better health for men and boys. The MHF has held a unique position at the centre of developments, particularly since it became an independent charity in 2001. Since then the MHF has managed several important research projects; held more than twenty national conferences and seminars; published a similar number of reports and policy papers; produced a wide range of health education materials; and generated substantial media debate. Perhaps most importantly, the MHF has also lobbied politicians, policy-makers and planners in favour of services which take better account of men's health needs.

Ten years ago, the idea of an organisation dedicated to better health for men and boys was still a novelty. Our issue was an invisible one. Yet, as in most other developed countries, men in England & Wales live shorter lives than women (77.2 years compared to 81.5 years). At all ages men are more likely to suffer from almost all forms of serious illness and injury (for example, incidence of the ten most common cancers that affect both sexes is almost twice as high in men). Men are also more likely to develop most forms of serious illness earlier in the lifespan (for example men aged 50 – 54 are five times more likely to die of coronary heart disease). Many "lifestyle" health risks are greater in men too (for example almost two thirds of men are overweight compared with just over half of women).

Poorer health and lower life expectancy may seem as inevitable a consequence of being male as having a larger shoe size. But this need not be the case. It is not possible to explore fully all the arguments here, but there is no convincing explanation for the extent of men's poorer health in England & Wales apart from the historical failure of UK health policy to recognise and tackle the problem. This is ironic in one sense since, prior to the foundation of the UK's publicly funded National Health Service (NHS) in 1948, priority in health care was often given to men - and perhaps the only way to understand this issue fully is to consider it within the context of long term political and social change.

Like many other countries, England & Wales saw a groundswell of activism from women's organisations during the twentieth century. The pioneers of this movement succeeded, in 1928, in finally achieving the vote for all women. Feminist objectives in the later decades of the century focused most strongly on matters of economic status and political representation but also included demands for health care more sensitive to the needs of women. Overall, women's activism has succeeded in bringing about the acceptance by most people and most institutions, that discrimination on the grounds of gender is unacceptable. This has been a significant political achievement and is arguably the most important social advance of the last century.

Men's health in England & Wales

The historical association with women's activism however has meant that in many contexts, the term "gender" is often seen as synonymous with "women" or "women's". It can be difficult to see that gender inequalities also sometimes affect men and boys. Health is the most significant case in point. Between the foundation of the NHS and the turn of the 21st century, there had been only sporadic recognition of the evidence that, as we have seen, it is male health that is much more commonly the poorer. This basic truth is of course at the centre of the present wave of international interest in the links between masculinity and health, of which this review is a part.

In setting the scene like this, it is also important also to note that the "movement" for better male health in England & Wales has largely been led by men and women with a professional or academic interest in the issue. These people have tended to be driven by professional concern. In other words, the campaign for better male health has differed fundamentally from the activism on women's health, which was essentially a "grass roots" or "consumer" movement. Interestingly,

the fact that this has been the case may in itself reflect some of the central themes believed to underpin men's poorer health – that men tend to be less interested than women in personal health issues, and less likely to engage with community processes built around mutual support.

The fact that the interest in better male health has developed in this way has had both advantages and disadvantages. The MHF has always believed that the best way to address the health needs of men is to position the issue where it properly belongs - within the debate about gender equalities. This ensures that there is common ground with women's organisations, enables consideration of overlapping equality issues, and provides a strong platform for the political argument. This approach – as we shall see later – has been crucial to the significant progress in the past two or three years in particular. An essay explaining why the differences in health status between men and women (whether to the disadvantage of either sex) should properly be regarded as a health inequality forms the introduction to a report published by the Department of Health in England in 2008¹.



Health check and shave!

The response of the government in England & Wales

In 2003, the MHF published a policy paper, "Getting It Sorted", (GIS) outlining the major male health issues and calling for a co-ordinated response from the UK government². Although well received by health professionals and academics, GIS had disappointingly little impact on health policy at either national or local level. Over the next three years, the MHF published papers on several specific aspects of men's health including men's sexual health, overweight in men, and cancer in men. Also during this period, National Men's Health Week (NMHW) became an established fixture on the "health events calendar" with well over 1500 small local events taking place each year throughout England & Wales.

The growing success of NMHW confirmed the existence of a reasonably-sized base among health workers and other professionals (e.g. teachers and youth workers) who recognised the need to take better account of male health need. There was also substantial demand for places at MHF conferences and seminars. Other indicators of the gradual increase in public and professional interest included steady sales of the MHF's series of men's health manuals and high levels of traffic at the MHF's consumer website, malehealth.co.uk. Especially encouraging was the greater willingness of funding bodies to support research projects in the field. This latter included government funding of an important two year project aimed at increasing uptake of chlamydia screening by young men, the findings from which were to become an important influence on future planning in this area of NHS provision. This period also saw greater interest from politicians; the MHF met on a number of occasions with health ministers in the Labour administration who were interested in being briefed on issues relating to the health of men.

Perhaps the most notable single development of this period however, was the establishment in 2004 of the UK's (and the world's) first specialist academic department, the Centre for Men's Health at Leeds Metropolitan University, under the leadership of Professor Alan White, a long-time advocate for better male health. Other individuals whose historical contribution should be recorded here include Dr Ian Banks, founder of the MHF, who had, for many years, been making the men's health case through medical organisations and the media, and Peter Baker, another established campaigner who had been appointed Director of the MHF in 2001.

Most observers would probably agree though, that the crucial turning point for men's health in the UK was not the result of activity in the field of health at all. It came in April 2006, when the Equality Act 2006 became law. This new legislation prohibited sex discrimination in the performance of public functions and created a duty on all public bodies (i.e. not just health bodies) actively to promote equality of opportunity between men and women.

There is not space here to describe the detailed provisions of the Equality Act but the MHF, recognising its potential importance, had been an enthusiastic supporter of the draft legislation as it has progressed through parliament. This support was welcomed by government departments keen to demonstrate that, although the primary political impetus was to build on the progress since the 1970s in achieving greater equality for women, there were benefits for both sexes in the new law. Crucially, the government made it clear that the legislation was intended not only to achieve cultural change in the planning of services but also to change outcomes where those were unequal. This is of central importance, since, in the field of health specifically, outcomes are inarguably poorer for men.

Men's health in England & Wales

This is not to say that the Equality Act has been a magic wand. Rather it has given a solid base in law for the arguments that the wisest advocates of better male health were already making. It has also created a climate in which health planners and policy makers are more willing to listen. The result has been a noticeable increase in the rate of progress and a sense that the improvements that are now steadily accruing are more likely to be lasting. Having said this, it should be added that the Equality Act

would not have been anywhere near as useful to men's health campaigners if it had not come at a time when there had already been several years of hard work and awareness-raising about men's health (not just by the MHF but by the many other activist individuals and groups within the NHS and elsewhere). If there had not been such a framework in place then the Equality Act might have been nothing more than an opportunity un-noticed and un-taken.

Instead, and as a direct consequence of policy-makers thinking in a more concentrated way about gender inequalities, England & Wales have seen specific account taken of male health at the highest possible level. It is not possible to list all the relevant national and local policy initiatives here but some important examples are as follows:

The Cancer Reform Strategy³ (the national ten year plan for cancer services) contains a specific commitment to tackle poorer outcomes in men; the National Chlamydia Screening Programme has published a detailed strategy and work programme for increasing male uptake of screening⁴; the national plan for the future of pharmacy services recommends a focus on men⁵; and the National Institute for Mental Health in England has

commissioned the MHF to undertake a review of the key issues in men's mental health. Furthermore the Department of Health's own guidance to the Equality Act⁶ includes a strong emphasis on men's health needs and behaviours. The important Department of Health report on gender differences in the use of primary care services was mentioned earlier in this chapter.



Delegates arrive at a national conference in London to discuss male obesity.

The future for male health in England & Wales

It is of the highest importance to recognise that improvements in health at population level often take decades to achieve. The first step has been to recognise that men's poorer health is an issue of inequality directly related to the way services are provided. It should consequently be taken as seriously as the other, more familiar, markers of inequality such as racial origin and social class. The next step may be to think about whether it is possible to help men, especially perhaps men from the most deprived backgrounds, to take better care of their own health. This would certainly require a long term commitment to the support and education of future generations while they are still at school.

One might always wish for more and faster progress of course but in an enormously encouraging development, the MHF has recently (March, 2009) been awarded formal "Strategic Partner" status by the Department of Health. This new initiative involves government "working together" with total of eleven non-governmental organisations "to improve knowledge and skill". The Department of Health promises that Strategic Partners will be "at the heart of shaping policy . .

. . . and contributing to improving health and well-being outcomes for individuals and communities."

The new NHS constitution, published in February 2009 also augurs well for future progress on men's health. It acknowledges unequivocally that the NHS:

. . . has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

Although men make up (almost) half the population and are not therefore the kind of "minority" group that we normally associate with needing "particular attention", there is no doubt that this clearly identified "social duty" is applicable. Overall therefore, the present situation in for male health England & Wales seems a positive one and, with good management and a little bit of luck, promises to remain so for the foreseeable future.



A panel of speakers discusses obesity in men at a national conference in London.

About the author

The Men's Health Forum for England and Wales (MHF) is the only independent national organisation campaigning for improved health for men and boys in England and Wales. The MHF's primary objective is to influence the development of health policy at national and local level in favour of better male health but it also runs research programmes; produces health promotion materials for men; maintains a consumer website - Malehealth; organises National Men's Health Week in England and Wales; and offers a training and consultation service to health organisations seeking to improve services for men and boys.

David Wilkins has worked for the MHF since 2002. He has written policy papers on several specific aspects of men's health and led a number of research projects. He is currently leading a three year government-funded project looking for ways to close the gap between men and women in the uptake of bowel cancer screening. He is also conducting a review (also government-funded) examining the most important issues in men's mental health. David has represented the "men's health interest" on a number of national and regional committees. Prior to joining the MHF, David worked in the NHS for 11 years, for the last three years on a joint academic appointment.

Men's Health Forum England & Wales: www.menshealthforum.org.uk

Malehealth: www.malehealth.co.uk

References

1. Wilkins D, Payne S, Granville G, Branney P. The gender and access to health services study. London: Department of Health; 2008.
2. Wilkins D, Baker P. Getting It Sorted. London: Men's Health Forum; 2003.
3. Department of Health. Cancer Reform Strategy. London: Department of Health; 2007.
4. National Chlamydia Screening Programme. Men too London: Health Protection Agency; 2007.
5. Department of Health. Choosing health through pharmacy. London: Department of Health; 2007.
6. Department of Health/NHS Employers. Creating a Gender Equality Scheme: a practical guide for the NHS. London: Department of Health; 2007.

Men's health in Ireland

Dr Noel Richardson and Dr Paula Carroll

The current state of male health in Ireland

There has been an upsurge of interest and activity in the area of men's health in Ireland over the past decade that has revolved around research, advocacy work and a variety of grass-roots work in both the statutory and voluntary sectors. What has arguably been the most significant development, however, has been the recent publication of a national men's health policy¹. The publication of the policy in January 2009 followed a commitment, as set out in the National Health Strategy², to develop a national policy for men's health. An increased focus in recent years on the statistics for men in relation to life expectancy, mortality and morbidity³⁻⁵ provided a strong impetus and mandate for men to be identified for the first time at a national health strategy level, as a specific population group for the strategic planning of health. With Ireland being the first country to publish a national men's health policy, it is important to document the evolution of men's health onto the policy agenda in Ireland. This chapter will focus on the key issues that led to the development and publication of the policy. It will describe the methodologies and key principles used for policy development and reflect on some of the opportunities and challenges in terms of making the policy succeed.

There has been a growing concern in western countries in recent years about the burden of ill-health experienced by men. In Ireland, male life expectancy is lower than that of women (almost 5 years)⁶ and men have higher death rates than women for most of the leading

causes of death and at all ages⁷⁻⁹. A more careful examination of aggregated data reveals substantial differences between different categories of men, particularly in relation to age⁷⁻⁹ and socio-economic status³. Compared to men in the highest occupational classes, men from the lower occupational classes have poorer health outcomes and experience significantly higher mortality rates³. Young men (15-24 years) are a particularly high risk group⁷⁻⁹, with suicide being the principal cause of death among this group. It is also well recognised in Ireland⁵ and internationally¹⁰⁻¹¹ that men are often reluctant to seek help and continue to present (too) late in the course of an illness.

There has also, in recent years, been an increased focus on gender in the context of men's health. Whilst in the past, the focus on gender and health in Ireland has tended to be synonymous with women's health¹², the significance of gendered health practices (particularly gendered patterns of help-seeking), have more recently come to the forefront in the context of men^{5,13}. This reflects more deep-rooted and widespread changes that have occurred in gender relations. In Ireland, as in other developed countries, the challenge to the position of men in gender relations has resulted in important changes in work practices, more 'democratic family structures'¹⁴ and the continued blurring between more traditional male and female roles. Not all men in Ireland benefited from unprecedented economic boom during

the 1990s¹⁵. Increasing economic disparity between the rich and poor coincided with rapid social change. The disintegration of rural communities has resulted in isolation, difficulties with access to services and specific adverse consequences for the mental health of rural men¹⁶. Such changes have occurred against a backdrop in Ireland of an increasing shift towards secularisation and individualism¹⁷. With the recent downturn in the economy in Ireland, labour market vulnerability and lack of security of job tenure are increasingly associated with poverty and social exclusion, and are issues that are now beginning to have a much greater bearing on men's health than before¹⁵.

A number of important and specific developments occurred in the area of men's health in Ireland prior to the publication of the policy that provided a momentum and a stable platform from which the policy evolved. The Health Services in Ireland (Health Service Executive - HSE) funded two men's health research initiatives^{5,13} that informed the development of the policy. The HSE was also instrumental in developing a number of regional men's health strategies¹⁸⁻²⁰, and funded a number of community development related health projects throughout the country. It also co-funds both the Men's Development Network (www.mens-network.net) which supports men affected by marginalisation via community based initiatives, and the Gay Men's Health Project in Dublin, which provides a wide range of clinical, outreach and counselling services for gay and bisexual men. The Irish Cancer Society has conducted innovative campaigns directed at increasing awareness and early

detection of cancers among men. The Crisis Pregnancy Agency has funded a number of research initiatives with a focus on men, including, barriers relating to men's use of sexual health services²¹, and men's experience of sex, contraception and crisis pregnancy²². The Family Support Agency at the Department of Social and Family Affairs has also funded research on policy and practice issues in relation to vulnerable fathers²³. The Men's Health Forum in Ireland (www.mhfi.org) has been engaged in men's health work at an advocacy level since 2002, and, in January 2004, launched a comprehensive report on men's health statistics in Ireland³. The Institute of Public Health's recent publication of an 'All-Ireland Men's Health Directory'²⁴ provides a very worthwhile database of activity in the area of men's health on the island of Ireland. Other organisations such as 'AMEN' and 'Parental Equality' provide support for male victims of domestic violence, and separated or divorced fathers respectively

In summary therefore, the increased attention on men's ill-health together with significant changes and challenges to more traditional male roles and to men's sense of place in Irish society, provide an important backdrop to the development of men's health at a policy level in Ireland. The momentum towards policy development was reinforced by a broad range of grass roots men's health work across a number of different sectors. The following section will outline the response of the Irish government to men's health, and, in particular, will chart the key methodologies and principles used for policy development.

The response of the Irish government

It was against the background of the issues highlighted in the previous section, that the Department of Health and Children in Ireland made a commitment in 2001 to develop 'national policy for men's health and health promotion'¹. This section will present a brief overview of the methodologies used and the key principles

that underpinned the development of a national men's health policy in Ireland.

The timeframe for the development of the policy is outlined in Table 1.

Table 1 Key steps in the development of the national men’s health policy

National Health Strategy 2001 ²	→	The development of a national men’s health policy identified as a priority
Research commissioned to inform the development of a policy	→	Jan 2002- Dec 2004 Men’s Health Report “Getting Inside Men’s Health” ⁵
National Conference	→	Dec 2004 1st National Conference on Men’s Health
Expert Steering Group	→	Nov 2004 Appointment of National Steering Committee
Nationwide Consultation	→	Feb – Dec 2005 National Men’s Health Days Hosted 7 Focus Groups Targeted and Public Call for Submissions
Review of Evidence	→	Feb 2005 – December 2006
Bilateral Meetings	→	January - August 2007 Meetings with key stakeholders and other Government Departments
Implementation & Evaluation	→	Jan 2009 – Dec 2013

Following publication of a specifically commissioned men’s health research project⁵ at the first National Conference on Men’s Health, an expert Men’s Health Steering Group was convened to develop the national policy with representatives from across a range of government departments, statutory, community/voluntary, advocacy and academic sectors. Under the terms of reference of the Steering Group, it was agreed that following an extensive nationwide consultation, both a Policy containing higher order recommendations and a specific Action Plan would be developed. Both the policy and action plan were to be evidence based and integrated into existing government policy.

The level of consultation engaged in for this policy was extensive, comprising four distinct phases with a strong focus on research. The framework adopted throughout each phase mirrored the five guiding principles of the Ottawa Charter²⁵. These principles span the five areas in which the health of any individual may be affected and therefore allowed for the analysis of health needs,

as well as structuring actions to meet those needs, with due regard to the broader determinants of health.

- Phase 1 comprised six men’s health days that were held in strategic locations all over Ireland, and which consulted with all key stakeholders in the statutory, community and voluntary sectors.
- Phase 2 comprised the hosting of a series of “focus groups” (discussion groups held for research purposes) with subpopulations of men whose voices were not represented at the men’s health days.
- Phase 3 consisted of an invited (n=94) and public call for submissions through the National Press.

Before embarking on the final phase of consultation, an extensive review of both the national and international literature on men’s health was conducted to establish the efficacy of translating the issues raised through the consultation process into policy recommendations and actions. While the issues raised did guide the review of the literature, it was not solely limited to those issues.

Other issues that emerged from the wider literature on men's health were also considered for inclusion in this policy. This review also took cognisance of: the scope within existing policy documents to promote men's health; the stakeholders who would commit to implementing policy at various levels; the steps to be taken and the key actions needed to ensure the implementation of policy initiatives; and an anticipation of the possible barriers to developing and implementing a men's health policy.

- Phase 4 consisted of bilateral meeting with key government departments to determine the key stakeholders who would agree and commit to the Recommendations and Actions that were contained in the policy. Prior to these meetings, a draft policy and action plan was circulated to each government department in advance, with follow-up meetings being held with each department.

A number of key theoretical and philosophical principles informed the development of the policy. The policy:

- is firmly positioned within existing government policy (inter-sectoral/inter-departmental) and has invested in an extensive consultation process to develop strong partnerships with existing policy across a number of government departments places a firm focus on the gendered nature of key men's health issues (e.g. alcohol, obesity, mental health, access to services) and promotes a "gender-mainstreaming" approach to men's health
- adopts a social determinants approach

- targets interventions at both an individual and a population level
- incorporates a community development approach
- focuses on prevention as well as cure
- adopts a strengths perspective
- seeks to support men to become more active agents and advocates for their own health

The dissemination of the policy has begun via a variety of media that include local and national media coverage at the time of the launch, online availability (www.dohc.ie/publications/national_mens_health_policy.html), the international men's health fora network, and indeed through this and other publications. Follow-up briefings and workshops are planned with relevant government departments and key stakeholders. There is also ongoing training of health service providers, community workers and academics in the area of men's health. The Implementation Group that is to be appointed to oversee the implementation and evaluation of the policy¹, will be responsible for monitoring and evaluating the policy and aligning the policy implementation to ongoing research findings. Evaluation of the policy must give consideration to the collection of data that is aligned to the policy recommendations and actions. The Department of Health and Children in Ireland is to be tasked with co-ordinating the implementation of the policy at an inter-departmental level.



NR (Noel Richardson, MHFI) MH (Mary Harney, Minister for Health and Children) and PR (Paula Rankin, MHFI), attending MHFI conference on men and mental health in 2006.

The future for male health in Ireland

The publication of a national men's health policy in Ireland is a significant and important step in being the first national policy to provide a clear blueprint and an unequivocal evidence base for tackling men's health. Undoubtedly, there will be much national and international interest in the progress of the policy in the years to come. Many challenges lie ahead in the implementation of this policy. Not least of these is the harsh economic climate in which the policy has been published and the reduction in public spending that is currently being implemented across all government departments. It is imperative therefore that the policy dovetails with existing policy across different government departments, and that all potential sources of funding and resources are targeted by focusing on collaboration and partnership in developing men's health work. There is also the challenge of making an explicit case

for men's health as a productivity issue, by promoting a healthy male workforce as a more productive workforce. One of the key promotional and marketing challenges for men's health policy in the future will be to reverse the paradigm that help-seeking is synonymous with weakness in men, and rather to portray good health maintenance and prompt help-seeking as being part and parcel of being a man²⁶. The principal challenge involved in monitoring and evaluating the policy will be to apply a cost-benefit analysis that should highlight the value of early interventions and a more preventative 'upstream' focus on men's health. Finally, in the context of a gender relations approach to men's health, there is the ongoing challenge of convincing all stakeholders that improving the health of men can have both direct and indirect benefits for women and children and for society as a whole.

About the authors

Men's Health Forum Ireland (MHFI) is a charitable organisation promoting all aspects of the health and well being of men and boys on the island of Ireland through research, education, health initiatives, campaigning and advocacy. MHFI works on an all-island basis and recognises the right of everyone to good health regardless of age, gender, sexual orientation, disability, race, culture, religious or political affiliations.

MHFI believes that men have the right to:

- the best possible health, irrespective of social, cultural, political or ethnic differences;
- gender-specific information and education initiatives on how to keep themselves healthy;
- equity of access to available, affordable and gender-sensitive services for all men;
- have their issues recognised and properly addressed - in a way that is not at the expense of women's or children's health, but seen as beneficial to society as a whole;

MHFI calls for a greater emphasis on a partnership approach in developing future strategies or initiatives on men's health. This includes consultation between policy-makers, healthcare providers, statutory and voluntary groups working on behalf of men, employers, and men themselves.

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Men's Health Forum Ireland: www.mhfi.org

References

1. Department of Health and Children [Prepared by; Richardson N and Carroll P.]. National Men's Health Policy 2008-2013. Working with men in Ireland to achieve optimum health and wellbeing. Dublin: Department of Health and Children; 2008.
2. Department of Health and Children. Health Strategy – Quality and Fairness, A Health System for You. Dublin: Department of Health and Children; 2001.
3. Balanda KP, Wilde J. Inequalities in Mortality – A Report on All-Ireland Mortality Data. Dublin: The Institute of Public Health in Ireland; 2001.
4. McEvoy R, Richardson N. Men's Health in Ireland. Belfast: The Men's Health Forum in Ireland; 2004. Available at: www.mhfi.org.
5. Richardson N. Getting Inside Men's Health. Kilkenny: Health Promotion Department; 2004.
6. Central Statistics Office. Measuring Ireland's Progress. Cork: Central Statistics Office; 2007.
7. Central Statistics Office. Vital Statistics Annuals. Cork: Central Statistics Office; 1996-2005.
8. Central Statistics Office. Population and Migration Estimates. Cork: Central Statistics Office; 2005.
9. Central Statistics Office. Population and Migration Estimates. Cork: Central Statistics Office; 2003.
10. Addis ME, Mahalik JR. Men, masculinity and the contexts of help seeking. *Am Psychol* 2003; 58(1); 5-14.
11. White A, Johnson M. Men making sense of their chest pain - niggles, doubts and denials. *J Clin Nurs* 2000; 9: 534-541.
12. The Equality Authority. Towards a vision for a gender-equal society. Dublin: The Equality Authority; 2001. Available at www.equality.ie.
13. North Eastern Health Board. Men Talking. Meath: Department of Public Health; 2001.
14. Swedin G. Modern Swedish fatherhood: the challenges and the opportunities. *Reproductive Health Matters* 1996; 7: 25-33.
15. Reynolds B. Mind the Gap between Rich and Poor. Belfast: Northern Ireland Council for Voluntary Action; 2005. Available at www.nivca.org.
16. North Leitrim's Men's Group. A study of the situation of single rural men. Leitrim: North Leitrim Men's Group; 2001.
17. Ferguson H. Men and masculinities in late-modern Ireland. In Pease B & Pringle K (eds) *Globalizing Men: Men and masculinities in international perspective*. London: Zed Books, 2001, pp118-134.
18. Western Health Board. *Us Men Our Health*. Galway: Western Health Board; 2003.
19. North Eastern Health Board. *Men's Health Action Plan 2004-2009*. Meath: North Eastern Health Board; 2004.
20. Mid Western Health Board. *A Plan for Men's Health*. Limerick: Mid Western Health Board; 2005.
21. Health Services Executive. *Men's use of sexual health services*. Cork: Health Promotion Department; 2007.
22. Ferguson H., Hogan F. *Men, sexuality and crisis pregnancy: A study of men's experiences*. Dublin: Crisis Pregnancy Agency; 2007.
23. Ferguson H., Hogan F. *Strengthening families through fathers: developing policy and practice in relation to vulnerable fathers and their families*. Waterford: The Centre for Social and Family Research, Waterford Institute of Technology; 2004.
24. Metcalfe O, Kavanagh P. *The Institute of Public Health in Ireland. All-Ireland Men's Health Directory*. Dublin: The Institute of Public Health in Ireland; 2006.
25. World Health Organisation. *Ottawa Charter for Health Promotion*. Geneva: WHO; 1986.
26. Bonhomme J.J. *Cultural and Attitudinal Barriers to Men's Participation in Health Care*. Proceedings of the National Men's Health Conference; 2004 May 20-22; Virginia, USA.
1. [.gov.my/kchs/KCHS%202005%20%20Setting%20Tempat%20Kerja/KCHS%202005.php](http://www.gov.my/kchs/KCHS%202005%20%20Setting%20Tempat%20Kerja/KCHS%202005.php)
2. Family development Division. Objective [homepage on internet] Ministry of Health. Healthy; 2007 [update 2009 Jan 25; cited 2009 Jan 29]. Available from http://fh.moh.gov.my/modules/xt_contentudo/index.php?id=3
3. National Population and Family Development Board. General Objective [homepage on internet] Ministry of Women, Family and Community Development; 2008 [updated 10 Dec 2008; cited 2009 Jan 29]. Available from www.lppkn.gov.my/BI/e-objective.asp

Men's health in Malaysia

Hui Meng Tan, Seng Fah Tong, Wah Yun Low, Chirk Jenn Ng

The current state of male health in Malaysia

Men outperform women in the top 15 causes of death in nearly all countries in the world¹. Men have more accumulated risk factors in all stages of life compared to women. Men's risk taking behaviours, significantly more stressful environment in their everyday life, and aberrant treatment seeking behaviour contribute to a much higher accumulated risk of disease and poorer health than that for women².

In Malaysia, The Malaysian Society of Andrology and The Study of The Aging Male (MSASAM) which was founded in 1995 is the key non-governmental organisation (NGO) spearheading research and dissemination on men's health issues in the country. The society has carried out 3 major men's health research projects in the Klang Valley and the findings have been published extensively.

A recent randomised community-based study on men's health in urban area, one of the projects conducted by MSASAM, revealed a worrying trend in men's health status. This 2006 study which involved 1046 middle-aged men (mean age of 56 years) showed that 66% were overweight and 70% smoked. A significant proportion (17 to 54%) had chronic medical conditions like diabetes, hypertension and dyslipidaemia. A high proportion was unaware that they had these conditions. The study also revealed that two thirds of the respondents had erectile dysfunction (ED) while a significant proportion had moderate to severe lower urinary tract symptoms (LUTS) (29%) and low testosterone levels (19%)³. Other smaller community-based study in a northern state of Malaysia (Penang), involving 353 men, showed prevalence of prostate problems in 6.3% and ED in 45.9% of men aged more than 40 years old⁴.

The 2006 study confirmed the findings from another community study on men's health in a highly developed region in Malaysia. This 2003 cross-sectional study on 351 men (response rate of 70%) above 50 years of age (mean age of 58 ± 7 years), carried out in Klang Valley, revealed a high disease burden and poor health status⁵. There were 30.2% self reported hypertension, 21.4% self reported diabetes mellitus, 10.8% self reported coronary artery disease, 79% of the men were overweight or obese, 34% consumed alcohol and 19.1% were smokers. There were similar prevalence of ED (69%), LUTS (29%) and total testosterone level ≤ 11.0 nmol/L (19.9%). Moreover, 11.1% had severe depression (Geriatric Depression Score of ≥ 10), 28.8% had a fasting blood sugar (FBS) ≥ 6.1 mmol/L and 70.1% had total cholesterol ≥ 5.2 mmol/L⁵. Further, based on the same data, Low et al⁶ examined the association between depression, erectile dysfunction (ED), and hormonal status of men. Significant association was found between depression (GDS ≥ 5) and men with ED ($p=0.014$). Almost three quarters of men (73%) with low testosterone level (total testosterone ≤ 11.0 nmol/L) had ED. Age and depression were predictive of erectile function. It was concluded that depression and ED should be screened for when either exists in the male patient and treatment directed accordingly⁶. In another sub-analysis, hypogonadal men compared to eugonadal men, had significantly poorer quality of life. Furthermore, 30% of the hypogonadal men had mild to moderate depression and 9.4% had severe depression⁷.

Men's health in Malaysia

The negative impact of premature ejaculation (PE) has also been well-documented. The prevalence of PE was 22.3% in an urban setting. PE was also found to be significantly associated with psychiatric morbidities, poorer sexual satisfaction, decreased sexual self-confidence and avoidance of relationship⁸.

One of the pioneering works on men's health, particularly in the area of erectile dysfunction, was a qualitative study on the knowledge, perceptions and practices of ED carried out when sildenafil first came to the shores of Malaysia in 1998. It showed that there were differences and similarities between men and women in terms of their knowledge and perception of ED among various ethnic groups in the country. It also revealed that physicians were reluctant to deal with their patients' sexual issues due to the lack of knowledge or embarrassment. Nevertheless, there was also a strong indication that men preferred the doctor to initiate discussion on sexual issues related to medical conditions⁹.

In 2008, MSASAM conducted a qualitative research study to explore Malaysian men's and women's views on men's health and their health-seeking behaviour¹⁰. A summary of the research findings is presented below:

Generally, men saw the need to keep a balance between physical, mental, spiritual and social well-being. Many

men knew what healthy life-style was. Their family and peer influence played a significant role in keeping them healthy. However, men faced health challenges, which included stress at work, inadequate time, inability to control their urge for unhealthy practices and inadequate knowledge on men's health issues. Men were fearful of being diagnosed to have illness. They postponed their contacts with health care provider until occurrence of a health crisis, which was then served a powerful factor that pushed men to take their health more seriously. With regards to sex, some men thought it was more than just a relationship issue. It was an indicator for ill health. However, not all men would seek medical advice if they had sexual problems. Some wanted doctors to initiate the discussion on sexual health. Men wished for more information specific to men's health problems and urged health care providers and government bodies took a more active role in promoting men's health. They also wanted financial support from employers and government in promoting men's health.

Women's view on what constitutes healthy men, healthy life-styles and men's challenges in keeping healthy were similar to men. Women thought some men were truly concerned about health while others could not care less. Women played a major role in their spouses' health but some men were more readily influenced by their peers.



Launch of a Men's health book during a Men's Health Symposium jointly organised by MSASAM and National Population and Family Development Board.

Women thought that men's poor healthy life-style was attributed to men's laziness. Similarly, women thought men only pay more attention to health following incidence of health crisis. Men were unlikely to seek medical treatment because of the fear of knowing their illnesses and the masculinity factor in men. In contrast to men's view, women thought they fared worse than men in terms of health. Sex was important for men and erectile dysfunction was an indicator of poor health. Women wanted more effort in dissemination of men's health information through multiple routes of media and more compulsory medical check-ups in workplace. Women were generally better informed about health matters and hence could potentially help their spouses in improving their health status.

The Malaysian experiences do indicate that denial, poor knowledge, work pressure and lack of preventive health measures are major contributors to the poor health status in the country. The findings also showed that women play a major role in the health and treatment seeking behaviour of their spouses. The pressure by, and concern of the family are key impetus for men to initiate preventive healthcare. Further, the study also showed that the women are more receptive and better equipped with health information and public awareness on men's health. Therefore, public campaigns to improve men's health should also be targeting at women, who will in turn reach out to their spouses and male family members.

The response of the Malaysian government

In Malaysia, there is currently no concerted effort to tackle the problem of men's health. A large proportion of men's health promotion activities for the public have been initiated and carried out by NGOs, special interested groups, the media and governmental agencies like the Ministry of Health and the Ministry of Women, Family and Community Development.

In 2005, there was an attempt by the Ministry of Health to draft a men's health policy. The Minister of Health in his opening address at the First National Men's Health and Aging Conference 2005 affirmed the importance of promoting men's health in Malaysia¹¹. However, for various reasons, the policy has yet to materialise. Nonetheless, the Ministry of Health, through its various departments, has been addressing many issues related to men such as non-communicable diseases and healthy lifestyles. The programmes addressing the issues above are targeting at the general population rather than men. An example is the Healthy Lifestyle Campaign started by the Division of Health Education in 1991¹². The campaign aimed at creating public awareness of cardiovascular diseases, prevention and control of AIDS/sexually transmitted infection, food hygiene, child health promotion, cancer and diabetes.

Subsequently, it concentrated on improving health behaviours and emphasised lifelong health. The scope included healthy eating, physical fitness, safety and injury prevention, mental health, healthy family and healthy environment, smoking cessation, stress management and abstinence from alcohol. Between 2005 and 2007, the campaign had focused its activities on workplace where the main workforce was men. It cannot be denied that all these health campaigns touched on many issues related to men's health; however, important factors underpinning men's poor health such as unwillingness of men to engage in healthy lifestyle, appropriate health seeking behaviour, accessibility to men's health services, are not being addressed.

With regards to service delivery, the Division of Family and Health Development from Ministry of Health had established an objective to promote health for both women and men¹³. However, many activities in the past had prioritised women and child health due to high maternal and infant mortality, which has improved tremendously over the years. Such programmes are not available for men. No doubt there are programmes that are related to men's health such as health screening programmes for general population, smoking cessation

clinics, methadone clinics and occupational health clinics; however, these are, again, targeting at the general population. In these screening programmes, men were screened at the health clinics for sexual and urological conditions by using self-administered questionnaires and several obstacles exist in the implementation of the screening programmes. There is a lack of opportunity to have an effective consultation with health care providers due to shortage of manpower and resources.

The National Population and Family Development Board (NPFDB) under the Ministry of Women, Family and Community Development is also partly responsible for men's health development in Malaysia. The objective of NPFDB is to contribute towards the development of quality population through strengthening and promotion of family

well-being¹⁴. The promotion of men's health, therefore, focuses on family development. To achieve this objective, NPFDB has developed services for reproductive and sexual health. Recently, men wellness screening package has been included as part of its service. These services require men to attend their outpatient centres and NPFDB is striving to improve the awareness of and accessibility to these centres.

To date, the government support for men's health has been integrated into general health care delivery and appears somewhat fragmented. It is still very much disease-oriented rather than men-focused. We need to develop a comprehensive men's health policy which is both sensitive to men's needs as well as addressing the health seeking behaviour of men.

The future for male health in Malaysia

Currently, the health status of Malaysia men is rather worrying. The prevalence of chronic diseases and health concerns like diabetes, cardiovascular diseases, smoking, obesity and overall metabolic syndrome is rising rapidly. The approach in men's health in Malaysia is still predominantly organ-specific and fragmented; it falls under the responsibility of a variety of specialties and subspecialties. There is still considerable lack of awareness among the general public and healthcare professionals alike. There is also an absence of close collaboration across disciplines as well as governmental and non-governmental bodies in the approach to men's health issues.

A multi-pronged and holistic strategy highlighting the prevailing men's health status, emphasising the importance of early preventive healthcare and the potential benefits of improving men's health status, should be spearheaded by governmental and non-governmental bodies. These concerted efforts should target men across all ages including school children, teenagers,

adult and older males. The importance of preventive health check and healthy lifestyle should be stressed to all men and their spouses and families. There is also a urgent need to develop an effective service delivery system sensitive to men's needs.

The numerous research and educational activities of NGOs like the MSASAM should be encouraged, and supported. Findings from the local and global research work on men's health should be disseminated to and utilized by the public, healthcare professionals and policy makers to inform healthcare decision making. Healthcare policies on men's health, based on good local and international research encompassing physical, psychological and social dimensions, will certainly encourage men in Malaysia to seek early professional advice and treatment to improve both their quality and quantity of life. It will also help to create awareness of the concept of men's health to the healthcare professionals and other stakeholders.

About the authors

The Malaysian Society of Andrology and The Study of Aging Male (MSASAM). MSASAM has conducted 3 projects with regards to men's health and initiated a cohort study on 1010 urban men starting 2008. The members of this group are from various backgrounds with the same interest in improving men's health in Malaysia. All the authors are members of MSASAM.

Dr. Dato' Hui Meng Tan is the founder and honourable president of MSASAM. He is also the Adjunct Professor and consultant urologist in the University of Malaya.

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References

1. Mathers CD, Saddana R, Salomon J, et al. Healthy life expectancy in 191 countries. *Lancet* 2001; 357: 1685-1697
2. Tan HM. Editorial. Men's Health and the Aging Male: Medical Perspectives for Asia Pacific 2004; 1(1): 2-3.
3. Tan HM, Ng CJ, Low WY, Khoo EM, Yap PK, Tan WS. The Subang Men's Health Research – A Multiethnic Community Based Study. *Aging Male* 2007; 10(2): 111.
4. Mariappan P, Chong WL. Prevalence and correlation of lower urinary tract symptoms, erectile dysfunction and incontinence in men from a multiethnic Asian population: Results of a regional population-based survey and comparison with industrialised nations. *BJU Int* 2006; 98(6): 1264-8
5. Khoo EM, Tan HM and Low WY. Erectile Dysfunction and Comorbidities in Aging Men: An Urban Cross-Sectional Study in Malaysia. *J Sex Med* 2008; 5: 2925-2934.
6. Low WY, Khoo EM, Tan HM, Hew FL, Teoh SH. Depression, hormonal Status and erectile dysfunction in the aging male: Results from a community study in Malaysia. *J Mens Health Gend* 2006; 3(3): 263-270.
7. Low WY, Khoo EM, HM Tan. Hypogonadal men and their quality of life. *Aging Male* 2007; 10(2): 77-87
8. Quek KF, Sallam AA, Ng CH, Chua CB. Prevalence of sexual problems and its association with social, psychological and physical factors among men in a Malaysian population: A cross-sectional study. *J Sex Med* 2008; 5:70-76.
9. Low WY, Wong YL, Zulkifli SN, Tan HM. Malaysian cultural differences in knowledge, attitudes and practices related to erectile dysfunction: focus group discussion. *Int J Impot Res* 2002; 14: 440-445
10. Low WY, Tan HM, Ng CJ, Tong SF, Khoo EM, Wong LP. About Men's Health- Views from Mars and Venus. Kuala Lumpur: Malaysian Society of Andrology and The Study of the Aging Male (MSASAM); 2008.
11. Chua SL, Minister of Health Malaysia. The first national men's health & aging conference in conjunction with Universiti Malaysia's 100th anniversary [document on the internet] Ministry of Health 2007; [updated 2009 Jan 22; cited 2009 Jan 29]. Available from: www.moh.gov.my/MohPortal/speechDetail.jsp?action=view&id=369
12. Health Education Division. Healthy Lifestyle Campaign 2005 [homepage on internet]. Ministry of Health; 2008 [updated 2009 Jan 28; cited 2009 Jan 29]. Available from www.infosihat.gov.my/kchs/KCHS%202005%20%20Setting%20Tempat%20Kerja/KCHS%202005.php
13. Family development Division. Objective [homepage on internet] Ministry of Health. Healthy; 2007 [update 2009 Jan 25; cited 2009 Jan 29]. Available from http://fh.moh.gov.my/modules/xt_contentudo/index.php?id=3
14. National Population and Family Development Board. General Objective [homepage on internet] Ministry of Women, Family and Community Development; 2008 [updated 10 Dec 2008; cited 2009 Jan 29]. Available from www.tppkn.gov.my/BI/e-objective.asp

Men's health in New Zealand

Rhys Jones & Tim McCreanor

The current state of male health in Aotearoa/New Zealand

In Aotearoa/New Zealand men's health has received relatively little attention as a public health issue per se. Issues of relevance to men's health have largely been framed and considered in the context of other policy decisions. There has never been an overarching framework or strategic approach from central government that provides guidance or consistency for decision making about issues that have particular implications for men's health. It could therefore be argued that the development of men's health policy and interventions has been somewhat ad hoc, resulting in a disjointed set of strategies and policies that has failed to comprehensively address the broad range of issues facing men in relation to health. The recent development of the aspirational concept of health equity – the elimination of the social determinants of health disparities – should be a goal for all societies within a generation¹.



As in many other countries, the development and maintenance of masculine identities in Aotearoa/New Zealand is strongly associated with problematic social environments that support unhealthy beliefs and behaviours². For example local ideologies and practices mean that achieving the ideals of conventional masculinity requires an unwillingness to admit weakness or to accept help and a propensity towards risk-taking behaviour. The process of male socialisation and the socio-cultural norms that underpin this process result in an adverse risk profile for men and subsequent poor health outcomes. Consequently, despite a more favourable distribution of the socioeconomic determinants of health, men have worse health on average than women.

Based on data from 2005–2007, life expectancy at birth was 78.1 years for males and 82.2 years for females in Aotearoa/New Zealand. Since the mid-1980s, gains in life expectancy have been greater for males (an increase of 7.0 years) than for females (an increase of 5.1 years), resulting in narrowing of the gender gap³.

The Warriors "go blue" for Prostate Cancer

Men's health in Aotearoa/New Zealand

In the most recent New Zealand Health Survey, men were more likely than women to be taking medication for high cholesterol (7.9% vs 5.7%), and to have diagnosed ischaemic heart disease (4.9% vs 3.1%), diabetes (4.7% vs 3.7%) and gout (2.0% vs 0.2%). Men scored generally higher than women in terms of self-reported physical and mental health⁴.

There were no significant gender differences in prevalence of current smoking or frequency of smoking among New Zealand adults. Men were more likely than women to have had a drink containing alcohol in the previous 12 months (87.9% versus 80.8%), and were more than twice as likely as women to have a potentially hazardous drinking pattern (27.6% versus 12.2%). Men were significantly more likely to report being regularly physically active (at least 30 minutes of activity per day on five or more days of the last week) than women (55.1% versus 47.9%)⁴.

There are differences between men and women in health service utilisation. Men (90.5%) were less likely than women (94.1%) to have a regular primary care provider that they go to first when feeling unwell or injured. Men were also significantly less likely than women to have seen a primary care doctor in the previous 12 months (76.6% vs 83.4%). There were no gender differences in emergency department use, but women

(20.2%) were more likely than men (14.5%) to have used public hospital services in the past year⁴.

Men's health in Aotearoa/New Zealand is characterised by stark inequalities by ethnicity and area-level socioeconomic deprivation. In 2000–2002, life expectancy at birth was over eight years lower for Māori men than for non-Māori men (69.0 versus 77.2 years)⁵. For the period 2000–2004, the age-standardised mortality rate for Māori males was approximately twice that of non-Māori males⁶. In 2000–2002, the life expectancy of males in the least socioeconomically deprived 10% of small areas in New Zealand was 8.9 years higher than that of males in the most deprived 10% of small areas (79.9 versus 71.0 years)³.

Recent papers^{7–10} note elevated rates of suicide, smoking, sexually transmitted infections, mental health disorders, eating disorders, alcohol-related harm and substance use problems among gay men, as well as issues with access to medical services. The national survey of the health and wellbeing of secondary school students¹¹ shows higher levels of binge drinking, marijuana use, sexual activity and violence toward others among male students, although there has been a steady decline on most of these indicators since the first survey in 2000.

The response of the New Zealand government

Until recently, men's health had never been specifically considered by the New Zealand government as a policy issue of itself. Historically, the only noteworthy initiative in this area was undertaken in 1995-96 by North Health, a Regional Health Authority (one of the country's four health funding bodies in the mid-1990s)¹². The project arose in response to Ministry of Health guidelines which identified particular groups of men with significant health needs. A discussion document was produced, which included recommendations about purchasing of health services, primary care service provision, health promotion and education including school-based programmes. Other possible actions included establishing men's needs assessment, marketing men's health as a concept and health professional education. Following the release of the discussion document a community consultation process was undertaken, but its completion coincided with the disestablishment of the Regional Health Authorities (including North Health). It has been surmised that the health system restructuring may have contributed to the demise of this men's health initiative¹³.

In 2008 the first major central government initiative to address men's health emerged, in response to various calls for men's health to be considered in its own right.

This was taken on by then Associate Minister of Health, Damien O'Connor: men's health became a new designation under the health portfolio and a funding commitment of NZ\$2.5 million was made. Proposed initiatives included setting up clinics in male-dominated workplaces, a social marketing campaign, fast-tracking a national screening programme for bowel cancer (which disproportionately affects men), and establishing a Men's Health Innovation Fund to be used for new and innovative approaches to improving men's health.

With the change of government in late 2008, and in the face of the current global economic recession, a review of all government expenditure was initiated. It would appear that there is no longer any certainty about any funding committed to men's health by the previous government that has not been spent or contracted. It is also our understanding that there is no ongoing men's health policy work in the Ministry of Health at the time of writing.

The only specific pieces of information we could find on men's health policy in Aotearoa/New Zealand from government ministries were the Men's Health website¹⁴ and a document from the Ministry of Youth Development that focuses on strengths-based approaches to working with young men¹⁵. These are outlined below.



Ruben Wiki 'painting it Blue' in Blue September

Ministry of Health Men's Health Website¹⁴

This government website outlines actions aimed at "encouraging men to be more aware of their health and to access healthcare", carries links to "News and updates" and details of a Men's Health Innovations Fund, and includes a recent men's health literature review, all of which are relevant to this summary.

➤ Men's Health Innovations Fund

The Men's Health Innovations Fund was established in 2008 to support community based men's health initiatives. It provided approximately NZ\$ 300,000 in funding for projects with new and innovative approaches to improving men's health. Fifty-three proposals were received covering a wide range of approaches to supporting men's health, of which 11 were funded.

➤ Men's health literature review

The review 13 notes that New Zealand men's health literature spans only about two decades with most of it appearing in the last ten years. Materials reviewed cover biological difference, gender disparity, masculinity, health service accessibility and uptake. The importance of the social determinants of men's health is reported as a significant theme in the literature emphasising the heterogeneity of the male population, particularly the impacts of ethnicity, class and age, and the effects of social policy (employment, education, housing, social welfare, and justice).

The issue of men's under-utilisation of health services was a focus with debates over appropriate remedial actions canvassed in terms of system change versus person change options. The review concludes that research on all dimensions of men's health is needed in order to improve understanding and design better policy and services.

Ministry of Youth Development Review¹⁵

This is a review of the research and best evidence in relation to strength-based and male-focused approaches, which is designed to inform the development of policy and programmes for young men. It identifies a number of areas where the experiences, feelings and behaviours of young males differ from those of young females. It describes existing initiatives and provides recommendations about designing programmes to support the positive development of young men.

One possible factor underlying the lack of specific policy development for men's health in Aotearoa/New Zealand is that the observed gender inequalities in health may have not been considered to be inequitable. That is, while differences between men's and women's health have been extensively documented, they are not seen as being unfair. They have become normalised and are therefore not perceived as requiring specific intervention¹³.



The Mad Butcher faces up to Prostate Cancer

The future for male health in Aotearoa/New Zealand

In striving to improve male health in Aotearoa/New Zealand, one of the major challenges will be to adopt a broad approach that addresses the social and economic determinants of health and inequalities. In a recent issue of the New Zealand Medical Journal, a viewpoint article¹⁶ and editorial¹⁷ provide important insights into what is required to improve men's health in Aotearoa/New Zealand. The focus of these commentaries is, however, largely on the health sector and health service interventions; it is essential that action is also taken in other sectors to address the wider social factors that influence male health. Policies and programmes must be developed with health equity as a cornerstone: interventions should first and foremost meet the needs of those men who currently experience the poorest health.

More research is required in order to understand the processes by which gender inequalities in health are created and maintained, and to build the evidence base for improving men's health. Relatively little attention has been paid to understanding the lived realities of men, including how men conceptualise health, the major factors that influence their health and how they respond to health problems. One notable exception is a recent national study of the health of Māori men, which attempts to address this knowledge gap for this important sector of the male population¹⁸. As argued by Smith¹⁹ in the Australian context, more evidence is required about these "lay perspectives" of men's health, and it is critical that this information is used to inform

policy responses to improve the health status of men in Aotearoa/New Zealand.

In order to meaningfully address men's health and reduce gender inequalities in health, it will be necessary to fundamentally transform the nature of dominant male identities, the processes of socialisation into these identities and the markers of masculinity. Such a culture change will realistically take generations to evolve, but without this as a foundation for change, any interventions designed to improve men's health will represent mere tinkering at the margins. We believe that it is necessary to begin working with boys and young men to support the development of reflexive understandings of masculinity and male roles (especially in parenting) using the informed provisions of the Youth Development Strategy Aotearoa²⁰. This framework envisages a paradigm shift that sees young men (and women) as a resource to nurtured, rather than a problem to be solved or contained. The strategy seeks policy-led systemic change to develop youth strengths and produce opportunities for youth participation in all areas of life. It stresses the importance of quality relationships with parents, families, peers and community that can support every young man to reach his full potential. The goal of health equity 1 argues that similar policy-led developments to deal with the social determinants of health disparities should be initiated through consultative and participatory processes, for men in general and for particular groups such as Maori and gay men⁸.

About the authors

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Dr. Tim McCreanor is a Senior Researcher at Whariki Research Group, Massey University in Auckland. Key interests include racism, marginalisation and exclusion and their impacts on health and wellbeing of populations and communities. Main approaches are qualitative or multimethods with an increasing emphasis on action research projects to achieve health and social equity.

References

1. CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008.
2. Worth H, Paris A, Allen L, editors. The life of Brian: masculinities, sexualities and health in New Zealand. Dunedin: University of Otago Press; 2002.
3. Ministry of Social Development. The Social Report 2008. Wellington: Ministry of Social Development; 2008.
4. Ministry of Health. A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey. Wellington: Ministry of Health; 2008.
5. Cormack D. The Māori Population. In: Robson B, Harris R, editors. Hauora: Māori Standards of Health IV. A study of the years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pūmare; 2007.
6. Robson B, Purdie G. Mortality. In: Robson B, Harris R, editors. Hauora: Māori Standards of Health IV. A study of the years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pūmare; 2007.
7. Adams J, Braun V, McCreanor T. Professional accounts of gay men's health in Aotearoa New Zealand. *Social Policy Journal of New Zealand*. 2007;30:199-215.
8. Adams J, Braun V, McCreanor T. Framing gay men's health: An analysis of policy documents. *Gay & Lesbian Issues and Psychology Review*. 2008;4(2):108-26.
9. Adams J, McCreanor T, Braun V. Vodka and the spirit of gay men's health. In: Clarke V, editor. *Out in Psychology*. London: John Wiley and sons; 2007.
10. Adams J, McCreanor T, Braun V. Doctoring New Zealand's gay men. *New Zealand Medical Journal*. 2008;121(1287):11-20.
11. Adolescent Health Research Group. Youth'07: The Health and Wellbeing of Secondary School Students in New Zealand. Initial Findings. Auckland: The University of Auckland; 2008.
12. North Health. The health of men. Auckland: Northern Regional Health Authority; 1996.
13. McKinlay E. Men and health: a literature review. Wellington: Public Health Advisory Committee; 2005.
14. Ministry of Health. Men's Health. 2008 [cited 29 January 2009]; Available from: <http://www.moh.govt.nz/menshealth>
15. Barwick H. Young Males: Strengths-Based and Male-Focused Approaches. A Review of the Research and Best Evidence. Wellington: Ministry of Youth Development; 2004.
16. Johnson L, Huggard P, Goodyear-Smith F. Men's health and the health of the nation. *New Zealand Medical Journal*. 2008;121(1287):69-76.
17. Neville S. Men and health. *New Zealand Medical Journal*. 2008;121(1287):7-10.
18. Jones R, Crengle S, McCreanor T. How Tikanga guides and protects the research process: insights from the Hauora Tāne project. *Social Policy Journal of New Zealand*. 2006;29:60-77.
19. Smith J. Addressing men's health policy concerns in Australia: what can be done? *Australia and New Zealand Health Policy*. 2007;4(1):20.
20. Ministry of Youth Affairs. Youth Development Strategy Aotearoa. Wellington: Ministry of Youth Affairs; 2002.

Men's health in Norway

Ulf Rikter-Svendsen

The current state of male health in Norway

Men between 15 and 40 years of age are rarely found as patients in the Norwegian health system unless they are the victim of an accident or have an acute illness. If they do come to the health system, it is often because they have been sent by their mother, sister, girlfriend or another woman. Do we have a health system that is not for men? Or do we have men who are not made to fit the Norwegian health system?

Men tend to differ from women in ways of communicating about health. Research findings and the experiences of health workers suggest that men and women have very different psycho-social approaches to the body and differ in the way they deal with health and illness. The most recent general practitioner survey shows that men use health services less than women. This applies both to general medicine and psychiatry. Studies also show that women are more satisfied with the health services than men are. To get the message about health across to men, it is therefore important to obtain more knowledge about how men deal with the body and health.

Women prevent health problems through a healthy lifestyle and good health habits to a greater degree than men do. According to a comparison of men's and women's health in Norway¹ there is reason to believe that the somewhat longer life expectancy of women is in part due to health habits.

Differences in health conditions between men and women are linked in large degree to differences in lifestyles and life habits. In 1999, a special committee published the first report on women's health, pointing out the necessity of a special "women and gender

perspective" in the health services. The report referred to measures aimed at improving the gender perspective. Available statistics show significant gender differences in the way individuals and physicians view the state of health in Norway today. There is still a close to five-year life-expectancy gap between men and women. The principal challenges when it comes to equality within the health and care sector is to increase knowledge on gender differences with respect to health and illness, and the health services, and to consider gender differences when deciding prevention and treatment measures. Efforts have been focused along two axes. One includes gender perspectives in all activities and research where this is relevant. The other focuses especially on ailments exclusive to men or women or illness that particularly impacts one gender, or where the one gender experiences particular difficulties.

The incidence of specific male diseases (particularly prostate or testicle cancer) is increasing, and men have a particularly high mortality rate due to accidents. Men are over-represented in suicide statistics, while men's mental problems appear to be under-treated. Recent research shows that every fourth parent undergoing a break-up of a marriage or partnership goes on sick leave after the break-up. This affects many men.

Men's life expectancy in Norway is unnecessarily low (77.7 years of age in 2004 compared to 82.5 years of age for women), and many men die too early from causes that might have been prevented. We also know that women report various health ailments and see a doctor more often than men.

The response of the Norwegian government

In December 2008, the Minister of Children and Equality published the world's first parliamentary report on men, the male role and equality². This report points out that equality traditionally has been synonymous with the struggle of women to achieve better conditions, but that a gender perspective on men is also necessary to maintain progress in the efforts to achieve equality. The report also states that one important goal is to obtain knowledge-based material and data on men and the male role. One chapter in the report is dedicated to men's lifestyle and health.

Through this report the Norwegian authorities show that they are aware of the necessity to adopt a gender perspective on health and life quality. Thus the authorities are aware that men and women have different experiences of health and sickness, and that a masculinity perspective is important in this context.

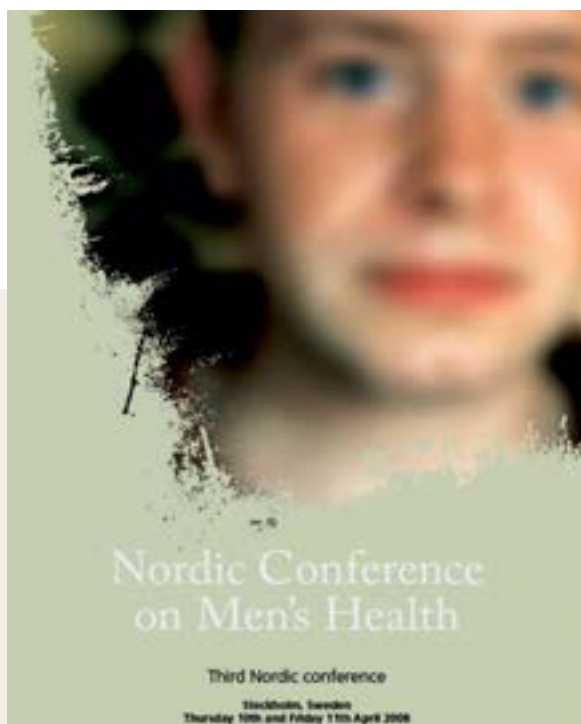
In the health and care sector, the authorities point out that the main challenge is to increase our knowledge on gender differences relating to health, diseases and the health services. The Ministry of Health and Care Services has

urged the regional health enterprises and the Directorate of Health to concentrate efforts on the development of health and care services with a gender perspective.

By highlighting gender differences, the report states, we may attain better health in the population and improve the quality of the health and care services. As crucial elements in these efforts, the Ministry highlights the following:

- Distributing health information that reaches both genders
- School health service and health clinics for young persons that are just as attractive for boys as for girls
- Gender perspectives to be embedded in health and care services and in research on health
- Increasing our knowledge on gender differences when it comes to using the health services
- Measures aimed at reducing the prevalence of sexually transmitted infections

The Government underlines that it is important to ensure that health information reaches both women and men. The report also states that in some cases, men and women should be provided with health information that is adapted to each gender, just as other social background variables must be taken into consideration when developing communication measures and when patients encounter medical staff.



The third Nordic conference on men's health (Spring 2008).

With respect to school health services and health clinics for young persons, the Government calls for a deliberate strategy to focus on boys so they will find these services more attractive. The Ministry finds it important to make these services available at school and visible in the school environment, and also states that several information channels must be employed to make the services more easily accessible. Information on the internet may encourage boys to use these services more. The "Klara Klok" (Ask Abby) website is an example of this. Sending SMSs is another possible channel that is suggested. Public health nurses report that using mobile phones and SMSs gets more boys to initiate contact with them. Other important channels in addition to information given to school classes could be special groups for boys, and newsletters and information brochures focusing on boys. The Ministry encourages the local authorities to develop the school health service to make it just as attractive for boys as for girls.

In the report to Parliament, the Ministry also points out the importance of measures aimed at reducing the prevalence of sexually transmitted infections (STIs). Work aimed at preventing STIs in particular and to improve the sexual health of young boys and men in general includes counselling, guidance and testing for STIs. The report also states that it is a very important task to get boys and men to care more about their own sexual health. In this context the Ministry also proposes the provision of information suited to the life experiences of boys and men. Studies show that boys know much less than girls about such crucial issues as sexual health. Boys also state that they want to obtain such knowledge, and that they would like to communicate with someone in the know when it comes to the problems they are facing. The Ministry states that the lack of adult men who can serve as mentors and advisers for young boys is a challenge. Health clinics for young persons are an arena dominated by women, both on the user and the health-worker sides, the Ministry states.

**Men's Health Week
i Oslo 2007**

Norsk konferanse
om menns sunnhet
og helse
14. juni 2007

reform **Ettli**

MANN - KROPP OG SJEI

PROGRAM

<p>09.45 Åpning</p> <p>10.30 Innlegg av Prof. Arvid Björntorp, Karolinska Institutet, Stockholm Innlegg av Prof. Ralf Busch, Universitetet i Oslo Innlegg av Prof. Ralf Busch, Universitetet i Oslo</p> <p>10.45 Seksuell helse og trykkløst forhold Innlegg av Prof. Ralf Busch, Universitetet i Oslo</p> <p>11.15 Frukt</p>	<p>11.30 Forsker og lestege Arvid Björntorp, Karolinska Institutet ved Åkeri universitetssjukhus. Menn og livsstilsmeninger - erfaringer fra Måltid-prosjektet</p> <p>12.00 Forsker Bjørn Eide, Oslo kommune Kroppen - et muskulært prosjekt</p> <p>12.30 Kaffe og lunsj</p> <p>13.15 Professor Ulla-Jill Lissels, Høgskolen i Agder Forskningsprosjekt, arbeidstid og menns helse. Innledningen av Simon Trette mann.</p>	<p>13.45 Tette menn - en kvifikk og en fytrologisk refleksjon om et ungt par hvor mannen plutselig får hjerte- og karsykdommer.</p> <p>14.00 Dr. Bjørn Mørkussen, Høgskolen i Agder Anorexi, emsorg og kjønnet. Nær tilværelse og fysiske hendelser av helse.</p> <p>14.30 Sjansing Carl Arvid Björntorp, Mann og kveff - en kvifikk studie av unge menns opplevelse og håndtering av kvifikk.</p>	<p>15.00 Fagenevnekonferanse i Driftsgruppen Menns Helse, Oslo Innlegg av Prof. Ralf Busch, Universitetet i Oslo</p> <p>15.30 Avslutning</p> <p>Benefansen er en del av det internasjonale arrangementet Men's Health Week 2007.</p>
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Påmelding:
Frist: 12. juni 2007
Åpent arrangement
Send e-post til: mennshelse@reform.no
med navn, institusjon og adresse.

For evt. kontakt med Reform på telefon 22 34 09 50

Sted: Reform, Driftsgruppen 34, 4 etasje, 0101 Oslo

Arrangert: Reform - ressursenter for menn, Driftsgruppen 34, 4 etasje, 0101 Oslo

The future for male health in Norway

The arguments for focusing on men's health and male specific diseases in relation to the health system may be summed up as follows:

- Men's life expectancy across the world, including in Norway, is unnecessarily low, and too many men die too early from causes that might have been prevented.
- The number of diseases that are specific to men (particularly prostate and testicular cancer) is rising rapidly.
- Men have a particularly high rate of accidents and suicide, while men's mental health problems appear to be under-treated.
- The health service in Norway has been too slow when it comes to dealing with men's gender-specific needs in relation to health and illness.

A male perspective on health and quality of life will increase equality, and will improve the living conditions and health of boys and men. The Norwegian authorities have made a great step ahead in pointing out the necessity of specific focus on men's quality of life, their health and male specific diseases and in identifying the need for a gender perspective that includes men.

However, just encouraging the local authorities to deal with the gender perspective on health is not enough. No concrete plans or measures for how to deal with the issue of men's health is promoted.

The former Minister for Gender Equality, Karita Bekkemellem, initiated the "Men's Panel" as a part of the work with the Report to Parliament No. 8 (2008-2009): About Men the Male Role and Equality. The panel was set up to discuss men's role in a gender equality perspective in the public debate, and consisted of 30 men chosen for this purpose in particular. The "Men's Panel" finalized their work with handing over to the Minister a conclusion note including more than 50 measures to be taken for including men in the gender equality work.

The following eight measures are highlighted from the "Men's Panel" conclusion note, especially focusing on men's health. Reform – resource centre for

men supports the need for improved knowledge about men's health in Norway through:

1. We urge the authorities to arrange for a public report on men and health, including a focus on men's mental health. The reason why more men are put on full disability pensions than women must be examined in more detail.
2. We urge the Government to increase funding of research on men's health within a gender perspective.
3. General practitioners must be instructed to call in male patients for regular checkups. We need more testing and prevention of diseases that are specific for men, and more consultations on lifestyle and life situations, where one special focus is on themes that are relevant to the phase of life in question, are needed. Focus on health, well-being and mental health is important during such checkups.
4. We propose that the school health service should be improved and should have better information for boys. Awareness-raising activities are crucial in school when it comes to men and health, lifestyle and prevention. The school health service in primary/lower secondary school and upper secondary school is an essential arena for establishing good contact between men and the health service at an early age.
5. We need gender-specific low-threshold measures for men connected to health and quality of life with easy access and good information about them. Experience shows that men avail themselves of such programmes when they exist.
6. We call for a report on a life-phase-based reform of working hours which takes into consideration the fact that parents of young children are under the greatest pressure when it comes to the balance between working life, home (care/household) and leisure time.
7. Extensive information measures must be introduced to inform about prostate cancer and the opportunity to take PSA tests.
8. A plan must be drawn up to raise the competence of all general practitioners when it comes to following up prostate-cancer patients.

About the author

Reform – resource centre for men is a national centre for knowledge on men, boys and gender equality in Norway. The centre is organized as an NGO promoting gender equality from a masculinity perspective, including men's health situation as one important perspective on gender and health. Reform offers low threshold services for men at the local level such as counselling and anger management courses, initiates several projects focused on men, and collects and disseminates knowledge on men and boys in the general public. Reform is funded by the Norwegian Ministry of Children and Equality.

Ulf Rikter-Svendsen, Director of Reform, is educated and trained as an ECE (Early Childhood Educator) and a Family Therapist. He has been working at Reform since 2002 with issues related to masculinity, health and fatherhood. His competence is mainly within men's ability to manage/cope with stress, men's health issues and what creates individual change. Gender equality in a masculinity perspective is the large context for his work.

Reform: www.reform.no

References

1. Statistics Norway. Samfunnsspeilet [Social Mirror] No. 3. Oslo: Statistics Norway; 2007.
2. Ministry for Children and Equality. Stortingsmelding nr. 8 (2008-2009) Om menn, mansroller og likestilling [Report to Parliament No. 8 (2008-2009): About men the male role and equality]. Oslo: Ministry for Children and Equality; 2009.

Men's health in Scotland

Mark Ward

The current state of male health in Scotland

Here in Scotland men don't have a great reputation for looking after their health, with an unhealthy diet and the love of few too many drams.

Research highlights the increase in male-specific cancers, and the growing prevalence of coronary heart disease, diabetes, and obesity. Male life expectancy is low, health service use is low, suicide rates among men are very high, violence between men and against women and children is common. In short the health and well being of the Scottish male could be much improved.

- ▶ Life expectancy for males, in Scotland, at 74.2 years, is still 5 years less than for females; while, within Scotland itself, male life expectancy varies enormously: 66 years in the 10% most deprived areas whilst 79 years in the 10% least deprived.
- ▶ Numbers of men in Scotland dying from alcohol related diseases are double those in England.
- ▶ In Scotland as a whole, male suicide rates increased by 22% between 1989 and 2004, compared with a 6% increase in females while 3 out of 4 suicides in Scotland are by men.
- ▶ Over a 10 year period, since 1995, the incidence of prostate cancer rose by 14.3%. Currently, 2500 men are diagnosed as having prostate cancer each year in Scotland, of whom 750 to 800 die.
- ▶ It is generally accepted that men access health services differently from women, yet this is not always currently factored into the design of NHS services.
- ▶ Violence remains a major issue for men in Scotland, both as victims and perpetrators. The social and personal costs of this are significant in terms of health and economics across our communities.

The reasons why Scotland's health compares unfavourably with the rest of the UK are complex. The Public Health Institute of Scotland in 2001 concluded that deprivation could only account for 40% of the difference and that the remaining 60% described as the "Scottish effect" was possibly due to psychological factors particular to our nation.

The pressure our Scottish society exerts on men to conform to its expectations of masculinity plays a large part in shaping their health and well being. The desirable male ideals of being strong and independent run counter to seeking help from our health services to maintain a healthy lifestyle.

Thankfully, this picture isn't the whole story. Attitudes towards men's health and work in the field of improving it are moving ahead at a very encouraging rate. Right across the medical and social sectors, we are making progress - rapidly in some areas, slowly but surely in others. Many committed individuals within the health service and the voluntary sector are working hard to get men thinking more about their health, and/or service providers to target men more effectively.

There are a number of specific pieces of work in Scotland that are worth highlighting as examples of how imaginative and innovative approaches can help to improve the health of men, through taking into account their specific needs, and what we already know about how men access services.

The Camelon Men's Health Clinic

The Camelon men's health centre was Scotland's first primary care nurse led service offering a range of services aimed entirely at improving the health of men. Since opening in September 2001, the Camelon Centre has offered comprehensive, individualised health assessments and health promotion activity designed specifically for men (www.emhf.org/re-source_images/Camelon_Report_08_Scotland.pdf).

Previous attempts to develop Well-Man clinics were reviewed and it became clear that lack of engagement with men and poor attendance were common problems that required to be overcome. With this in mind, the following emerged as the key principles for a new service aimed specifically for men:

- Evening availability – thus attracting working men who were unable to access conventional daytime services.
- Available on an appointment system to avoid the pit-falls of a drop-in service and also a more comprehensive engagement.
- Publicity of the service through traditional means, and invitations sent out from GP practices inviting men to attend.
- Advertising focus on "what men wanted" from a "health check". The "men only" aspect of the centre is highlighted in the advertisements.

The service has proved popular with 3604 men having attended the service until August 2008. Having reached its seventh year the Men's Health Service is now well established within NHS Forth Valley. It has proved effective in achieving its main target of engaging with men regarding their health. The service is providing services that will improve the health outcomes of local men and continues to lead the way in providing gender specific services for men. The convenient time of the service (in the evening out with normal working hours) has been cited as a major reason for attendance.

MHFS 10k for Men

The Men's Health Forum Scotland 10K for Men is the only running event exclusively for men in Scotland and was devised to respond to the following aims:

- To raise the profile of men's health in Scotland
- To provide a major focus for National Men's Health Week
- To raise awareness of Men's Health Forum Scotland
- To engage men in Scotland of all ages and abilities in healthy activity

The 2006 event was highly successful, with more than 1400 men taking part, aged from 15-77. We worked with more than thirty different partner organisations, and the MHFS 10k for Men has now become a major annual event with the capacity for growth year on year. It is intended that 5000 men will take part in 2009.

MHFS Men's Jogging Network

To support the MHFS 10k for Men we have established a network of more than 30 men-only jogging groups supported by fully trained jog leaders. These groups are free to men of all ages and abilities and encourage men not only to take part in the MHFS 10k for Men, but perhaps more importantly to keep up healthy activity all year round with the support of peers.

Stop Violence Against Women

Men's Health Forum Scotland have been involved in a range of conferences and campaigns to challenge male violence, particularly against women. We work closely with women's organisations and government to encourage all men to challenge violence against women.

This work has included a major international conference hosted by Men's Health Forum Scotland in partnership with Amnesty Scotland, local conferences examining best practice, and the initiation of a White Ribbon Campaign in Scotland.

We are currently developing a programme of work to support violent men to change their behaviour, and hope to establish this as a major project within our portfolio of work.

The response of the Scottish government

The establishment of a Scottish Parliament in 1999 brought about fundamental changes in the political landscape in Scotland, and has presented many new and exciting opportunities. Not least of these has been the opportunity to engage directly with politicians, policy makers, and the parliamentary process. Men's Health Forum Scotland works closely with the Scottish Government and has seen real influence coming to bear on their approach to men's health issues. However, much remains to be done and the struggle to keep men's health on the political agenda is not always easy.

The single most significant change in relation to policy and service design to take place in Scotland in recent times has been the introduction of the Gender Equality Duty in 2007. This duty places a legal obligation on all public sector bodies including the NHS to take into account the specific needs of both men and women in the way they carry out their work. This includes the design and delivery of services.

This new legislation means that for the first time there is an obligation on public bodies not only to take gender into account, but to publish Gender Equality Schemes which detail the actions they will undertake, and to report on progress. We are already seeing the impact of this within the NHS with the establishment of a new directorate to support the NHS in Scotland in implementing the Equality Duties in relation to gender, race, age, disability, faith and sexual orientation. Clearly men are affected across all these strands, and part of the work of Men's Health Forum Scotland is to ensure that all men's needs are taken into account in relation to both generic and gender-specific service provision.

In order for the GED to have the most positive impact, there is a need to develop closer links between policy makers and practitioners and to use these links

to increase understanding of the concept of gender as a social construct rather than a biological definition. Gender determines how we experience the world around us, how we relate to it, and how it impacts upon our health and lifestyle. These fundamental principles are experienced throughout life by both men and women, but in different ways. It is these differences which need to be recognised from the outset when determining health policy and practice. A crucial element is that gender sensitive health policy on its own is not sufficient; a gender perspective supported by the GED must be brought to bear on other areas of policy development such as education, social justice, housing, employment, poverty and equality, as all of these ultimately have an impact on health.

An effective response to planning and delivering health care in its widest sense requires a robust and dynamic evidence base. We believe it should be a priority to ensure that this evidence base is developed in relation to gender specific research of the health experience of Scottish men and women. Effective responses to the needs associated with that experience can then be considered.

One clear issue that will have a future impact on health services in Scotland is the increase in the male population over 60 years of age. This will have an impact on the nature of services required, and the resources that require to be made available. As treatments advance, there will be more men living longer with potentially increasing health needs to be met. This clearly has implications for service planning and delivery, particularly in relation to CHD, COPD, diabetes, cancer, obesity, and in particular male specific conditions such as prostate disease.

The future for male health in Scotland

As we look to the future, we believe it is vital that we develop in all areas of health care a recognition of the value of a social model of health, alongside a clinical approach. While effective and accessible clinical services are imperative, it is also essential that we recognise the other social determinants of health. As has been said many times, health is not just about the absence of disease, but about well being and the experience of the individual in relation to the world around them.

From a gender perspective, this is greatly influenced by the role of men in society and the family. We support work to examine how changes in Scottish society's attitudes to gender and masculinity can be better understood and how we can support positive outcomes from the changing role of men. There is a need to examine how gender impacts on the development of individuals from an early age, and in turn how this impacts on health throughout life.

Public health policy in Scotland must recognise the value of health promotion as a vital aspect of health improvement. Effective health promotion forms an integral part of a gendered approach to health, and should

be valued as such. In order for health promotion to have the fullest impact, it requires to be resourced and valued within the wider public health agenda.

Recent changes that have seen health promotion activity within Scottish Health Boards move to a community level within Community Health Partnerships may have advantages, but there is also a need to maintain a central focus and critical mass of expertise at a Health Board level. In specific areas, such as sexual health, it may not always be appropriate to coordinate resources at a local level.

Men's health in Scotland remains a major challenge for Men's Health Forum Scotland, the NHS, government and NGOs. Not least it is a vital issue for men themselves. Much has been done, but there is a long way to go to improve Scotland's international standing in the league of men's health outcomes.

There are real opportunities in relation to policy development; our challenge is in maximising the impact these have on the lives of men in Scotland and ultimately on Scotland as a nation.



2008 Men's Health Week:
Participants to the annual 10km run.

About the author

Men's Health Forum Scotland (MHFS) is a charity registered in Scotland and exists to:

- ensure government policy supports the development of men's health initiatives
- support and resource the efforts of those working to improve men's health
- share knowledge and information on what works
- challenge the social influences from, for example, the media and institutions that impact negatively on men's health

The main aim of Men's Health Forum Scotland is to increase the capacity of men in Scotland to fulfil their potential, through exploration and development of new perspectives on masculinity, both by men themselves and in society as a whole.

Men's Health Forum Scotland exists to promote men's health and well-being in Scotland. It seeks to improve the quality of men's lives through raising public, personal and policy awareness of men's health and well-being issues, challenging stereotypes and developing an understanding of men's changing roles in society.

Through an inclusive and co-operative approach, it wishes to identify and establish positive policies regarding men's health and to foster communication and respect for and between men. The Men's Health Forum Scotland equally recognises mutual benefit in working with women's interests and concerns and works in partnership with women's health interests towards mainstreaming a gendered approach to health in Scotland.

Mark Ward has been National Coordinator of Men's Health Forum Scotland since June 2004. He has a background of working in sexual health promotion, with a particular interest in gay men's work and HIV prevention. Mark has played a leading role in the development of the organisation over the past five years, and has initiated a number of innovative projects with the support of a dedicated staff team and charity trustees.

Men's Health Forum Scotland: www.mhfs.org.uk



Launch of the 10km run by Scottish Health Minister Andy Kerr (front row left) during Men's Health Week.

Men's health in Switzerland

René Setz

The current state of male health in Switzerland

For several years, health reporting in Switzerland has explicitly taken notice of male health. Increasingly, a gender-related perspective is establishing itself on health problems and the related resources and skills, going further than purely presenting a gender comparison of health indicators. Male-specific health needs and health resources can be accessed in national gender-sensitive health reports by going to www.genderhealth.ch and then selecting Bundesamt für Gesundheit (Federal Office of Public Health). The Federal Office of Public Health is committed to non-discriminatory health policy. It has long been known that gender is a key factor in the development of human health and disease. The work of the Gender Health Project, in the Multisectoral Health Policy Division, contributes to improving and maintaining the health of women and men in Switzerland. Its goal is that the health needs, risks and resources of women and men should be considered systematically in all areas of health and in other areas of policy. The Gender Health Project is involved agenda-setting, transfer of information, coordination, prevention and the promotion of health.

What is the situation for male health in Switzerland? Life expectancy for men in Switzerland is nearly 79 years. The main causes of death are cardiovascular diseases and cancer. Men subjectively consider their state of health to be good, and this positive view is increasingly prevalent as household income goes up. Men die more frequently than women from accidents and suicide. Their behaviour as regards health is riskier

than that of women (greater consumption of tobacco and alcohol, unhealthy food, more road accidents, higher rate of HIV/AIDS). As a result of people's career choices, which are still highly gender-specific, men's work often involves physical effort and exposure to noise, dirt, heat and stress. Such working conditions mean a high health risk. Men suffer from stress, mainly in connection with their gainful employment, and this stress is greater for men having a higher level of education and higher socio-professional status. Men and women are affected to different degrees by mental disorders, with men getting less frequent treatment for mental problems than women. In Switzerland, men generally ask for less medical care than women. As far as check-ups are concerned, men under 70 receive less treatment than women.

In the area of promoting health, over the period 2000-2008, the RADIX foundation (the Swiss competence centre for the promotion of health and for prevention) ran the platform for male health, amongst other things under contract to the federal government. The focus of the work was to transfer information through proposals for the training and further education of qualified employees, advice for qualified employees on work with men that is specific for target groups, initiation of pilot projects (www.gesunde-maenner.ch/html/angebote.html) and in basic work (www.gesunde-maenner.ch).

The response of the Swiss government

Male health is a priority in prevention programmes at the national and cantonal levels, especially in the areas of preventing AIDS/HIV and addiction. The male focus of the national HIV/AIDS programme 2004 - 2010 is reflected in the orientation of prevention towards target groups. The greatest need for prevention, and the greatest potential for prevention is among homosexual men, prisoners, intravenous drug users, migrants from countries with a high incidence of HIV/AIDS and their (male or female) sexual partners, (male or female) sex workers and between girlfriends and boyfriends. The number of HIV diagnoses has been constantly decreasing in the case of heterosexual transmission, among migrants from countries where HIV/AIDS is prevalent and among intravenous drug users. However, the decrease in these groups is almost entirely offset by a new outbreak of the HIV epidemic among homosexuals, observed since 2003.

The third package of federal government measures to reduce the drug problem over the period 2005 - 2011 is based on the premise that work on addiction is more effective if not only the biological differences between genders is taken into account, but also the socio-cultural differences between genders. Gender-appropriate work on prevention and addiction attempts to deal equitably with the different needs and experience of men and women, and the realities of their lives, so it makes a substantial contribution to developing quality. We need to ensure that whatever is made available and the institutions involved are organised appropriately. Since the launching of this package of measures, a wide range of gender-related measures to prevent addiction have started, contracted to the federal government, with male-specific concerns picked out as central themes (www.infodrog.ch/pages/de/them/gend) and (www.drug-sandgender.ch).

Non-governmental organisations and national foundations have also picked out the target groups boys and men, when focussing on the topic of gender. The UND technical office supports not only individual fathers but also employers and their male employees in making family and work compatible, through proposals specific for men (www.und-online.ch). Swiss Health Promotion has developed a project

management tool to support qualified employees in gender-sensitive work (www.quint-essenz.ch).

In recent years, with a view to having a structural basis, professionals in different organisations involved in gender-sensitive work have associated young men and men in networks on specific topics. These include in particular:

- Netzwerk Schulische Bubenarbeit (Network of school-based boys' work): Representatives of various institutions from the German-speaking part of Switzerland united as an association, wishing to reinforce gender-related work with boys and youths in school – in teaching, projects, the school day and teacher-training. (www.nwsb.ch)
- IG Bubenarbeit Schweiz (Trade Union Swiss boys' work): This interest-based association is a federation of qualified employees in the area of youth work and regularly organises conferences. (no homepage)
- VäterNetz.CH (Swiss Network of Fathers): This is a platform for networking and mutual coordination of specialists in their work with fathers. In this work, VäterNetz.CH can act as the organiser, or launch projects. (www.vaeternetz.ch)
- Arbeitskreis Männer und Gleichstellung (Working group for men and equality): This working group devotes itself to setting up interdisciplinary exchanges of research results and experience from projects in the areas of gender and men. (www.iamug.ch)
- Männer.ch (Swiss men): This umbrella association of organisations of Swiss men and of fathers is an association representing interest groups, acting at the federal level, and it sets the national agenda regarding policy on topics related to men and fathers. Männer.ch sees itself as the alliance partner in the association of players in society who are oriented towards cohesion and progressiveness. The objective is to implement a new policy on men including by lobbying from the male perspective. This is intended to make a contribution to equal opportunities useful in life and to gender democracy. (www.maenner.ch)

In order to make optimum use of the resources available in Switzerland to promote male health there is active interdisciplinary cooperation between organisations involved in health and in education and socio-political interest groups.

The future for male health in Switzerland

The 2006 Swiss national Gender Health Report and in particular the 2008 Focus Report on Gender and Health and various cantonal health reports show clearly where there is need for action and research in the area of male health. Specific prevention for men is required above all in the area of mental health (stress caused by working conditions detrimental to health, depression); violence (domestic and outside the home); accidents (road traffic); suicide (young and older men); and the consumption of tobacco and alcohol (men from lower social classes).

Thus the statement “for male health – see under various aspects of female health” no longer applies.

Despite the deficiencies that exist, we have the basis for the promotion of male-specific health and prevention, but there is unfortunately a lack of the practical implementation that is needed. For this, we need to have consistent calls for and implementation of gender mainstreaming. Experts in the area of prevention and health promotion need simple access to tools and good practice proposals. The development of the RADIX’ “platform for male health” to a “platform for female and male health” among other things should ensure this access. Appropriate responsibility for this should be supported as broadly as possible.

About the author

RADIX is a private foundation that undertakes, contracts and develops proposals which contribute to improving individual competence in connection with health and disease, and to arranging people’s life, work and free time in ways that promote health. Therefore, RADIX is oriented to a policy enabling everyone to take responsibility for their own health, to be aware of possibilities in the area of health, and to arrange their lives, work and free time appropriately. RADIX follows the principles of the Ottawa Charter for Health Promotion and its follow-up conferences.

René Setz has worked for RADIX since 2000. Coaching organisations and health professionals in their work with youngsters and men is one of his main duties. Besides that he has built up the health information platform www.gesunde-maenner.ch, which provides professionals with basic information on mens health and examples of good practice. Currently René is involved in the founding of the Men’s Health Forum Switzerland.

Men's health in the USA

Scott T. Williams

The current state of male health in the USA

The situation for men's health in the United States is dire:

- Men are leading in 9 out of the top 10 causes of death (heart disease, cancer, COPD, suicide, etc.)
- 1 in 2 men and 1 in 3 women in their lifetime will be diagnosed with cancer
- The life expectancy gap between men and women has increased from one year in 1920 to 5.2 years in 2005.
- Centers for Disease Control and Prevention (CDC) studies show that women are 100 percent more likely than men to visit a doctor for prevention.

While this health crisis is of particular concern to men, it is also a concern for women regarding their fathers, husbands, sons, and brothers. According to the United States Census Bureau, the ratio of men to women in the early retirement years (age group 65-69) reduces to 85 men per 100 women. The growing disparity in this statistic suggests that among other factors, the declining health of men increases the risk of women entering retirement

age as widows. According to the Administration on Aging, more than half of elderly widows now living in poverty were not poor before the death of their husbands.

Men's health is a concern to Federal and State governments that absorb the enormous costs of premature death and disability, including the costs of caring for dependents left behind. Educating men, their families, and health care providers about the importance of early detection of male health issues (i.e. cardiovascular, mental, prostate health, cancer [lung, prostate, skin, colorectal, testicular, and more], HIV/AIDS, osteoporosis, and other pertinent health issues) can result in reducing rates of mortality for male-specific diseases, as well as improve the health of America's men and its overall economic well-being.

Scientific studies have shown that regular medical exams, preventative screenings, regular exercise, and healthy eating habits can help save lives. Appropriate use of tests, such as prostate specific antigen (PSA) exams, blood pressure, blood sugar, lipid panel, and colorectal screenings, in conjunction with clinical exams and/or self-testing can result in the early detection of many problems and in increased survival rates. Men's health is also a major concern for employers in the United States, who often pay the high costs of medical care and lose the productivity of their employees due to absenteeism and presenteeism.



MHN hosted a Free Health Screening called "Timeout for Veteran's Health" in partnership with the Washington Redskins at FedExField (football stadium) in the players locker room. The event attracted over 700 military veterans and their families.

Also of concern is the physical, mental, and emotional well-being of our military men (and women) returning from war zones, and our veterans. The suicide rate among Army soldiers reached its highest level in three decades in 2008. As a nation, the United States must pay better attention to their needs and the needs of their families.

The data and statistical information around men's health issues reinforces the need for increased attention, investment, and prioritization on the national level. Prostate cancer is the most frequently diagnosed cancer in the United States among men, accounting for 25 percent of all male cancer cases, with African American men at highest risk. Over 185,000 men will be newly diagnosed with prostate cancer this year alone and almost 29,000 will die. Costs associated with prostate cancer detection and treatments exceed \$8 billion annually and represent 8% of cancer and 0.4% of all health related expenditures in the U.S. Prostate cancer rates increase sharply with age, resulting in 2/3 of the annual prostate cancer expenditures in the U.S. being paid for by Medicare.

Other men's cancers do not fare much better:

- It was estimated that in 2008, approximately 115,000 men were diagnosed with lung cancer, and almost 91,000 of America's men will have lost their lives due to lung cancer
- It was estimated that in 2008, approximately 54,000 men were diagnosed with colorectal cancer, and over 24,000 of America's men will have lost their lives due to colorectal cancer
- It was estimated that in 2008 over 8,000 men, ages 15 to 40 were diagnosed with testicular cancer, and 380 of these men will have lost their lives

On the cardiovascular health front, men and their families face steep challenges:

- Approximately one in three adult men have some form of cardiovascular disease. In 2004 cardiovascular disease caused the deaths of 410,628 males
- Approximately 21 million Americans are living with diabetes, with men over age 20 making up more than half of those patients (nearly 1/3 of them do not know they have diabetes), and they are 30% more likely to die from the disease

- People with diagnosed diabetes have medical expenditures that are 2-3 times higher than patients without diabetes and the estimated cost of diabetes in 2007 was \$174 billion, including \$116 billion in excess medical expenditures and \$58 billion in reduced national productivity
- Among men age 18 and older, 67 percent do not partake in regular leisure-time physical activity

It is important to note that men over past decades have shown poorer health outcomes than women across all racial and ethnic groups as well as socioeconomic status. This can be attributed to cultural attitudes that have been ingrained in American boys and men for decades. Men are taught at an early age to "suck it up" and that big boys don't cry. When a boy is 5 years old and falls down and skins his knee, his mother tells him to shake it off – when he is 50 years old and having chest pain, he believes it is just indigestion but really it may be the first sign of a cardiac event.

In response to these alarming statistics and societal perceptions, Men's Health Network (MHN) has taken the lead in laying the groundwork for favorable men's health infrastructure and policies through the following work and activities:

- Congressional Men's Health Caucus established within United States House of Representatives.
- Men's Health Network has worked with the United States Senate and House of Representatives to introduce legislation that would create an Office of Men's Health (OMH) within the US Department of Health and Human Services.
- In 1993-94, MHN led efforts to pass legislation recognizing the week leading up to and ending on Father's Day as National Men's Health Week. Men's Health Network then worked closely with key international men's health organizations in establishing and recognizing International Men's Health Week.
- MHN works closely with U.S. State Governor's issuing proclamations every June recognizing Men's Health Week in their state.
- MHN has worked with 7 State Legislatures on establishing Commissions of Men's Health (for example: Georgia, Louisiana, Maryland, and more).

The response of the US government

As of yet, there has been no centralized national effort to coordinate fragmented men's health awareness, prevention, and research efforts on the regional, state, and local level. That role is currently being filled by Men's Health Network. Exacerbating the problem is a lack of a concerted government effort to reach out to men and engage them in the healthcare system in the United States.

Some obstacles to establishing a national men's health policy movement have included:

- Health entities and corporations not targeting men with health messages
- Men not prioritizing their health because of work or other personal/family obligations
- Advertising campaigns which target men to take risks (physical or sexual in nature) and "Eat Like a Man"
- Only recently have women been targeted to advocate for improved men's health, led by Men's Health Network and Women Against Prostate Cancer
- Unwillingness of men to historically address sensitive issues within the media (impotence, incontinence, infertility, etc.)
- Lack of male celebrities and role models joining health oriented national media and educational campaigns

Despite this, through the efforts of Men's Health Network over the past 17 years, seeds and programs have begun to be established within federal health and related agencies to address the health of men and their families. MHN was able to work with several key members of the United States House of Representatives to establish a Congressional Men's Health Caucus whose primary purpose is to promote legislation that will improve the health of men and their loved ones. The Caucus is focused on raising awareness of men's health issues, not the least of which is increasing the percentage of men who are screened for health related problems.

Other progress includes:

The Department of Defense (DOD) Prostate Cancer Research Program (PCRP) which was established in fiscal year 1997 by Joint Appropriations Conference Committee Report No. 104-863, provided \$45M for prostate cancer research. The PCRP has built a multidisciplinary portfolio of innovative basic, translational, and clinical research that complements initiatives sponsored by other federal agencies. An important element in the PCRP is its partnership with consumer advocates, who, along with scientists and clinicians, participate during both levels of review. The success of the PCRP has encouraged Congress to appropriate additional funds each year since FY97, for a total of \$810M through FY07. The PCRP has funded a total of 1,837 awards through FY07.

Men's Health Network was encouraged by President Barak Obama's speech on Father's Day 2008 supporting the role of fathers in families, "Of all the rocks upon which we build our lives, we are reminded today that family is the most important. And we are called to recognize and honor how critical every father is to that foundation. They are teachers and coaches. They are mentors and role models. They are examples of success and the men who constantly push us toward it." We plan to work with the Obama Administration to re-energize former President Bill Clinton's original platform on fatherhood.

The passage of National Men's Health Week in 1994. The purpose of National Men's Health Week is to heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys. This week gives health care providers, public policy makers, the media, and individuals an opportunity to encourage men and boys to seek regular medical advice and early treatment for disease and injury. The response has been overwhelming with hundreds of awareness activities in the USA and around the globe.

Men's health in the USA

Establishment of State Commissions on Men's Health. The goals of the State Commissions on Men's Health are to identify, assess, and develop strategies for men and boys, including community outreach activities, public-private partnerships, and coordination of community and state resources, to:

- Encourage an awareness of men's health needs;
- Examine the causes for, and recommend solutions to low participation in medical care;
- Develop strategies to lower the suicide rate among boys and men; and
- Examine the causes of work site deaths and injuries and develop strategies to enhance work site safety.

The future for male health in the USA

We would like to see the following happen:

- Establishment of a Men's Health Caucus within the American Public Health Association
- Further exploration of gender differences in health and health outcomes through the Department of Health and Human Services, Office of Disease Prevention and Health Promotion's, Healthy People 2020 objectives
- Establishment of Commissions on Men's Health in every U.S. state and territory
- Non-residential parents would be allowed to claim their children for SCHIP and Medicaid program eligibility purposes. Covering low-income parents (men and women) increases enrollment of eligible children giving them better access to healthcare and improves their use of preventative health services.

We believe that the following is going to happen:

- Passage of legislation establishing an Office of Men's Health within the U.S. Department of Health and Human Services (HHS), which would coordinate national, state, and local activities, programs, and research within the men's health field. Past language in Appropriations bills, inserted through the efforts of Men's Health Network has encouraged the Secretary of HHS to do more on men's health and/or "establish an office for men". This office would mirror the work of the existing Office of Women's Health, which has helped to save thousands of women's lives and has improved the lives of many more. An Office of Men's Health would be a resource center for health information, best practices, messaging, and resources to reach men where they live, work, play, and pray.



MHN providing free bladder cancer screenings for Firefighters.

About the author

Men's Health Network is a national non-profit organization whose mission is to reach men and their families where they live, work, play, and pray with health prevention messages and tools, screening programs, educational materials, advocacy opportunities, and patient navigation. With a network of chapters, affiliates, and partners, we have a presence in every state and 30 countries. Men's Health Network is composed of physicians, researchers, public health workers, other health professionals, and individuals. MHN is committed to improving the health and wellness of men, boys, and their families through education campaigns, data collection, surveys, toll-free hotlines, and work with health care providers. Men's Health Network is known as the leading authority on men's health in the United States of America, with a Board of Advisors totalling over 800+ physicians and key thought leaders.

Scott T. Williams is currently Vice President, Professional Relations and Public Policy for Men's Health Network. Scott is actively sought out as a speaker and resource on men's health issues by the media, policy-makers, public health professionals, government agencies, physician key thought leaders, and other patient advocacy leaders. He has been featured as an expert in the New York Times, CNN, MSNBC, Washington Post, Baltimore Times, Medicare Reimbursement Weekly, Chicago Tribune, National Public Radio, St. Petersburg Times, Inside CMS, Dallas Morning News, Seattle Post-Intelligencer, among others.

Scott has presented at the Food and Drug Administration (FDA), Massachusetts Medical Society, World Congress on Men's Health in Vienna, Austria, State Medicaid Pharmacy & Therapeutics Committees, and the United States Senate. Most recently, he attended and spoke at health policy briefings and receptions at both the 2008 Democratic and Republican National Conventions.

Scott is a contributing author to the American Journal of Men's Health, a SAGE Publication. He has recently been nominated to serve as the Membership Chair for the American Public Health Association's Community Health Planning and Policy Development Section. He is Chairman of the Maryland Men's Health Network Board of Directors, member and former President of the Sigma Phi Epsilon Alumni Volunteer Corporation, and current member of the Moravian College Alumni Association Board. Scott was recently elected to the RetireSafe Board of Directors.

Prior to joining Men's Health Network, Scott was a Senior Analyst of Strategic Services at PharmaStrat, Inc. based in Flemington, NJ. He has also worked as Public Relations Manager for sanofi pasteur in Swiftwater, PA.

Scott received his BA in Political Science with Honors and a minor in Business Management from Moravian College in Bethlehem, Pennsylvania.

Men's Health Network: www.menshealthnetwork.org

Men's health in Europe: an overview

Erick Savoye

The current state of male health in Europe

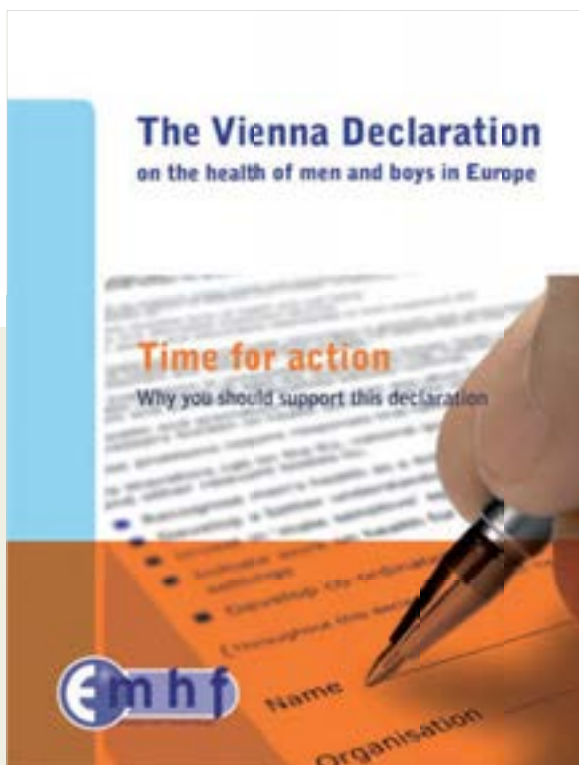
In Europe, the main causes of death are cardiovascular diseases, cancer and external causes of injury and poisoning for all of which the overall rate is much higher in men.

In the 15-64 age group, men have four times the death rate due to an accident compared to women, with the majority of them related to transport. Higher rates of accidents (traffic accidents, work-related accidents) and violence-related mortality in men are expected to be largely due to differences in gender norms about risk-taking and social protection. Cardiovascular disease is the second most common cause of death in men after accidents. Death from cardiovascular disease seems to

occur about 10 years earlier than in women, probably due to the lack of oestrogen protection. There are overall more men registered with cancer than women, and men have a lower survival rate than women for all non gender-specific cancers. Lung/bronchus cancer is the most common cause of cancer death in men.

For men who survive up to 60, the gap in life expectancy, as compared to women, is much smaller than at birth but there is a growing problem of social isolation in older men as a result of changing patterns of marriage.

Although average life expectancies and quality of life have increased over the last sixty years, concerns have grown over health inequalities with the European region. According to the most recent Eurostat figures, the largest difference in life expectancy at birth between EU countries for women is eight years (Bulgaria 76.3, France 84.4) and for men it is 13 years (Latvia 65.4, Sweden 78.8).



The Vienna Declaration brings together politicians, health professionals, academics, patient organisations and health NGOs

Men's health in Europe

The "health gap" is characterised by much higher although decreasing mortality rates from cardiovascular diseases in Eastern European countries.

In EU neighbouring countries such as Russia and Ukraine, the health status of the population is already critical for both men and women. It is set to worsen with the deepening of the current economic crisis. The report, *Health inequalities: Europe in profile*¹ noted in particular that life expectancy in men in countries undergoing social and economic change drops dramatically as seen in the Eastern European countries since the collapse of the communist regime. The average life expectancy of a Russian man is currently 59. In Estonia and Latvia the death rate in men was over four and a half times that in women in the age groups 15-24 and 25-34 years

National life expectancy figures can hide profound variations between groups of men at local level, even in countries reporting some of the longest average life expectancies in Europe. In the UK, men in the most deprived areas of Glasgow are only expected to live until 54 (Carlton). This is 8 years less than the average life expectancy for men in India (62) and 28 years less than in the more affluent areas of the same city (82 in Lenzie)².

Men are less likely to make effective use of health services, which adds to their risk of premature death.

This situation could be exacerbated by marked lifestyle differences between countries (tobacco smoking, diet and alcohol consumption) and by disparities in EU healthcare systems, not least in terms of availability and access to information, services and innovative treatments.

Morbidity rates and rates of premature mortality are higher among those with lower levels of education, occupational class, or income. Such inequalities exist in all age groups and can be found for many specific causes of death, including cardiovascular disease, many cancers, and injuries. Across Europe as a whole, these inequalities are more marked among men than among women and, are calculated to represent a reduction in life expectancy at birth of 4-6 years among men, and 2-4 years among women³.

In many Western European countries mortality differences between socio-economic groups widened during the last three decades of the 20th century. This is, at least partially, explained by a faster mortality decline in higher socio-economic groups who seem to have most benefited from improvements in cardiovascular disease prevention and treatment.



European Network meeting

The response of the EU

New EU health strategies are emerging that aim to incorporate a focus on gender-related issues. Given EU's limited competence in the field of public health (see box), the European perspective should be considered alongside complementary policy measures taken by the governments of EU Member States.

Enabling Good Health for All, a reflection process for a new EU Health Strategy⁴ introduced the Commission's focus on reducing health inequalities and drew the following observation from David Byrne, the then Commissioner for Health: "Life expectancy for men in the enlarged EU varies from 64 to 77 years, ... Can we allow such inequalities in health status in the EU?"

This was followed by the Commission's "roadmap" for equality between women and men recognising the gender dimension in health [COM(2006) 192] and in October 2007, by a new overarching health strategy, Together for Health – A Strategic Approach for the EU 2008-2013⁵ in which the reduction of health inequities is mentioned as a main priority including through targeted health promotion, and best practice exchange. In particular, mainstreaming of gender issues in relation to health policy is to be undertaken with the aim of reducing health inequities related to gender, and the quality and comparability of gender specific health data is to be improved.



Portuguese High Commissioner for health signs the Declaration

EU Competence in public health

In 1992, the Maastricht Treaty marked the recognition of a limited EU competence in 'Public Health'. This was consolidated by the Amsterdam Treaty in 1996 through its Art. 152 on '*Public health*', which gave a supporting competence to the EU, including the aim to '*promote and protect EU citizens' health*'. With a clear reference to the cross-border dimension, the European Commission is able to take action to encourage and support Member State cooperation, but at the same time the specific reference to Member State competence to organise their own health-care systems (Art 152.7) sets the limits of EU involvement.

The Council of Europe Recommendation of the Committee of Ministers to Member States on the inclusion of gender differences in health policy in January 2008 [CM/Rec(2008)1] recommended that 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;"

The text from the Council is not legally binding and enforceable. Most competence for action in the field of health is held by Member States (Art 152 Amsterdam Treaty)⁶ but the EU has the responsibility to undertake actions which complement the work done by Member States, for example in relation to reducing health inequalities. Nevertheless, the position of the Commission seems quite strong and suggests there may be provisions EU policy initiatives likely to benefit men's health specifically.

The earlier overview of men's health in Europe provides clues as to the policy areas with particular potential for improving men's health.

MEN'S HEALTH DETERMINANT	EU POLICY AREA
Accidents, Injury prevention	Environment; Employment, Social Affairs and Equal Opportunities; Transport
Violence/homicides	Employment, Social Affairs and Equal Opportunities; Justice, Freedom and Security
Specific disease, lifestyle conditions	Public Health
Health inequalities	Public Health: Employment, Social Affairs and Equal Opportunities; Regional Policy (health infrastructure, housing, etc); Research
Primary care delivery	Public health (limited EU healthcare competence) Sports; Employment, ...(Outreach health services)
Environment	Public Health, Environment
Health literacy	Public Health, Education & Culture
Health information	Public Health, Enterprise and Industry (medicines)
Masculinities	Research

For each of these areas, most recent initiatives to be reviewed include legislative texts (e.g. communications, recommendations, directives); the text of funding programmes; aims and activities of other EU initiatives such as platforms, working groups and awareness programmes.

This paper reviews EU public health policy only as defined by initiatives run by DG Sanco, the Commission Directorate for health and is limited to publicly available EU documentation.

Financing

The Council of Ministers Recommendation, referred to earlier in this section, provides strong guidelines for the consideration of gender in health policy. This is reflected in two of the three main objectives of the second programme of Community action in the field of health (2008-13), the main financing mechanism at Community level in the field of public health:

- To promote health, including the reduction of health inequalities (which includes action on health determinants, measures on the prevention of major diseases and reducing health inequalities across the EU).
- Health information and knowledge which includes action on health indicators and ways of disseminating information to citizens; focus on Community added-value action to exchange knowledge in areas such as gender issues.

In the 2008 and 2009 calls for grant application (proposals and tenders), information should be included on the inclusion of considerations for gender and for health inequalities, particularly in the project's impact assessment. In a specific call for tender, improving communication skills of health professionals in order to address the needs of patients is expected to take into consideration gender, age and other socio-economic and cultural variables. However, no gender-related evaluation criteria could be identified for the granted projects.

Main diseases

(Cancer, CVD, Mental health, sexual health)

Health Ministers of the European Union, unanimously adopted a Council Recommendation on Cancer Screening⁷ in December 2003 which sets out fundamental principles of best practice in early detection of cancer, and invited all Member States to take common action to implement national population-based screening programmes for breast, cervical and colorectal cancer. The Commission considered that current evidence regarding prostate cancer was insufficient to allow

inclusion in this Recommendation. The development of European Guidelines for Quality Assurance in Colorectal Cancer Screening are expected to be published in 2009 but so far they seem focused on harmonising the provision of secondary prevention with no regard for a likely gender imbalance in the uptake of these services.

Community action in the area of cardiovascular disease (CVD) tackles main determinants (nutrition/physical activity, tobacco, alcohol) through regulations controlling availability and use, and a raft of initiatives aiming to foster information exchange, health promotion and prevention. In the area of nutrition, the Commission issued a White Paper in 2007⁸ which recognises children as the priority group without reference to the need for gendered approach to implementation. In the work of the EU Platform for Action on Diet, Physical Activity and Health and of the High Level Group on Nutrition and Physical Activity, epidemiological background presentations are occasionally broken down by sex but no gender-based recommendations could be identified in any of their working papers. Note: the EU Strategy on nutrition involves several sectors of the Commission from public health to agriculture, transport, education and sports.

Together for Mental Health and Well-being, a June 2008 EU conference, established the European Pact for Mental Health and Well-being⁹. It recognised that mental disorders are on the rise in the EU with men and women developing and exhibiting different symptoms. It also acknowledges that suicide remains a major cause of death in the EU, 75% of fatalities being men. The Pact recommended that mental health and well-being of citizens and groups, including all age groups, different genders, ethnic origins and socio-economic groups, needs to be promoted based on targeted interventions that take into account and are sensitive to the diversity of the European population. The Commission organised a conference in Spring 2009 to explore the impact of gender on mental health. It is expected to inform a proposal for a Council Recommendation on Mental Health and Well-being later in the year.

The workshop, Towards a European Strategy on Sexual Health for Young People - Realities, Gaps and Needs held in Brussels in May 2008 was organised by the EU's Sexual Health Forum. By nature sexual health is an area naturally approached according to biological differences. A platform for action at European level is being formed (March 2009) hence recommendations from this group haven't yet been identified at the time of the review.

Socio-economic determinants

In March 2006, an EU expert group on social determinants and health inequalities was established. The European Commission funded the Closing the Gap project, which concluded that "radical strengthening of policies and infrastructures" is needed. However, most gender-based inequities reported affected women and little was said about men. The current health programme, Together for Health: Health Programme (2008-2013), mentioned previously, aims to support the development of strategies and measures on socio-economic health determinants and identifying health inequalities using data from the Community health information system. EMHF responded to the Commission's consultation on the reduction of health inequalities but it is yet unknown whether inequalities relating to men's health will be included within the scope of the Commission's review.

Information provision

Health information to patients on pharmaceuticals was one of the themes of the Commission's Pharmaceutical Forum, a body set up in 2005. Launched in March 2009 its recommendations, particularly the set about accessibility and dissemination did explicitly appear to harness the benefits of gender differentiation. The fact that the dissemination of information is only considered within healthcare settings doesn't appear to take account of men's rarer contacts with the health system.

The Health-EU Portal aims to provide health information across a wide range of topics and policies/decisions taken at European, national and international level. The Portal is also an important source of information for health professionals, administrations, policy makers and other stakeholders including the general public. Text and links provided in the men's health section fall short of providing a meaningful description of and information about men's health issues

The Commission has so far funded two consecutive reports on the state of women's health in Europe, the latest of which was published under the Austrian Presidency of the EU in 2006. The European Men's Health Forum's, Report on the State of Men's Health in 17 European Countries¹¹,



EMHF Board member and first Professor of men's Health, Alan White, during IMHW 2007 conference on Long term medical conditions.

remains the only document of its kind up to now. Through a collaboration with the European Men's Health Forum, the EU project EUGLOREH (March 2009)³ now gives the story of men's health in Europe added visibility. EMHF remains hopeful that an EU-funded European men's health report will be commissioned in 2009.

The EU project European Community Health Indicators (ECHI) aims to provide quality and comparable data for use by policy makers at national and EU levels. Indicators are at the crossroads of policy questions and data sets. They are therefore expected to be broken down by sex but for the most part the data across main diseases, health determinants and health interventions/services is not currently disaggregated. Female specific interventions (cervical and breast cancer) are the only ones documented at present.

Tobacco, alcohol, drugs and substance misuse

The European Community is actively developing a comprehensive tobacco control policy, which is characterised by control activities based on (2003-2004) legislative measures mainstreamed into a range of other Community policies (e.g. agricultural policy, taxation policy, development policy) and support for

Europe-wide smoking prevention and cessation activities under the current health programme. However no gender considerations could be found in the key texts reviewed in the public health area.

In October 2006 the European Commission set out a strategy to support Member States in reducing alcohol-related harm¹². The priorities identified in the Communication only implicitly targeted men through the reduction of injuries and deaths from alcohol-related road accidents; preventing harm among adults and reducing the negative impact on the workplace. Approaches recommended to increase awareness among EU citizens did not appear to consider gender explicitly.

The Commission funds the development of activities on drug treatment, prevention, treatment and harm reduction services and on drugs and prisons as foreseen by the EU Drugs Strategy 2005-2012. The second Public Health Programme (2008-2013) supports actions on drug prevention in the strand "Promoting Health". The majority of actions in this area tend to cater to men. A major 2008 European status report¹³ refers largely to gender-specific treatment and facilities to mean women, and particularly pregnant women.



Conference delegates signing the Vienna Declaration

The future of men's health policy in Europe

A political will to take account of gender as a health determinant in policy clearly exists at the highest levels of EU institutions. However gender sensitiveness seems relatively absent from policy development and implementation.

Male/female breakdowns may appear in epidemiological data underpinning EU policy planning, but their interpretation from a gender perspective is seldom reflected in policy interventions. Initiatives to tackle health determinants provide major opportunities to take account of gender yet few explicitly do.

It appears that many gender-specific initiatives have been aiming at women rather than men and the term gender has often been used in reference to women. EU policy-makers have identified a number of priority population groups according to the vulnerability of their health, however men's health has not been recognised as a particular area for public health concern so far.

However attempts to make an effective use of gender in health policy are becoming more frequent: the European Global Health Report has just outlined key men's health

issues in Europe; the EU PACT strategy currently aims to explore the gender aspects of EU mental health policy; and EU-funded projects are increasingly being conducted with a gender perspective in mind (e.g. Value+).

Additional research in men's health is urgently needed to support future health policy improvements and to accelerate the development of good practice across Europe. This could fall within the Commission's mandate to foster and coordinate across Member States. It may also be appropriate for the Commission to support the dissemination of existing men's health expertise which, for historical reasons, remains largely concentrated among a few Member States.

EMHF will pursue its efforts to promote the Vienna Declaration and to advocate for men's health as an area for public health concern. The forum aims progress this issue through debate with stakeholder groups, contributions to EU consultations and participation in relevant EU working groups. Long overlooked, men's health now deserves our full attention.



Launch of the first European report on men's health by EMHF

About the author

The European Men's Health Forum (EMHF) is an independent, non-governmental, non-profit making organisation established to raise male awareness across Europe. It aims to promote collaboration between interested individuals and organisations on the development and application of health policies, research, education and prevention programmes. EMHF provides a unique platform for non-discriminatory co-operation and information exchange within Europe and with other countries worldwide.

Erick Savoye has been the Director of EMHF since 2001. He has been responsible for EMHF's participation in EU health policy consultations and for the development and management of the Vienna Declaration for the Health of Men and Boys in Europe. He is EMHF's spokesperson with European Institutions and a contributor to the recently published EU global health report. Erick is currently EMHF's coordinator for two EU-funded initiatives where he assesses their impact from a gender and men's health perspective.

European Men's Health Forum: www.emhf.org

References

1. Mackenbach JP. Health inequalities: Europe in profile. An independent expert report commissioned by and published under the auspices of the United Kingdom Presidency of the European Union. October 2005.
2. Commission for the Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. World Health Organisation: Geneva; 2008.
3. Eugloreh Project. The Status of Health in the European Union: Towards a Healthier Europe 2009. EU public health programme project, global report on the health status of the European Union. 2009 [retrieved March 2009 from www.eugloreh.it/ActionPagina_993.do].
4. Byrne D. Enabling Good Health for all A reflection process for a new EU Health Strategy. Brussels: European Commission of the European Communities; 2004
5. Commission of the European Communities. Together for health: a strategic approach for the EU 2008-2013. Brussels: European Commission of the European Communities; 2007.
6. Treaty of Amsterdam Amending the Treaty on European Union, the Treaties Establishing the European Communities and Certain Related Acts, 1997 O.J. [C 340], incorporated into the Treaty Establishing the European Community, Feb. 7, 1992, O.J. [C 224] 1 (1992), [1992] 1 C.M.L.R. 573 (1992), art. 141(4) (as in effect in 1999) As of May 1999, the Amsterdam Treaty's provisions have been incorporated into both the EC Treaty and the Treaty on European Union.
7. Council of the European Communities. Council Recommendation of 2 December 2003 on cancer screening. Council of the European Communities: Brussels; 2003. OJ L 327, 16/12/2003 P. 0034 – 0038
8. Commission of the European Communities. COM(2007) 279 final. White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity related health issues. Brussels: Commission of the European Communities; 2007.
9. World Health Organisation/Slovenian Presidency of the EU. European Pact for Mental Health and Well-being, report of the EU High Level Conference "Together for Mental Health and Wellbeing". Brussels; 2008.
10. http://ec.europa.eu/health-eu/my_health/men/index_en.htm (accessed March 2009).
11. Cash K. and White A. Report on the State of Men's Health in 17 European Countries. Brussels: European Men's Health Forum; 2003.
12. Commission of the European Communities. COM(2006) 625 final. Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions. An EU strategy to support Member States in reducing alcohol related harm. Brussels; 2006.
13. University of Hamburg Centre for Interdisciplinary Addiction Research (CIAR). Quality of treatment services in Europe – drug treatment situation and exchange of good practice. Brussels: Commission of the European Communities; 2008.
14. <http://www.eu-patient.eu/projects/valueplus/> (accessed March 2009).



Is the health of men important?

This may seem like a rather fundamental question to ask at the beginning of a review of policy and progress in male health across eleven countries. On one level, the answer is bound to be “yes”. Of course the health of every individual man everywhere in the world matters to him and to the people who care about him. The evidence about whether men’s health is important to politicians and health planners however, is rather less convincing. Campaigners for better male health from three continents report in this paper that, despite enormous progress in public health and the sophistication of modern treatment approaches, men consistently suffer more serious illness than women and die at an earlier age.

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