

Getting It Sorted: A New Policy for Men's Health

A Consultative Document

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The Men's Health Forum is a charity that aims to improve men's health in England and Wales through:

- Research and policy development
- Professional training
- Providing information services
- Stimulating professional and public debate
- Working with MPs and Government
- Developing innovative and imaginative projects
- Collaborating with the widest possible range of interested organisations and individuals

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INTRODUCTION

It has been said that 'men's health' is a contradiction in terms. At first sight, that might sound a somewhat dramatic statement. But even a glance at the statistics demonstrates the scale of the problem. In many respects, men's health in England and Wales has not improved over the past 30 years.

- **Men in social class 5 still have a life expectancy at birth that is below average male life expectancy in the early 1970s.**¹ The average life expectancy of a man in social class 5 (unskilled manual) is currently 68.2 years; average life expectancy for all men in 1972-76 was 69.2 years.
- **Men living in some disadvantaged communities continue to have a life expectancy similar to the national average male life expectancy for the late 1970s.**² The life expectancy at birth of all men in Manchester is currently 70.5 years; average life expectancy for all men in 1977-81 was 70.0 years.³
- **Death rates for men aged 16-34 are virtually the same as in 1971.**⁴ The death rate for men aged 16-24 and 25-34 was 100 per 100,000 population in 1971; in 1999, the death rates were 80 per 100,000 for men aged 16-24 and 100 for men aged 25-34.
- **Suicide rates for men aged 15-24 have more than doubled since 1971.**⁵ There were 16 suicides per 100,000 population aged 15-24 in 1999 compared to 'only' seven per 100,000 in 1971. The majority of suicides now occur in young adult males and suicide is the most common cause of death in men aged under 35.⁶
- **The incidence of prostate cancer has increased by over 135 per cent since 1971.**⁷ 30 men per 100,000 were diagnosed with prostate cancer in 1971; by 1997, 71 men per 100,000 were diagnosed. 18,300 men are now diagnosed with prostate cancer each year and 8,500 die.
- **The number of men with testicular cancer more than doubled between 1971 and 1997.**⁸ There are now over 1,440 new cases diagnosed each year, although 'only' 70 deaths.⁹
- **The number of men aged 25-64 dying from chronic liver disease has increased five-fold in the period 1970-2000.**¹⁰ Alcohol misuse is the biggest single cause of chronic liver disease. 27 per cent of men now drink more than the recommended limits. 36 per cent of those aged 16-24 drink excessively.¹¹
- **The proportion of men who are obese has more than tripled since 1980; the proportion of men who are overweight has increased by one-third.**¹² 45 per cent of men are now overweight and another 17 per cent are obese.

There is now, fortunately, increasing recognition of men's health problems. The Department of Health, the Health Development Agency, health charities and others have started to realise that men's health requires particular attention if it is to be improved.

The Men's Health Forum believes there now exists an historic opportunity to take the decisive action that is needed to improve the health of men. But this means it is time to stop talking and time to take action. Good intentions must be translated into policy and practice initiatives that will make a difference.

This is why the Forum is publishing *Getting It Sorted*, the first men's health policy statement for England and Wales. Fittingly, the Forum is launching this initiative during the first National Men's Health Week (June 10-16th 2002). The

Forum has organised the Week to draw attention to men's health and to encourage health providers and others to develop new ways of working with men.

Getting It Sorted is a consultation document. Men's health is a relatively new field and the Forum does not claim to have all the answers. It is hoped that as many organisations and individuals as possible will take the opportunity to contribute to the debate about how best to improve men's health. A final version of this policy statement will be published in early 2003.

One thing is clear. No single organisation can make men's health better. It will require a partnership of government, health services, local authorities, a wide range of non-statutory bodies and, of course, men themselves. Working together, we can get it sorted.

EXECUTIVE SUMMARY

The problems with men's health

1. Men's health remains poor – average male life expectancy at birth is just 75 years and, in some areas and among certain groups of men, it is five or six years lower. In many respects – including suicide rates for young men, the incidence of prostate and testicular cancers, death rates from chronic liver disease and obesity levels – men's health has actually deteriorated over the past 30 years.
2. Men are generally reluctant users of primary care services, making little use of preventative services and often presenting late in the course of an illness.
3. Men's knowledge of sexual health services is low and they face significant access barriers to GUM (genito-urinary medicine) clinics, not least delays in obtaining appointments.
4. Men's health is under-researched, both clinically and in terms of health promotion.
5. The Department of Health has largely ignored men in its policies and plans. This has also meant that there has been little interest shown in the development of men's health policy and practice at the local level.
6. Men have not campaigned for improvements in men's health and, individually and collectively, they have often been viewed negatively by health providers and policymakers.

Men's health – a new awareness

7. Men's health is becoming more mainstream, however. This is reflected in the statements of the public health minister, Yvette Cooper MP, and the Health Development Agency's work on young men.
8. The government's health inequalities agenda, and its overall approach to public health, provide a helpful context for highlighting the importance of gender and men's health in particular.
9. There is now an increasing men's health lobby, not least a range of charities working on male-specific cancers and sexual dysfunctions. The All Party Parliamentary Group on Men's Health is also becoming increasingly influential.
10. There is increasing evidence that men do care about their health and will ask for information and help if provided in ways with which they feel comfortable.
11. The potential for improving men's health is clear – men are not doomed by genetics to an early death. The Men's Health Forum believes there now exists an historic opportunity to take a decisive leap forward in improving men's health providing appropriate policy and practice frameworks are put in place.

The importance of gender

12. Despite recent social and economic changes in the roles of men and women, traditional attitudes towards gender remain surprisingly and stubbornly prevalent. Boys and young men continue to be socialised to be tough and strong, to appear in control and to take risks.
13. To work effectively with men, policymakers and practitioners must improve their understanding of male gender roles and seek to develop and deliver services that are aimed at men as they are and not as some might wish them to be.

Tackling men's health effectively

New policies are needed

14. Health policies at all levels must become more 'gender sensitive' and, specifically, include men's health.
15. The Department of Health should establish a national men's health policy, following the example of the Irish Department of Health and Children.
16. The Department of Health should, as a first step, establish a Men's Health Development Group.
17. Every health policy produced by the Department of Health must include a gender dimension that covers men's health as a specific issue (unless there are clear and obvious reasons for not doing so).
18. The potential impact of all health policy and decision-making on men should be evaluated to ensure their needs are not side lined.
19. Targets must be set for the achievement of key men's health goals.
20. Health Improvement and Modernisation Programmes must be required to address men's health issues.
21. Local partnership approaches to improving men's health must be developed involving Health Action Zones, Healthy Living Centres, Education Action Zones and others.
22. Primary care trusts should be required to complete an assessment of men's health needs as part of their health inequalities work.
23. Local authorities should be encouraged to address men's health issues.
24. Training must be provided for health professionals on men's health issues.
25. The restrictions on GP prescribing of NHS treatments for erectile dysfunction must be lifted.

Health services must become more attractive and accessible to men

26. Primary care services should have longer opening hours and attempt to create a more male-friendly environment (e.g. by displaying male-interest magazines and men's health posters and leaflets).
27. Men's access to appropriate confidential and anonymous sources of health information, including telephone helplines and the Internet should be increased.
28. More primary care services should be provided outside of the traditional primary care setting, including community-based outreach clinics.
29. The new NHS Walk-In Centres should be encouraged to target men and to evaluate their effectiveness.
30. There should be more points of direct access to health care for men seeking help for a sexual dysfunction.
31. There is a need for a diverse range of sexual health services for men, including primary and direct-access secondary care, family planning clinics, telephone helplines and websites.
32. Delays in accessing GUM services need to be tackled as a matter of urgency. There is also a need to market GUM services more effectively and proactively to men.
33. Pharmacy services should be developed as a source of advice, information and self-treatment for men.

Health services must target specific groups of men

34. Men must not be treated as a homogenous group by policymakers or service providers: specific groups of men require specific interventions.
35. There is a clear need for the development of a national strategy specifically on the health of black and minority ethnic men.
36. Gay men's health issues must be seen as much broader than HIV/AIDS or sexual health in general.
37. Young men have specific health issues and needs and are particularly affected by high accident rates, smoking, alcohol and drug misuse, sexual health, mental health problems and suicide.
38. Older men's health and well-being must no longer be overlooked. Social isolation is a particular problem following retirement and/or the loss of a partner.

Health services must actively seek out men

39. A more imaginative approach to providing accessible men's outreach health services must be developed. Services in pubs, the workplace and sporting venues have considerable potential.
40. There is a need for improved funding for such services at all levels to broaden the range of projects available and to facilitate the development of good practice through proper evaluation.

Health promotion initiatives specifically aimed at men are required

41. There is an urgent need for more health promotion initiatives that are specifically targeted at men rather than based on the traditional population-wide approach.
42. Targeted interventions are needed to tackle men's risk-taking behaviours such as excessive drinking, smoking, eating a high-fat diet and dangerous driving.
43. The idea that it is possible to tackle men's health problems just by health promotion initiatives aimed at women should be abandoned.
44. National and sustained publicly-funded health promotion programmes for men on sexual dysfunctions, sexually transmitted infections and prostate health are urgently needed.

Men's health research must be a priority

45. It is vital that health research increasingly takes gender into account.
46. There must be greater investment in clinical research into specific under-researched areas of male health (including prostate disease).
47. Research into effective health promotion work with men should be encouraged.
48. Research in men's health policy and practice must be more effectively disseminated.
49. Men's health – and gender in general – should be included in the Department of Health's research and development agenda.
50. Research and development work at all levels must involve 'ordinary' men. It is essential that men (who can speak about their experiences and needs as men) are brought into the process of policy and practice development.

Men's awareness of their health needs must be improved

51. Parenting and childcare information must address bringing up boys to encourage them to become more aware of their mental and physical health.
52. Teacher education and training should also address this issue.
53. Men should be encouraged and enabled to become involved fathers, not least because active parenting can bring men more into contact with health services.
54. School-based initiatives that encourage boys to take a greater interest in health and health-related issues should be introduced.
55. There must be a significant improvement in the delivery of sex education for boys in schools.
56. Homophobia and sexism must be challenged. Traditional gender roles are held in place by homophobia and sexism – these ideologies determine the boundaries for what is considered acceptable and normal male behaviour.
57. National Men's Health Week must be developed and supported as a key awareness-raising tool.
58. Men's health advocates must be encouraged at every level – community, local, regional and national – in order to lobby and campaign for improvements to men's health policy and services and to act as men's health 'champions' for 'ordinary' men.
59. The introduction of the male-friendly policies and practices contained throughout this report would help to encourage men to see health as a much more 'normal' activity rather than as something that is primarily for women and children.

The problems with men's health

Men's health is poor

Men's health is poor. Whichever way the statistics are sliced, it is obvious that men's health is a problem – for men themselves, for women, for health services and for society in general. Men still die too young – average male life expectancy at birth is just 75 years and, in some parts of England and Wales and among certain groups of men, it is 70 years or fewer.¹³ As the data in the introduction to this report makes clear, in many respects men's health has not significantly improved since the 1970s. Many men still take too many risks with their health, not least by smoking, drinking alcohol excessively and driving too fast. Almost two-thirds of men are now overweight or obese, putting them at increased risk of cardiovascular disease and diabetes in particular. Men are also reluctant users of health services, especially primary care.

Defining men's health

It is difficult to discuss men's health without a working definition. The following, first formulated in Australia, has been suggested:

*A men's health issue is a disease or condition unique to men, more prevalent in men, more serious among men, for which risk factors are different for men or for which different interventions are required for men.*¹⁴

What this definition makes clear is that men's health is not, as some still seem to believe, just about male-specific problems like testicular cancer or prostate disease. In fact, virtually any condition (with the obvious exception of female-specific conditions such as cervical cancer) is a men's health issue. Suicide is a classic example. It is, of course, not a male-specific problem but men are much more likely than women to kill themselves, they have risk factors specific to their gender (such as a marked reluctance to ask for help with mental health problems) and require gender-specific suicide prevention interventions (e.g. services that are confidential, easily-accessible and which have an understanding of how to work with men effectively on mental health issues).

The main problem with this definition is that it is too medically-oriented. It ignores the issue of 'well-being' which, of course, features in the World Health Organisation's general definition of health. The Men's Health Forum believes that well-being must be seen as an important dimension of men's health.

It is also important to note that 'men's health' must include 'boys' health'. Male health problems do not start at the age of 16. Male children are much more likely to have accidents, for example, and more likely to be diagnosed with a range of mental health conditions, not least hyperkinetic disorder (also known as attention deficit hyperactivity disorder).¹⁵ The continuing significant levels of medically unnecessary circumcisions performed on boys is another important although little discussed health issue.¹⁶

The Men's Health Forum intends to develop an appropriate, comprehensive definition of men's/male health.

Men are reluctant users of primary care and sexual health services

Men are generally poor users of primary care services. Once they reach the age of 16 and their parents (usually their mothers) stop taking them to the GP, it is commonplace for men to avoid primary care unless they are in extreme pain or an illness has obviously become severe. Men also make little use of the preventative services available through primary care. This matters for two main reasons: first, late presentation makes men's health problems harder to treat (and explains, for example, why men are half as likely as women to develop malignant melanoma but are twice as likely to die¹⁷); secondly, primary care is the gateway to most other health services and, following recent NHS reforms, is assuming an even more important role in healthcare provision.

Men and primary care

The reasons for men's reluctance to attend primary care include:

- A belief that primary care is 'not really for men' – it is perceived to be a service primarily for women and children. This perception is reinforced by the frequent failure to display health information about men's health issues; even the magazines on display are usually exclusively or overwhelmingly published for women.
- It is difficult to access by men in full-time work – a man's GP is likely to be based some distance from his workplace and appointments tend to be available only during normal working hours. Men in full-time employment work an average of 40 hours a week¹⁸ and many do not feel comfortable about taking time off work to visit the doctor.
- Men often believe that their role is to 'tough out' illness for as long as possible rather than admit to what feels like a 'weakness'.
- Many men lack the confidence and even the language to discuss their health concerns with a health professional. Many doctors find, for example, that men often use the term 'impotence' (which is normally understood to mean erectile dysfunction) to describe a range of conditions including infertility and premature ejaculation.
- It is not unusual for men to be concerned that they would be 'wasting the doctor's time'.
- Racism and homophobia are also issues for many men. Black men are more likely than white men to be diagnosed as having a mental illness, for example, and many gay men who have come out to health professionals have found that their homosexuality is seen as 'a problem'.

Erectile dysfunction (ED) provides a good example of men's delayed attendance at primary care. Impotence Association research, based on an ongoing survey of over 2000 men, suggests that 85 per cent of men with ED take over six months to seek treatment; nearly half of men with ED take over two years to seek treatment.¹⁹ This matters, not least because ED can affect a man's quality of life and is frequently the symptom of a serious underlying condition such as cardiovascular disease or diabetes.

Sexual health services are another key point of access to health care. Men's use of GUM (genito-urinary medicine) services is also in urgent need of improvement, however. Relatively few asymptomatic men attend for screening and, indeed, many men's knowledge of services is low: a Men's Health Forum/Doctor Patient Partnership survey in 2000 found that only half of adult men knew a GUM clinic provides sexual health advice and treatment, 13 per cent thought a GUM clinic had something to do with treating gum disease and six per cent thought it treated elderly people.²⁰

Even if a man is motivated to contact a GUM clinic, delays of up to a week for urgent appointments and four weeks for routine appointments are not unusual, according to the Department of Health's sexual health strategy document.²¹ In fact, up to one in five people with acute symptoms of a sexually transmitted infection (STI) are unable to obtain a GUM clinic appointment within the recommended 48 hours, according to Southampton University research.²² The British Medical Association's recent report, *Sexually transmitted infections*, observed that 'there is evidence of increasing problems with access to GUM clinics, which is of great concern at a time of rapidly rising rates of STI incidence. This needs to be addressed urgently, and will require increased resources.'²³ Many men are likely to be deterred by problems accessing sexual health services with potentially serious effects on their own health as well as the health of their partners.

Men's health is under-researched

Although most clinical research has used men as its subjects, it has rarely investigated them as men. For example, many clinical trials look at the impact of a particular treatment on a sample of men but do not draw conclusions based on any analysis of their gender; men are simply taken to represent 'people'. It is still common for research which covers both men and women to aggregate data so that separate findings for men and women are not available.

There are also some clinical areas specifically affecting men where research is notoriously inadequate. Prostate disease is the most obvious example. Other clinical areas that require further research include male infertility and the cause of the decline in sperm counts, the rise in the incidence of testicular cancer, the so-called 'andropause' (often referred to as the 'male menopause' – it is still unclear whether or not this is a genuine medical condition), and Peyronie's Disease (a condition which results in curvature of the penis).

There is also a serious lack of research into effective health promotion with men (and specific groups of men). There is a dearth of information about how to work with men on a wide range of key issues, including smoking, alcohol, diet, weight reduction, exercise and sexual health.

Men's health is absent from policy

The Department of Health has largely ignored men, and the wider issue of gender, in its policies and plans.²⁴ The Department's consultation document *Tackling Health Inequalities* mentioned gender as a 'dimension' of health inequalities but this was not subsequently followed through in any significant way. The health of men and boys was virtually ignored. The NHS Cancer Plan and The National Service Framework (NSF) on Coronary Heart Disease also take a generally gender-neutral approach. An editorial in the *BMJ* has highlighted the particular problems with the NSF on heart disease:

Although the framework acknowledges gender differences there is no clear recognition in the guidelines of how these are to be addressed. Gender must be seen as an important factor in health care planning and delivery. Coronary heart disease is a prime example of where there are known gender differences. We need investment in research and inclusion of gender within educational programmes, without which health professionals will remain ignorant of the problems created by gender neutral health care.²⁵

The NSF for mental health is similarly problematic. It states the government's target of reducing the suicide rate by least one-fifth by 2010 but pays no attention to how this is to be achieved in the context of a male:female suicide ratio of 3:1. Given that suicide is a highly 'gendered' phenomenon, it is surely necessary for any effective suicide prevention strategy to pay particular attention to gender.²⁶

The Department of Health's sexual health strategy²⁷ proposes a national chlamydia screening programme for women but is silent about the issue of chlamydia and men, even though the rate of male infections has increased dramatically over the past decade. Chlamydia is an important men's health issue because most men with the condition are asymptomatic or have minor symptoms that can be easily ignored. However, chlamydia can cause urethritis, epididymitis, prostatitis, proctitis and Reiter's syndrome.²⁸ It has also been hypothesised, although not yet proven, that chlamydia is linked to the development of prostate cancer.²⁹ There is no doubt, however, that chlamydial infection can have potentially catastrophic implications for women's health, including pelvic inflammatory disease and ectopic pregnancy. Unless men are also encouraged to get tested for the infection and to seek treatment, women and men will continue to be infected in large numbers.

An awareness of the importance of men's health is not only missing from broad health policies. It is also absent from government policy on a key and specific men's health issue: the prescription of NHS treatments for erectile dysfunction (ED, or impotence). Currently, GPs can only prescribe NHS treatments for men whose ED is caused by a range of specific conditions. These include diabetes and severe pelvic injury but, crucially, exclude cardiovascular disease and depression. This issue is dealt with more fully later in this report, but the Men's Health Forum believes

that these rules strongly suggest that men's health issues are not taken as seriously by the NHS as they should be.

The omission of men's health from the Department of Health's policy agenda has meant that there has also been little interest shown in the development of policy and practice by health services at the local level. Health authorities, as they existed before April 2002, did very little to address men's health (although there have been some notable exceptions, such as Worcestershire Health Authority's Health Improvement Programme for Men³⁰ and Nottingham Health Authority's men's health report³¹). Primary care, the level to which power and resources is shifting within the NHS, has a generally poor record when it comes to providing the type of services that best meet men's needs. The vast majority of health authorities and primary care groups/trusts have not considered how to deliver men's health services more effectively. The assumption made is that 'the services are there and men can use them'. Given what is now known about men's attitudes to and use of health services, it is perhaps not surprising that the NHS has been described as 'a no man's land'.³²

The reasons for inaction

Part of the reason why men's health remains neglected is that men themselves have not argued, campaigned or lobbied for improvements. In marked contrast to the history of women's health, most men's health advocates have been health professionals, academics or policymakers, not 'ordinary' men. (Gay men are the only exception to this – they have led the response to the HIV epidemic.) As far as most men are concerned, it seems they are collectively and individually reluctant to ask for help with their health.

There is another important explanation for the relative lack of interest in men's health, however. Men are often viewed negatively by health providers and policymakers. Male risk-taking behaviour and men's apparent unwillingness to take better care of their own health has led many in the health services to assume that any attempt to improve men's health is doomed to failure. Worse, men in general are seen as unreliable, irresponsible and difficult to work with. In particular, young men and black men are seen as aggressive; gay men are held responsible for their health problems. It is unusual for men to be perceived positively as a group worth taking the time and trouble to work with. From this perspective, it is easy to believe that the scarce resources that exist for health should be allocated to other initiatives that are more likely to succeed.

Men's health – a new awareness

A focus on men

Fortunately, there are now some positive signs of change. Issues concerning men – including the role of fathers, criminal behaviour, educational attainment, the changing labour market and health – have become a focus for public and professional attention and debate over the past 10-15 years. Despite their undoubted continuing advantages in many spheres of public and private life, men have been identified as having specific concerns, experiences and needs.

Men's health is becoming mainstream

It is certainly becoming clear to many health professionals and policymakers that men's health is a problem in itself and, more broadly, that the health of the general population will not be significantly improved until men's health issues are properly addressed. The Chief Medical Officer's 1992 report on the state of the public health³³ and Sir Donald Acheson's more recent report on health inequalities³⁴ have been particularly influential in pushing men's health higher up the mainstream health agenda. The Health Development Agency has published authoritative research into the health of young men³⁵ and the minister for public health, Yvette Cooper MP, has also spoken of the need to tackle men's health problems. It is no longer the case that men's health advocates are few, far between and fairly marginal.

The minister for public health

The minister for public health, Yvette Cooper MP, has gone further than any of her predecessors in acknowledging the importance of improving men's health:

'This government has made clear its determination to improve health across the board and to tackle health inequalities. Men die five years younger than women on average – it is one of the starkest health inequalities we face. Heart disease, cancer, high blood pressure, suicide and accidents are all generally more prevalent among men and men on average visit GPs less than women. Those on low incomes have the worst life expectancy of all, and the health gap between men on high incomes and men on low incomes has grown.

'Traditional health promotion campaigns have often not been a great success when it comes to men's health and NHS services are often perceived as being geared towards women rather than men.

'Both men and women will decide how to lead their lives, but we should ensure that health campaigns and health services respond to the needs of both sexes.'³⁶

One of the most significant recent indications of the 'mainstreaming' of men's health was the *BMJ's* special edition on men's health in November 2001.³⁷ This contained several articles on the subject and, in an editorial, called for 'strategic and innovative research on men's health.'³⁸ This issue of the *BMJ* was timed to coincide with the First World Congress on Men's Health, held in Vienna, an event which brought together over 300 delegates from a wide variety of clinical and non-clinical backgrounds. Further evidence of the new, wider interest in men's health can also be found in *The Lancet*. In an editorial in 2001, the journal argued that 'clearly there is a need for a stronger evidence base, and more creative thinking on the part of health-care professionals, to help engage men of all ages in caring for their own health.'³⁹

The launch of the *Men's Health Journal* in September 2001 further reflects this mainstreaming process. Aimed mainly at the primary care team, the *Journal* aims to cover a mix of clinical, policy and practice issues.

A new governmental approach

The government's health inequalities agenda has provided an important context for identifying men's health as an area in need of attention. Clearly, it is not feasible to highlight inequalities linked to social class and ethnicity but to ignore the impact of gender. Equally influential and helpful has been the new focus on the social determinants of health – which again include gender – and the move away from a perspective which held that health was primarily the responsibility of individuals.

The men's health lobby

There is also now an increasing number of organisations pushing for improvements in men's health. These include the Prostate Cancer Charity, the Impotence Association, the Orchid Cancer Appeal and the British Prostate Group. Other organisations, such as the Health Development Agency, the Institute of Cancer Research, the World Cancer Research Fund and Community Health UK, are also paying more attention to men's issues as part of their wider work programmes. There are now over 120 organisations and/or practitioners in the UK undertaking work of some kind on men's health.⁴⁰ The Men's Health Forum, which works in England and Wales, is working with Men's Health Forum Scotland and Men's Health Forum Ireland (which covers Northern Ireland as well as the Republic) to promote men's health as widely as possible.

One particularly significant recent development has been the launch, in March 2001, of the All Party Parliamentary Group on Men's Health. This Group, chaired by Dr Howard Stoate MP, has members from all three main parties and has been highly active. The issues it has addressed to date include young men and suicide, prostate disease, alcohol misuse, obesity and sexual health. MPs have also supported Early Day Motions on men's health issues and tabled questions to ministers.

The pharmaceutical industry has recognised the importance of tackling men's health. This is partly due to the industry's commitment to improving public health, not least through health advice and promotion aimed at the general public, and partly due to its search for new market opportunities. It is obvious that if more men can be encouraged to seek treatment sooner for a wide range of conditions this will benefit both men and the companies that produce the drugs that they will be prescribed. Recent breakthroughs in the pharmacological treatment of erectile dysfunction and prostate disease have, of course, also contributed to this process.

Men do care about their health

One of the key lessons of projects that have worked with men effectively is that men are in fact much more interested in their health than has usually been assumed. In the right environment, men are surprisingly willing to talk about their concerns, request information and ask for help. The Impotence Association's telephone helpline is a good example of this: it receives thousands of calls a year from men about what is one of the most difficult health issues for most men to talk about. The very large number of visits to the UK's only comprehensive and dedicated consumer-oriented men's health website, www.malehealth.co.uk, reflects men's willingness to access health information if it is provided in a way with which they feel comfortable.

A recent survey of men's health in Knowsley, based on a sample of 436 men, further contradicts the generally held view that men are not interested in their health.⁴¹ 86 per cent of the men wanted more health information, especially about diet, exercise, testicular cancer and prostate cancer. 62 per cent of the men also felt there was a need for male-specific health services. The Men's Health Forum's Prostate Health Awareness project with Consignia employees also found that an overwhelming majority of male staff welcomed the provision of health information in the workplace.⁴² About three-quarters of the 458 men surveyed said they would be willing to discuss health in the workplace, over 95% felt leaflets and posters should be available in the workplace and about two-thirds reported that they would talk to a nurse at work.

The potential for improvement

The potential for improving men's health is now clear. Men are not doomed by genetics to an early death. The difference in life expectancy at birth – some 9.5 years – between men in social classes 1 and 5 shows the potential for improvement. The difference in life expectancy between different parts of the UK reveals a similar picture: men living in central Glasgow can expect to live for 69 years; men living in East Dorset, for 79 years.⁴³ There is no biological reason why all men should not live at least as long as those in the most affluent social groups. Having said that, however, increasing average male life expectancy to 79 years represents a relatively modest goal given that most men have the biological potential to live well into their 80s or 90s (or beyond).

An historic opportunity

The Men's Health Forum believes that there now exists an historic opportunity to take a decisive leap forward in improving men's health. To achieve this, the government and health providers and practitioners at all levels must implement appropriate policy and practice frameworks which take account of men's particular needs, concerns and experiences. This report, on which the Forum intends to widely consult, suggests what those frameworks could look like. If they are adopted, 'men's health' could soon cease to be a contradiction in terms. The goal must be nothing less than the achievement of optimal health and well-being for all men.

The importance of gender

A new approach is needed

Over the past 30 or so years, women's health advocates have rightly argued, with some considerable success, that women have in general been ill-served by a male-dominated health service and that health policies and practices must change to reflect the specific needs of women. It is now becoming clear that, surprisingly perhaps, men have not benefited from a male-dominated health service either and that they too require a new approach that takes into account the specific needs of their gender.

What is gender?

Gender and sex are different. 'Sex' refers to the biological differences between males and females. 'Gender', on the other hand, refers to the social and cultural meanings assigned to being male or female.

Understanding male gender – or masculinity (in fact, 'masculinities' is the term now used by many sociologists to take into account differences between different groups of men) – is crucial to understanding men's health. It helps to explain, for instance, why so many men take risks with their health – because risk-taking is one way males are brought up to prove their maleness to each other and themselves. It helps to explain why men are often reluctant to seek help – because help-seeking is widely interpreted as a sign of weakness whereas males are 'supposed' to be strong and always in control.

There is also evidence that men's relationship with their own bodies affects their health attitudes and behaviour.⁴⁵ Men expect their bodies to be capable of doing 'manly' things and not to be weak or vulnerable. Many also perceive their bodies as mechanical objects and see health care as 'fix-it' cure and use analogies such as going to the plumber to fix a leaking tap or a garage to get the car repaired.

Understanding male gender can help the development of more appropriate services for men. For example, because men are not 'allowed' to reveal weakness publicly, providing them with the means of accessing health information anonymously and confidentially (e.g. via telephone helplines or websites) might prove useful to many. Health promotion materials that use the metaphor of body as machine could also be more appealing to many men. It is clear that health services cannot meet men's needs by simply opening the doors of traditional services, especially primary care, and expecting them to walk through. A different approach is needed.

The male role

The Men's Health Forum believes that, despite recent social and economic changes in the roles of men and women, traditional attitudes towards gender remain surprisingly and stubbornly prevalent. Boys and young men continue to be socialised to be tough and strong, to appear in control and to take risks. This creates obvious dangers – with respect to dangerous driving, for instance, or alcohol misuse – and makes it harder for males to ask for help with any kind of physical or emotional health problem. Men often believe that their role is to 'tough out' illness for as long as possible rather than admit to what feels like a 'weakness'. The importance attached to being 'rational' also makes many men feel disconnected from their bodies and their physical needs. Men often speak about their bodies as if they were machines and think about illness in terms of the failure of a particular body part.

An analysis of sex, gender and health in the men's health issue of the *BMJ* in 2001 examined some of the links between male gender and ill-health. It suggested that 'the development and maintenance of a heterosexual male identity usually requires the taking of risks that are seriously hazardous to health.'⁴⁶ An obvious example of such risks come from employment – men are at high risk of dying prematurely from occupational accidents or diseases – but men are also at particular risk through violence, traffic accidents and dangerous sports. The need to be seen as 'hard' also has implications for men's mental health, preventing men from taking health promotion messages seriously and inhibiting them from seeing a doctor when problems arise. The article argued that 'greater sensitivity to sex and gender is needed in medical research, service delivery, and wider social policies.'

It is important to understand that male gender roles are neither a product of biology (in other words, they are not inevitable) nor an identity that men as individuals can easily choose to adopt or discard. Male gender roles are primarily socially and culturally determined and, because they have existed for a very long time, difficult to change. This means that, to work effectively with men, health policymakers and practitioners must improve their understanding of male gender roles and seek to develop and deliver services that are aimed at men as they are and not as some might wish them to be.

The importance of developing a new understanding of gender and health that includes both men's and women's

health needs was reflected in a recent World Health Organisation seminar on Gender Mainstreaming Health Policies in Europe. The seminar, attended by delegates from 28 European countries, agreed that: 'Mainstreaming gender in health is recognised as the most effective strategy to achieve gender equity. This promotes the integration of gender concerns into the formulation, monitoring and analysis of policies, programmes and projects, with the objective of ensuring that men and women achieve the highest health status.'⁴⁶

Comparing men's and women's health – a help or a hindrance?

The Men's Health Forum believes that one consequence of the new understanding of the importance of a gender-based approach to health is that it is important not to compare directly men's health and women's health.

In the 1990s, when the Men's Health Forum and other men's health advocates were making the case for men's health to be taken more seriously, they often suggested that a key indicator of men's poor health was that they died, on average, five years younger than women or that more money was spent on cervical cancer research than prostate cancer research. Such comparisons are now generally seen as unhelpful:

- They imply that there are no inherent biological differences between men and women. In fact, there are plausible genetic explanations for women's greater longevity.
- They can suggest that women's health is the 'gold standard' against which men's health must be measured. In fact, women's health is far from a 'gold standard' – women have at least as many unmet health needs as men.
- They can obscure health inequalities between men related to social class, ethnicity and sexuality.
- They can easily lead to a competition for resources between men's and women's health projects. The reality is that resources are needed for the development of better health services for men *and* women.
- They can create a competition between men and women about which sex is the bigger 'victim'. This is not only divisive it is politically dangerous – it can play into the hands of so-called 'men's rights' advocates, misogynists who believe that men are in fact the oppressed sex and that traditional gender roles should be re-established.

Men's and women's health issues are, in fact, closely intertwined, at least for heterosexual men and women. It is obvious that a woman in a relationship with a man with prostate cancer, or a man in a relationship with a woman with cervical cancer, is likely to suffer poorer mental and physical health because of the inevitable anxiety and stress. Men and women can pass sexually transmitted infections to one another and unprotected sex can result in unwanted pregnancies. There is also evidence that men in relationships with women generally experience better health than single men; women in relationships with men, on the other hand, tend to experience poorer health than single women. It seems reasonable to conclude that improvements in men's health – and men taking greater responsibility for their own health – will improve women's health. Better women's health is also likely to be good for men.

Tackling men's health effectively

New policies are needed

The Men's Health Forum recommends:

- Health policies at all levels must become more 'gender sensitive' and, specifically, include men's health. The issue should be highlighted in all national, strategic health plans and policies.
- The Department of Health should follow the example set by the Irish Government's Department of Health and Children and establish a national men's health policy. (The Irish men's health policy is expected to be in place by 2003.)
- The Department of Health should, as a first step, establish a Men's Health Development Group (MHDG) that includes members from a wide range of disciplines and organisations with an interest in men's health. (The establishment of such a Group was in fact mooted by the Department in 2000 but the idea appears to have been shelved.) The MHDG will need to review what is known about men's health problems and how to tackle them. This will include an examination of issues beyond the traditional remit of the Department of Health, such as occupational health and safety, working hours and transport policy. The MHDG will have to pay particular attention to the mechanisms that will be needed to turn policy into practice. One thing is clear: it will not be enough simply to tell primary care trusts and other health services that they must pay more attention to men's health.
- Unless there are clear and obvious reasons for not doing so, every health policy document produced by the Department of Health must include a gender dimension that covers men's health as a specific issue. Men's health must become as obvious a subject for inclusion as the health of minority ethnic communities or the health of socially disadvantaged groups. The Department of Health's National Suicide Prevention Strategy for England, published in April 2002, is one of the few policy documents to take the male health dimension into account. Although it needs to go further in this direction, in many ways this report provides a model for how a much broader range of health issues should be addressed.
- There should be a process whereby the potential impact of all health policy and decision-making on men is evaluated to ensure that their needs are not sidelined and, indeed, that they are at the centre of policy-making. The Government has adopted a similar model (known as 'rural proofing') to ensure that rural issues are taken fully into account and that an urban perspective does not dominate policy-making.
- Targets must be set for the achievement of key men's health goals. There will need to be further discussion about which health areas should have targets and what they should be, but they could include suicide, cardiovascular disease, traffic accidents, obesity levels, smoking and alcohol consumption. In many cases, targets for men could be derived from the targets already set for the general population.
- Health Improvement and Modernisation Programmes must be required to address men's health issues. Gender as a determinant of health has been overlooked by the vast majority of the Health Improvement Programmes established by health authorities before April 2002. The Health Improvement Programme for men established by Worcestershire Health Authority in 2000 is a clear demonstration of how policy initiatives at this level can make a direct impact on the development of services.
- Health Action Zones (HAZs), Education Action Zones, Neighbourhood Renewal, Healthy Living Centres and Local Strategic Partnerships should have a role in developing partnership approaches

to tackling men's health problems. The new strategic health authorities can also take a lead in ensuring that men's health is part of the health inequalities agenda.

- Primary care trusts should be required to complete an assessment of men's health needs as part of their health inequalities work. Each primary care trust should also be required to appoint someone with specific responsibility for men's health (although this need not be a full-time job in itself).
- Local authorities should be encouraged to address men's health issues. As providers of leisure, education, housing, environmental and social services, they have a potentially enormous role to play in developing health initiatives for men, especially those in disadvantaged groups. The Department of Health should inform local authorities of the importance of addressing men's health issues and suggest appropriate initiatives for local implementation.
- Training must be provided for health professionals on men's health issues. Because men's health is a relatively new area of work, there is currently a dearth of knowledge, skills and experience at all levels. Training is particularly needed on how to identify men's health needs at the local level and how to design and deliver effective services for men. The Men's Health Forum receives a growing number of requests from health organisations for information and training in these areas and, indeed, the Forum is launching its own training programme in the autumn of 2002. The demand for training over the next few years is likely to overwhelm the resources of a single voluntary organisation, however. In the longer-term, training in men's health must become part of the core curriculum of initial training for doctors, nurses and health promotion specialists. There is also a separate requirement for improved clinical training on specific issues affecting men, such as ED and prostate disease.
- The restrictions on GP prescribing of NHS treatments for ED must be lifted. There is also a need for greater resources for the treatment of all sexual dysfunctions, including the provision of more sexual counselling/therapy for men and their partners. This would enable the implementation of what is now known to be best practice in the treatment of these conditions.

Restrictions on GP prescribing of NHS treatments for erectile dysfunction

The Department of Health reviewed its policy on GP prescribing of NHS ED treatments in 2001 and decided, against the advice of the majority of those consulted, that it would continue to restrict the ability of GPs to prescribe NHS ED drug treatments of any sort to men whose ED is not caused by a specified problem. This means that men whose ED is caused by depression or cardiovascular disease, for example, are excluded from treatment.

The Men's Health Forum believes that these restrictions:

- Are arbitrary and illogical. There is no obvious reason why a man whose ED is caused by cardiovascular disease should be denied treatment while a man whose ED is caused by diabetes should be able to receive it.
- Imply that ED is not a serious problem. In fact, ED often has a severe impact on the quality of men's lives. Impotence Association research shows that 65 per cent of men with ED say that their condition makes them feel worried or anxious; 56 per cent say it makes them feel depressed. ED can also cause relationship difficulties.
- Reinforce health inequalities. It is well-known that the incidence of ED is correlated with socio-economic status – basically, the lower a man's income, the more likely he is to develop ED. There is also a clear and similar link between social class and cardiovascular disease, one of the main causes of ED. However,

men with low incomes who are not entitled to NHS treatment from their GP are least likely to be able to afford a private prescription.

- Are unlikely to be understood by many men. This, in turn, will deter a substantial number from seeking treatment, even if they are currently entitled to it. This is a serious problem because ED is often a symptom of an as-yet undiagnosed condition and, at present, only about one in 10 of the estimated 2.3 million men in the UK with ED actually receives treatment.
- Can affect women's health. The partners of men with ED can suffer from stress, loss of self-esteem, anxiety and depression.

The Men's Health Forum considers that the prescribing restrictions directly contradict the Department of Health's approach to sexual health, as stated in the national strategy, and its repeatedly stated intention to tackle health inequalities. The Forum believes that GPs should be able to prescribe NHS ED treatments as they see clinically fit.

Health services must become more attractive and accessible to men ***The Men's Health Forum recommends:***

- Primary care services should open for longer, extending access to services into the evenings and weekends. Services should also attempt to create a more male-friendly environment, e.g. by displaying male-interest magazines and men's health posters and leaflets.
- Men's access to appropriate confidential and anonymous sources of health information, including telephone helplines and the Internet, should be increased. The experience of the Impotence Association helpline and the malehealth.co.uk website suggests that men will use these types of services in relatively large numbers. (Even without significant publicity, the malehealth website recorded almost two million hits in its first year.) They can provide important and useful advice and information and help men to feel more comfortable about taking the next step of accessing primary care.
- More primary care services should be provided outside of the traditional primary care setting. One recent innovation is the outreach clinic specifically aimed at men. These have been set up in pubs, barbers' shops, sporting venues and elsewhere. The format is normally that basic health checks and advice are provided by practice nurses or health visitors in a male-friendly environment. The evidence available suggests that outreach clinics are popular, detect potentially serious diseases (e.g. diabetes and hypertension) and result in more men seeing a GP.
- The new NHS Walk-In Centres are a potentially important new service for men, not least because of their extended opening hours, and they should be encouraged to target this group and evaluate their effectiveness.
- There should be more points of access to health care for men seeking help for a sexual dysfunction. Men are very reluctant to access primary care yet there is currently just one direct-access secondary care sexual dysfunctions clinic in the UK. The introduction of direct-access sexual health clinics which treat sexual dysfunctions, alongside other sexual health problems, could well make a difference. The Department of Health plans to fund three 'one-stop' sexual health clinics to evaluate their impact on sexual health.⁴⁷ The Men's Health Forum hopes that these clinics will cover sexual dysfunctions and that they will actively promote their services to men.

- There is a need for a diverse range of sexual health services for men, including primary and direct-access secondary care (GUM and 'one-stop' clinics), family planning clinics, telephone helplines and websites. The possibilities for taking services directly to men at the workplace and other sites where men may feel more comfortable about seeking advice and information (e.g. sports venues, pubs and barbers' shops) should also be investigated.
- Delays in accessing GUM services need to be tackled as a matter of urgency. There is also a need to market GUM services more effectively and proactively to men so that there is wider knowledge of what is available and a dispelling of myths (particularly about some of the STI diagnostic tests). The Men's Health Forum also recommends a change of name – 'Genito-Urinary Medicine' is a medical term not readily understood by many.
- Pharmacy services should be developed as a source of advice, information and self-treatment for men. Men under-use pharmacies even though they are potentially the kind of service men are more likely to use: they are anonymous and relatively easily accessible. However, most pharmacies do not allocate space for confidential consultations and their product displays often give the impression that they are a service primarily for women.

Are well man clinics the answer?

Well man clinics are often proposed as a significant part of the solution to men's health problems.⁴⁸ However, the experience of many in primary care who attempted to establish such clinics, especially in the early 1990s when NHS funding arrangements encouraged this sort of initiative, has been rather negative: men simply have not turned up in sufficient numbers and services have eventually been withdrawn.

The failure of many well man clinics is not surprising given men's general reluctance to attend primary care, especially for health check-ups. Further, many well man clinics have been accessible only during the working day, clearly not the most promising time for men who work 'normal' hours. It is possible that the very name ('well man') is off-putting to many men, perhaps suggesting that such clinics are aimed at men who are already healthy rather than for those who might have health concerns. Overall, it seems that a service based on a concept that works for women ('well women' clinics) is not appropriate for all men.

However, there are a few examples of well man clinics that seem to have been much more effective. Open for Men in south London provides an accessible service on Friday evenings from a site separate from primary care. It sees significant numbers of men on either an appointment or drop-in basis and offers both general health checks and advice on specific problems. Men using the service can see either a nurse or a doctor.

It seems that although well man clinics will probably never be a major part of the solution to men's health problems, if appropriately designed and delivered they may well have a useful role as one part of a range of services targeted at men.⁴⁹

Health services must target specific groups of men**The Men's Health Forum recommends:**

- Men must not be treated as a homogenous group by policymakers or service providers. While paying greater attention to men's health in general would be a welcome improvement on the current situation, it is clear that specific groups of men require specific interventions. Improving the health of older men requires a different approach from that aimed at young men, for instance. Tackling gay men's sexual health issues requires interventions that would not appeal to most heterosexual men. Health interventions that work with white men may not be effective with black and minority ethnic men. Health providers and policymakers must become sensitive to

the needs, concerns and experiences of these (and other) groups of men.

- There is a clear need for the development of a national strategy specifically on the health of black and minority ethnic (BME) men. This is necessary because while men in general have difficulties accessing services, the problem is far greater for BME men. Such a strategy must also take into account that BME men are not a homogenous group and that they are differentiated by ethnicity, age, social class and sexuality. The national strategy for BME men should be developed through a process of genuine community consultation that assesses needs, raises awareness and achieves sustained and equitable provision of appropriate services.

The health needs of black and minority ethnic men

The UK's black and minority ethnic (BME) male population is obviously smaller than the white male population but is growing faster and therefore likely to make increasing demands on health services. The BME male population is younger than the white population and more likely to be living on low incomes. This population is also affected by racism, whether direct or indirect, from the general population and health and other public services.

The 1999 Health Survey for England⁵⁰, the most extensive survey ever conducted on the health of the UK's black and minority ethnic communities, highlighted some of the key inequalities facing BME men:

- Indian, Bangladeshi and Irish men reported higher rates of ischaemic heart disease. In fact all men (with the exception of the Chinese) showed higher rates for heart attack than the general population.
- Higher rates of stroke in Black Caribbean and Indian men – over two thirds higher than the general population.
- The South Asian communities in general had higher rates of diabetes with Black Caribbean and Indian men being particularly vulnerable.
- Bangladeshi men are the least likely to eat fresh fruit and Pakistani men are the least likely to eat fresh vegetables.
- South Asian and Chinese men are least likely to participate in physical activity.
- Bangladeshi men are nearly twice as likely to smoke as men in the general population and smoking rates are also higher among Irish and Black Caribbean men.
- All men from BME communities are less likely than the general population to visit the dentist regularly.

Black Caribbean men are also thought to be at significantly higher risk of prostate cancer than white men, although this is an under-researched area in the UK.⁵¹

There are significant barriers to accessing secondary mental health care and even greater problems around the identification of mental health symptoms within primary care. Anecdotal evidence exists that when young men, in particular, do access secondary services they leave treatment early.⁵² Black men are also more likely than white men to be diagnosed with a mental illness and are over-represented in psychiatric institutions.⁵³

Research conducted by the Centre for Ethnicity and Health around drug and mental health services has found that services are often seen to be culturally inappropriate – factors such as location, language barriers, a lack of staff from black and minority ethnic communities and a lack of staff with the awareness of the specific cultural and

religious needs of clients are all symptomatic of institutional racism. This is arguably one of the greatest barriers to equitable service design, development and delivery.⁵⁴

There is also a lack of awareness and sometimes denial, stigma and shame within some communities. For example, in the Pakistani Muslim community, there is a cultural resistance to help-seeking behaviour.⁵⁵ These factors also have to be addressed in order to improve the health of the BME population in general and BME men in particular.

Working with Asian men in West Yorkshire

The health promotion service has actively targeted the male Asian population with work on heart disease and diabetes after undertaking a needs assessment of the young male population in the area and a review of health services. This showed that Asian men were particularly poor users of local services.

The health promotion service has established a strong working relationship with a local community centre and has worked with various groups of Asian men. The service operates an annual health event aimed at Asian men, with formal information giving through displays and stalls and informal talk time. The event attracted over 300 men in 2001. Health promotion also operates drop-in services which now have over 40% of their attendees from the Asian community.

This development work has led to stronger links with other organisations that work with Asian men and work with Asian men being incorporated into other work areas covered by the health promotion service, such as school-based activities on sex education and lifestyle issues, the local 'Walking for Health' programme, monthly New Deal sessions (looking at risk taking), heart health and general health and well-being.

- Gay men's health issues must be seen as much broader than HIV/AIDS or sexual health in general. In particular, it is vital to actively tackle homophobia in health services and the discrimination, prejudice and inappropriateness it engenders. The visibility of gay men as health service users must be raised – positive images of gay men can help build confidence in a service being gay-friendly. Confidentiality must be guaranteed so that gay men feel more comfortable about coming out in situations where sexuality may be a relevant factor. Improved training and development for staff is needed to enable them to understand homophobia and its impact and to improve the delivery of services to gay men. Health services should also undertake more joint work with specialist lesbian and gay organisations – sometimes these are better equipped to deal with particular situations, protocols can be developed for joint work and referral and they may be able to provide training.

The health needs of gay men

Estimates of the prevalence of homosexual activity between men in the population vary from 1–6%. Not all men who have sex with men would identify as gay with a proportion leading outwardly heterosexual lives but having sexual contact with other men. Gay men are no more prone to illness or mental and emotional distress than any other men; the difference is the influence of social factors in a world which still regards gay sexuality as 'not as good' and puts obstacles in the way of achieving health and well-being. Inequality continues to be enshrined in legislation in the form of the notorious Section 28 (which prevents local government from dealing positively with the issue) and the age of consent has only recently been equalised.

Young gay men grow up in a hostile environment where 'gay' is still a term of abuse. Homophobic bullying in school is commonplace with one study finding that almost three quarters of young lesbians and gay men having played truant or feigned illness to avoid homophobic abuse.^{lvi} Some people experience severe mistreatment including rejection by family and homelessness. Problems also arise from the internalisation of negative messages. These include low self-esteem, drug and alcohol problems, self-harm, depression and attempted suicide, which is

higher than among young heterosexuals. People who do not disclose their sexual identity suffer the stresses and psychological damage of leading a 'double' life.

When gay men have sought help with these problems they have often been mistreated by the range of professionals from GPs through to counsellors and psychiatrists who often see their homosexuality as 'a problem'. For this reason, many gay men, particularly when young, would rather access voluntary and community services which cater exclusively for this group.

Gay men continue to be the population group most severely affected by HIV, accounting for around 70% of cases. It has been estimated that a gay man is 48 times more likely to contract the virus than his heterosexual counterpart. Rates of other sexually transmitted infections, particularly gonorrhoea, are high, and there have been outbreaks of syphilis in several urban areas. While there has been a massive community response to HIV particularly, consistent rates of infection show that gay men continue to put themselves at risk. The reasons for this are complex but factors such as low self-esteem, difficulties in forming relationships, perceptions of risk based on masculinity and low educational attainment all play a part.

The arrival of HIV in the 1980s saw a growth in projects specialising in HIV prevention. Much of the early work focused on health information and the distribution of condoms. In time, the gay men's health sector has come to realise that this individualistic approach is insufficient to bring about health improvement. Current initiatives take a broader view, addressing the wider determinants of health as well as the impact of these on the individual. However, despite a new emphasis on inequality and social exclusion in health policy, gay men's health rarely appears on the mainstream agenda. Gay men's health initiatives have been funded from ring-fenced HIV prevention monies in England but, with the mainstreaming of the budgets from April 2002, there is an urgent need to integrate the issue as a priority in Health Improvement and Modernisation Programmes.

In terms of generic health services, gay men have often been reluctant to access these when sexuality may be a relevant factor. In the early days of the HIV epidemic, gay men were happy to use GUM clinics for HIV testing and management because of their non-judgemental attitude and strict adherence to confidentiality. Many gay men are particularly reluctant to use primary care services because of concerns about a lack of awareness of gay issues.

- Young men have specific health issues and needs and, moreover, should not be viewed as a homogenous group. Issues such as ethnicity, social class, disability and sexuality all need to be taken into account when considering effective ways of working with this group. Young men are particularly affected by high accident rates, smoking, alcohol and drug misuse, sexual health, mental health problems and suicide. The Young People's Health Network, based within the National Healthy School Standard programme at the Health Development Agency, held a major conference on young men's health in March 2000. (The Men's Health Forum was one of the official sponsors of this event.) The delegates, most of whom worked with young men, produced a list of recommendations which suggested how to work effectively with young men. These included⁵⁷:
 - creating safe, confidential and appropriate environments which will encourage young men to talk
 - employing more designated male workers in projects
 - introducing more training for professionals, particularly for medical professionals, in order that they can engage more successfully with young men
 - enabling teachers to adapt their practice to take account of boys' preferred learning methods
 - consulting with young men about their needs
 - building young men's self esteem from an early age
 - encouraging young men to take responsibility for their health

- ending the 'problematizing' of young men and developing positive frameworks for the work planned for them
- taking masculinity into account when planning work with boys and young men – work used successfully with young women will not always translate successfully when used with young men
- introducing more services specifically for young men – these need to be accessible, informal, flexible and attractive (e.g. attaching a free gym to a family planning clinic)

The Men's Health Forum endorses these recommendations and welcomes the Health Development Agency's continuing involvement in this area, including the publication of reports on the health of young men and boys. These represent a major contribution to this area of work.

Young men and suicide

The Forum's research on young men and suicide⁵⁸ suggests that traditional suicide prevention work has been largely ineffective because it has failed to understand why young men are more likely to kill themselves and to design services accordingly.

In general, suicide prevention work has been based on an assumption that those at risk can be identified when they attend primary care or other local mental health services, such as counselling. However, young men are very poor voluntary users of such services. They are reluctant to ask for help and, for many, acknowledging their personal problems contradicts their sense of what it means to be a man.

Suicide prevention initiatives that have been more successful in their work with young men have been underpinned by an understanding of gender and its impact on young men's attitudes and behaviour. Dorset Health Authority's work, based on this approach, has succeeded in reducing the number of suicides among young men. This was achieved, in part, by developing multi-agency, town-centre based, drop-in services for young people and by an intensive campaign to encourage young people in emotional distress to make use of the confidential and anonymous services provided by the Samaritans.⁵⁹

CALM (Campaign Against Living Miserably) is another important example of effective work with young men at risk of suicide. It is a telephone helpline for young men which operates services in Cumbria, Manchester, Merseyside and Bedfordshire. Each individual helpline offers a counselling and information service that aims to work with young men on solving their individual problems before they get to the point of depression. CALM will often refer on individual cases to local GPs, Citizens Advice Bureaux and counselling agencies for the individual to receive on-going support with their problem. CALM also campaigns to raise awareness of – and to de-stigmatise – depression.

CALM has been successful in making its service approachable and attractive to the target group of young men by using marketing approaches that young men find appealing and which links into their particular culture. CALM has used designs, commissioned from a highly-regarded national advertising agency, that reflect youth culture and contain images and language that young men might expect to see on CD covers, club flyers or in men's magazines. These designs have been used on posters and flyers that are distributed to pubs, clubs and sporting venues where young men are likely to be as well as used in advertising on pizza boxes.

As young men are highly sensitive to branding and marketing tools aimed at them it is highly significant that this marketing campaign has been successful in reaching its audience and that the men have keyed into the services on offer. The success of this approach has been highlighted in a recent evaluation.

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- Older men's health and well-being must no longer be overlooked. The assumption often made is that because male life expectancy is relatively short, men do not experience health problems

related to old age. Nothing could be further from the truth. Older men clearly have a range of specific concerns and needs. The loss of social networks as men retire and move out of the workplace, for example, can have wide-ranging impact on health and is often a cause of depression in older men who no longer feel that they have a role or that the experience and skills that they have built up over a lifetime are still useful. The death of a partner can also have a significant impact on men, not least because they often lack some of the essential life skills required to maintain basic well-being, such as cooking. Further work is needed to identify the particular issues and concerns of older men and to enable health promoters and health service providers to work effectively with this group.

Health services must actively seek out men

The Men's Health Forum recommends:

- A more imaginative approach to providing accessible men's outreach health services must be developed. Services in pubs, barbers' shops, the workplace and at sporting venues appear to have considerable potential for reaching a much wider constituency of men.
- There is a need for improved funding for such services at all levels to broaden the range of projects available and to facilitate the development of good practice through proper evaluation.

Outreach initiatives with men

Men's pub clinics have generated considerable professional and media interest. One such initiative, established in Walsall in 1997, was developed by a practice nurse who had tried and failed to get men to attend a 'well man' clinic based in a primary care clinic.⁶⁰ The experience of the first pub clinics in Walsall could not have been more different: over 100 men attended in three days and, of those seen, almost three-quarters had one or more previously undiagnosed long-term health risk problem. These included blood pressures with diastolic readings over 100, BMIs over 34, cholesterol readings over 7.6, blood sugar readings over 10, alcohol intake over 150 units a week, drug problems, smoking-related disorders and depression.

Another innovative approach is the Harley Health Checks, where a nurse offers free health checks to men at the Harley-Davidson Garage in Wolverhampton. This project has managed to reach a group of men not known for their use of traditional health services. The health checks are held at the Garage during their open weekend, which is a major attraction for the bike enthusiasts in the region and attracts large numbers. The health checks are offered in the form of personal MOT and take around 15-20 minutes, including discussion time for testicular, prostate and bowel awareness. During a recent open weekend, a majority of those seen (65%) failed their MOT with one or more long-term health risk problems and 34% failed with two or more long-term health risk problems. Other issues raised by men included difficulties in getting GPs to take their health worries seriously, in particular where mental health was concerned. Several men discussed feeling low and depressed but felt there was no one for them to turn to.

Worcestershire Health Authority and Bovis co-operated to run health checks for male contract construction workers as part of European Health and Safety Week in 2001.⁶¹ Out of 200 workers, 89 men signed up for a free, confidential health check. As expected, the health check revealed many problems related to smoking, drinking and diet but none of the health professionals was prepared for the depth, complexity and range of issues the men chose to discuss. Many reported high levels of stress and relationship worries related to living away from partners and children. Mental health concerns were also highlighted and some men showed signs of clinical depression. The opportunity to talk on a private, one-to-one basis allowed one man to discuss, for the first time, his feelings about a bereavement suffered some time before.

The 'Keeping It Up Challenge' run by Healthworks, Dorset Health Authority's health promotion agency, is another good example of a successful workplace health initiative with men.⁶² Here, teams of eight men from different

workplaces compete in a league where points are awarded for reductions in body fat. The overall aim of the initiative is to reduce men's risk of developing cardiovascular disease. The competition takes place over a fixed period (3-6 months) and team membership is restricted to men aged between 40 and 55 whose body mass index is over 25 (i.e. they are clinically overweight or obese). The body fat of each team member is measured monthly and points awarded for the team's aggregate reduction. Again, the indications are that this type of health promotion initiative produces positive outcomes: almost three-quarters of participants in the Keeping It Up Challenge reduced their BMI over the duration of the campaign and over half increased their physical fitness. A follow-up survey eight months after the completion of the programme also showed that a majority of respondents had maintained or improved their weight loss.

The experience of successful outreach initiatives of this sort strongly suggests that the stereotyped assumption that men are neither interested in their health nor willing to use health services is not correct. It seems that if a service is provided in the right environment and in an appropriate format then many men are likely to make use of it. One problem, however, is that outreach initiatives with men remain few in number, are almost always small-scale and short-lived, and are seldom independently evaluated. It has proved difficult, therefore, to develop a body of good practice that practitioners can draw on with confidence to develop their own projects.

Health promotion initiatives specifically aimed at men are required ***The Men's Health Forum recommends:***

- There is an urgent need for more health promotion initiatives that are specifically targeted at men rather than based on the traditional population-wide approach. The Men's Health Forum's prostate health awareness-raising campaign in the workplace (run in partnership with Consignia) shows the potential for this approach.⁶³ Even relatively simple health promotion interventions produced a significant increase in symptom awareness.
- Targeted interventions are needed to tackle men's risk-taking behaviours such as excessive drinking, smoking, eating a high-fat diet and dangerous driving.
- The idea that it is possible to tackle men's health problems just by health promotion initiatives aimed at women should be abandoned. There is no evidence that this approach is effective and it is based on an outdated concept of gender roles. It also stems from the defeatist belief that men will not take more responsibility for their own health.

Women are not the solution to men's health problems

Many health promotion initiatives have attempted to improve men's health via women. The assumption is that women can encourage men to eat healthier food, drink less alcohol and go to the doctor when worrying symptoms appear. While it is undoubtedly true that men in relationships with women experience better health than single men, this is not a viable health promotion strategy for men:

- It does nothing to encourage men to take greater responsibility for their own health.
 - It places an additional burden on women and is based on an outdated view of male and female roles in the home.
 - It ignores the fact that many men are not in relationships with women. They may be single, divorced/separated, widowed or gay. One in 10 35-44 year old men currently lives alone, as does one in five men aged 65 or over.⁶⁴ It is predicted that by 2016, well over one in five of all men will be living alone.⁶⁵
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- National and sustained publicly-funded health promotion programmes for men on sexual dysfunctions, STIs and prostate health are urgently needed. Many men lack information about these problems – it is still common, for example, for men to believe that ED or ‘waterworks problems’ are simply caused by the ageing process. The Men’s Health Forum and the Impotence Association have for the last two years been running a public awareness campaign on ED but this is no substitute for the sustained and comprehensive programme that is required.

Prostate disease

Most men know very little about prostate disease. According to a MORI poll published in 2001 on behalf of the Prostate Cancer Charity, only 12% of men knew what the prostate gland does and 20% wrongly believed that it is located in the testes.⁶⁶ A recent small-scale study of 15-17 year old male school students in Cheshire found that they knew nothing about the prostate and its function.⁶⁷ The Men’s Prostate Health Project at the University of Wolverhampton, which conducted a study of 565 men with benign prostate disease, concluded that ‘there is very great widespread ignorance about BPH and prostatitis’.⁶⁸ It is still common for men to believe that ‘waterworks’ problems are a consequence of ageing rather than a possible symptom of an underlying disease.

Even when men have been diagnosed, they often still feel under-informed. The Prostate Cancer Charity states: ‘We often encounter men who have been diagnosed with BPH or prostatitis seeking information through our Helpline. This indicates that perhaps it is difficult for them to find specific information sources for non-cancerous conditions and that there may be confusion about the difference’.⁶⁹

To date, there has been no national health promotion campaign on benign prostate disease led by the Department of Health or other public health organisations. The campaigns that have been run have been relatively small-scale and initiated by the pharmaceutical industry or the voluntary sector.

Research by the Men’s Prostate Health Project suggests there is a need for much better patient information about benign prostate disease. Men and their families could benefit from good quality information on a wide range of areas, including diagnosis, symptoms, treatment and intervention options (and their possible side-effects), the likely course of conditions, available services (both inside and outside the NHS) and other men’s experiences of the conditions.⁷⁰

Men’s health research must be a priority**The Men’s Health Forum recommends:**

- It is vital that health research increasingly takes gender into account. Where the population analysed includes men and women, wherever possible, the findings should be broken down by sex. This is as important as findings stratified by age, social class or ethnicity. Even more importantly, an understanding of gender should inform research. For instance, a study of patterns of alcohol consumption might investigate whether masculinity has any impact on drinking. One research issue could be whether men who are most strongly ‘sex-typed’ (i.e. they conform closely with the traditional male gender role) tend to consume alcohol at higher levels.
- There must be greater investment in clinical research into specific under-researched areas of male health (including prostate disease).
- Research into effective health promotion work with men should be encouraged. The Health Development Agency has made a good start with its recent work on young men. This approach should be replicated with a wide variety of other groups, including older men, black and minority ethnic men and ‘hard-to-reach’ men.

- Research in men's health policy and practice must be more effectively disseminated. The creation of accessible online databases would help enormously. The Health Development Agency could play an important role here.
- Men's health – and gender in general – should be included in the Department of Health's research and development agenda.
- Research and development work at all levels must involve 'ordinary' men. It is essential that men (who can speak about their experiences and needs as men) are brought into the process of policy and practice development, especially at the community level. The establishment of Patients' Forums and the Commission for Patient and Public Involvement will also provide opportunities to consult with men at different levels.

The need for prostate health research

The Department of Health is now funding much-needed research into the best treatments for prostate cancer and the merits of screening. In the meantime, however, asymptomatic men and their doctors still do not know whether or not screening is useful and men with localised prostate cancer do not know which treatment is most likely to ensure their long-term survival. It is not even clear whether no treatment at all (the so-called 'watchful waiting' option) is better or worse than radiotherapy or surgery.

Prostatitis is another chronically under-researched prostate problem. Although prostatitis covers a range of conditions, it is most commonly an inflammation of the prostate gland with symptoms that may include fever, pain in the pelvic region and urinary problems. Despite being little known by men, it is a relatively common condition. The chronic form of prostatitis alone affects 9-14% of men worldwide.⁷¹ Prostatitis in general accounts for almost one-quarter of all consultations with urologists in the UK⁷² The disease most often affects men aged 30-50 but men of any age can develop it. Many cases become chronic and can be very painful or debilitating.

The causes of prostatitis are not fully understood and it is notoriously difficult to treat effectively; many men with the condition are described as 'heart-sink' patients by their doctors – in other words, they keep returning to their doctor for help but the doctor eventually runs out of treatment options. A leading urologist has commented that 'this disease is still largely a conundrum and more work needs to be done to define more precisely the causes and the treatments that are effective in this chronic and sometimes disabling condition'.⁷³ Very little progress has been made in the management of prostatitis over the past several decades and treatment is often ineffective.

Men's awareness of their health needs must be improved

The Men's Health Forum recommends:

- Parenting and childcare information must address bringing up boys. To enable boys to become more 'emotionally literate', for example, it is important for parents to encourage their sons' emotional expressiveness rather than attempt to repress it. Many parents also need more information and support to enable them to talk to their sons about their physical development during puberty and beyond.
- Teacher education and training should also address this issue. Teachers must understand masculinity and how to encourage boys and young men to develop greater emotional and health awareness.
- Men should be encouraged and enabled to become involved fathers. This is an important public policy objective in its own right. It could also produce significant health benefits for men, not least because active parenting can bring men more into contact with health services (midwives, health visitors and GPs). This could help men to understand better how the health system works

and make using it seem more normal.

- School-based initiatives that encourage boys to take a greater interest in health and health-related issues should be introduced. The Orchid Cancer Appeal has recently launched a testicular cancer awareness initiative aimed at school students that uses a video containing contributions from male role models. There is enormous potential for similar projects on a wide range of men's health issues. The National Healthy Schools Standard scheme could provide one platform for good quality work with boys and young men.
- There must be a significant improvement in the delivery of sex education for boys in schools. Boys' experience of school sex and relationship education (SRE) tends to be that it is too little, too late and too biological.⁷⁴ The bias is towards female reproduction, homosexuality is not addressed and sex education is mostly taught by women teachers. Boys too often end up feeling disengaged and that sex, relationships and contraception are a 'girl's issue'.
- Homophobia and sexism must be challenged. Traditional gender roles are held in place by homophobia and sexism – these ideologies determine the boundaries for what is considered acceptable and normal male behaviour. The potential for work in schools in particular to tackle homophobia and sexism is enormous. This could make boys and men feel more comfortable about admitting their health problems and asking for help.
- National Men's Health Week must be developed as a key awareness-raising tool. The Week will be launched by the Men's Health Forum in June 2002 and would benefit greatly from the active support of the Department of Health and other major health agencies.
- Men's health advocates must be encouraged at every level – community, local, regional and national – in order to lobby and campaign for improvements to men's health policy and services and to act as men's health 'champions' for 'ordinary' men. The current dearth of such advocates reduces the pressure on policy-makers and service providers to take men's needs into account and inhibits 'ordinary' men from demanding better healthcare. Such advocates could be supported by community- or workplace-based initiatives that seek to raise the profile of men's health. The Men's Health Forum's Prostate Health Awareness project with Consignia employees found that one important spin-off was a new interest among local Communication Workers Union shop stewards in seeking to raise men's health issues more widely within the Union.
- The introduction of the male-friendly policies and practices contained throughout this report would help to encourage men to see health as a much more 'normal' activity rather than as something that is primarily for women and children. If implemented, they would lead to a radical improvement in men's health at every level – that would not only mean that men would lead healthier and happier lives but that women and society as a whole would also benefit.

Conclusion

Men's health is in urgent need of attention. Men in England and Wales may not suffer problems on a scale that compares to men in much of eastern Europe or Africa – parts of the world where it is entirely legitimate to speak of a 'men's health crisis' – but they do suffer from marked health inequalities which significantly and unnecessarily reduce their length and quality of life. Men who live in deprived areas or who belong to disadvantaged groups are particularly badly affected.

Tackling these inequalities effectively requires a new understanding of gender and of men in particular by health policy makers and providers. Policies and services must be tailored to meet men's specific needs, concerns and experiences. They must also, where appropriate, be targeted at particular groups of men, such as young men, older

men, black and minority ethnic men, gay men and 'hard-to-reach' men. Traditional services, especially primary care, can no longer sit back and wait for men to walk through the doors – and then blame them when they fail to appear. Men are increasingly interested in taking care of their health but innovative approaches are required to reach them where they are – workplaces, clubs and pubs, sports venues, even barbers' shops. Research into men's health, particularly the impact of gender, is urgently needed and men's awareness and knowledge of their own health must be improved.

The Men's Health Forum hopes that *Getting It Sorted* will help to create the kind of debate about men's health that will result in the changes that are needed. The potential benefits of a new approach are huge. By working together, all the organisations and individuals interested in improving the nation's health can end what has been one of the biggest, but until recently one of the least-recognised, health inequalities.

APPENDIX ONE

The consultation process

The Men's Health Forum intends to consult widely on this report. Copies are being sent to all the Forum's members and other organisations with which it works closely. The document is also available on (and downloadable from) the Forum's website, www.menshealthforum.org.uk.

Written comments may be sent by post, fax or email to:

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Fax: 020 7388 4477

Email: policy@menshealthforum.org.uk

You may wish to use the form at the back of this report for your comments.

The Men's Health Forum intends to host several seminars to discuss this report. If you are interested in participating, please email us at policy@menshealthforum.org.uk as soon as possible or tick the box on the form at the back of this report.

The deadline for comments in whatever form is 30 September 2002.

A final version of this document will be published in early 2003.

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Getting It Sorted: Responding to the consultation process

The Men's Health Forum welcomes comments on any aspect of this policy document. If you wish, you may use this form.

Key Questions

A. Do you believe that this report has identified the key issues important to improving the health of men in the UK?

Yes No

If No, then please state what changes are needed to the identified issues.

C. Has this report included an appropriate set of recommendations?

Yes No

If No, then please indicate what changes are required in order to set out a suitable set of recommendations?

B. Has this report identified a suitable approach to improving the health of men in the UK?

Yes No

If No, then please indicate what changes are required to the suggested approach?

D. I am interested in taking part in a seminar to discuss this report.

Yes No



Name:

Job Title:

Organisation:

Address:

Postcode

Tel:

Email:

Please return this form to: The Men's Health Forum, Tavistock House, Tavistock Square, London WC1H 9HR. Fax: 020 7388 4477.



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