

Improving the Health of Men+Women

THINGS began to change when women took to the streets in the 70s, seeking control of their own health. With books like *Our Bodies Ourselves*, a feminist critique identified a new fight for equal opportunity in a patriarchal system. Gradually, women and minorities gained ground in the medical professions. And then in the 90s, the issue of men's health surfaced with concern about lower male life expectancy rates, soaring suicide rates, boys doing less well at school and the vulnerability of unemployed men. A "men's health" movement emerged.

The stage was set for conflict. Some women felt aggrieved. They had struggled to develop a new analysis and discourse, but lacked money and media attention. They looked at the men's movement: who were these upstarts jumping on the

bandwagon, gaining commercial sponsorship and with the media transfixed? It seemed less than fair to women, especially as, in their analysis, men were part of the problem.

But men had grievances too. From their point of view, women had dominated the debate for too long, making a fuss about not very much. Campaigning for men's health was no bed of roses. Yet their case was a statistical no brainer and they deserved all the help they could get. Surely it was time for the sisters to stop whingeing, take a back seat and give the guys a spell in the limelight?

Fortunately, sense has prevailed. Both sides recognise that gender is a shared perspective, that we have far more interests in common than in conflict. Men acknowledge a debt to feminism and a partnership has been born. The Gender and Health Partnership has come together

to develop a joint project. We are building a new agenda for research, policy and practice, with support from, among others, the Government and the Equal Opportunities Commission. Now the Government plans to create a Public Sector Duty to Promote Gender Equality, giving fresh impetus to this new way of looking at healthcare. This important development should encourage services to take account of gendered needs of individuals to maximise health outcomes. We have a long way to go.



Anna Coote is Head of Patient and Public Engagement at the Healthcare Commission and former Director of Health Policy for the King's Fund.

Peter Baker **The sex war in health is over**

MANY commentators including ministers – and, I should add, the Men’s Health Forum in the past – fall into a trap over gender and health inequalities. They almost inevitably concentrate on the inequalities that exist between men and women. Men die five years younger than women on average, is a widely repeated statistic.

And it is accurate. But looking at health in this way is no longer particularly helpful. For a start, it implies there are no inherent

can also obscure health inequalities between different groups of men and women related to social class, ethnicity and other factors.

Crude comparisons can easily lead to a competition for resources between men’s and women’s health services. Yet, in reality, better health services are needed for both men and women. Finally, comparisons between men and women, which typically emphasise men’s much shorter life expectancy, can lead to a fruitless argument about which sex is the most hard done by.

the only cause of men’s health problems but it is a root cause.

Both men and women are currently ill-served by gender-insensitive policies and practices. Change could hugely benefit both sexes. We should focus not on eliminating the differences between men and women in terms of health statistics. Rather, the key issue is understanding gender in order to improve the health of both sexes. Unless we take gender into account, we are far less likely to succeed in changing inequalities related to social class, ethnicity and other key factors.

Here are some examples. You don’t need to be a criminologist to know that the vast majority of prisoners are working-class men. So approaches to their health problems that ignore this simple fact are much less likely to succeed, especially given the value attached to ‘hyper-masculinity’ in the prison environment. But a gender-sensitive approach is also needed for women prisoners. Oonagh O’Brien from Women’s Health wisely points out that, when she did work on HIV in European prisons, none of the drugs programmes in prisons were being done with women and yet they were still called ‘National prison drug programmes’.

The Department of Health’s Programme for Action on health inequalities, quite correctly, attaches

great importance to reducing smoking among manual groups.

However, while gender-neutral anti-smoking campaigns have undoubtedly had some considerable long-term success, it is highly likely that a gender-sensitive approach could have a bigger impact. Understanding why teenage boys and girls begin to smoke could lead to much more effective and targeted health promotion interventions. They could, for example, take into account boys’ desires to see themselves as rebellious risk-takers.

Likewise, we need to apply the insights of gender to tackle obesity, another particular problem in manual groups. Gender-based approaches, taking into account different understandings of body image and diet, are likely to be important.

We must understand gender if we are to tackle health inequalities effectively. The DH’s inequalities strategy has so far failed to take gender adequately into account and it should be re-viewed through a gender lens. Failure to do so means that health targets are unlikely to be met. Persistent and stubborn health inequalities will continue to reduce unnecessarily the quality and length of life for both men and women.

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Buzz Words

Sex

Differences between men and women that appear to be primarily biological.

Gender

The social construction of roles allocated to men and women. These roles vary geographically and change over time. Gender refers to men and women and the relations between them. The roots of gender may lie in biology but it is shaped by environment and experience.

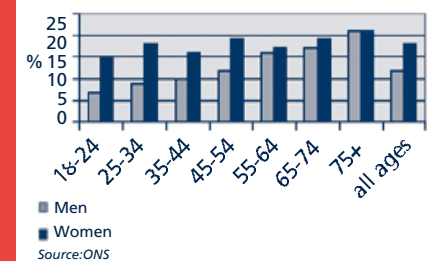
Gender mainstreaming

A commitment to ensure that women’s and men’s concerns and experiences are integral to the work of an organisation, incorporating all aspects of its activities, from employment issues, through to organisational governance, delivery and outcomes.

Source: Gender and Health: “The case for gender-sensitive health policy and health care delivery”.

Oonagh O’Brien & Alan White

Consultation with GPs by gender (UK, 1998-99)



Lesley Doyal **The case for NHS gender mainstreaming**

TWO arguments justify focussing on gender in health care. First, justice requires that women and men be given equal opportunities to realise their potential for health through access to appropriate services. Secondly, the more pragmatic goal of optimising the efficiency and effectiveness of health services requires differences between men and women to be taken seriously.

It is widely recognised that women's reproductive capacities give them "special needs" for health care. But these biological differences go beyond the reproductive system. We are realising that variations between men and women in the incidence, symptoms and prognosis of many diseases affecting both sexes are due largely to previously unrecognised genetic, hormonal and metabolic differences between men and women.

But biology is not the only factor shaping differences in patterns of morbidity and mortality. Gender differences in living and working conditions and in access to resources put males and females at differential risk of developing some health problems while protecting them from others.

For example, domestic responsibilities, usually associated with female gender, can have a negative impact on both physical and mental health. This is especially true for women raising families in poverty. Gender violence is a major health hazard for women worldwide.

The potential risks of masculinity are also emerging. It may apparently offer privileged access to health promoting resources, but it may also require more risk-taking. Men remain more likely than women to die prematurely from occupational diseases and injuries. Socialisation of men makes them more likely to

smoke, drink excessively, drive dangerously and have unsafe sex.

Gender influences experience of health care. Health workers may make different diagnoses of men and women based on similar evidence and offer different treatment in the same clinical situations.

Sex and gender are, therefore, important determinants of health. In England in 1999, life expectancy at birth for a female child was 80.2 years compared with 75.8 for a male.

Important factors are different patterns of exercise, food and alcohol consumption and smoking. These behavioural differences are mediated by social class and by ethnicity and also vary over time. For example, similar percentages of men and women smoke in younger age groups while there are more middle-aged male smokers. Both sexes in lower income groups are more likely to smoke. Black Caribbean women and men are more likely to be "light" smokers. However they are less likely to smoke more than 20 a day.

Men are about twice as likely as women to consume harmful levels of alcohol. In England about three times as many men as women seek help for substance misuse. Recent data from Wales indicates that nine out of ten young men take regular exercise compared with 75 per cent of young women.

So how does this influence NHS modernisation? The NHS plan emphasises the importance of taking diversity into account. Surprisingly, however, little attempt has been made to include sex and gender concerns in this new paradigm. Most initiatives have been gender blind - they fail to acknowledge the impact of gender differences on health outcomes and the delivery of health care.

Of course policies do pay some attention to the different needs of men and women. But this applies only when specialist services – such as breast screening – are considered for one group or the other. There is also acknowledgement that targeted services may be needed if men are to be persuaded to take greater care of their own health. But there is little understanding that sex and health should be not an optional extra but central to all NHS planning. Only in Scotland are there clear moves towards developing guidelines for such gender mainstreaming. A programme for meeting gaps in UK health policy, medical research and service delivery is laid out on page 8. Sources: "Promoting Gender Equality in Health", by Lesley Doyal, Sarah Payne and Ailsa Cameron (2003, Equal Opportunities Commission) Lesley Doyal is Professor of Health and Social Care, University of Bristol. l.doyal@bristol.ac.uk

Spot la différence

Biology

- Men typically develop heart disease ten years earlier than women
- Male-female infection with HIV is more than twice as efficient as female-male infection
- Women are around 2.7 times more likely than men to develop an auto-immune disease such as diabetes.
- Women's immune systems make them more resistant than men to some kinds of infection including tuberculosis.

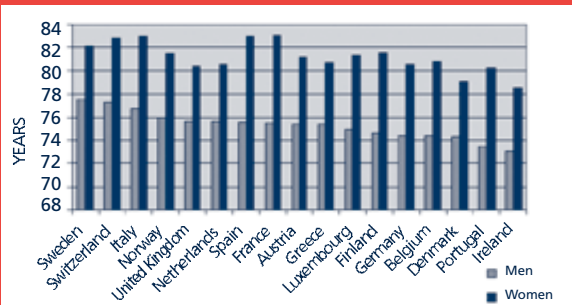
Gender

- Men are more likely than women to commit suicide
- Community-based studies and statistics on service use show that women are 2-3 times more likely than men to be affected by depression or anxiety.
- Men are more likely than women to die of injuries but women are more likely to die of injuries sustained in the home.
- The gap between male and female smoking rates is beginning to narrow as young women are taking up the habit more frequently than young men.

Source: "Promoting Gender Equality in Health", Lesley Doyal, Sarah Payne and Ailsa Cameron (2003, Equal Opportunities Commission)

Life expectancy at birth for men and women 2001, by country

Source: White, AK & Cash, K (2003) The state of men's health across 17 European countries. Brussels, The European Men's Health Forum ISBN 1 - 898883 - 94 - 7



Gender pioneers

Pat Armstrong **Canada – world leader in gender and health**

EVIDENCE and pressure from the women's movement led Canada to adopt a Federal Plan for gender equality in 1995, requiring legislation and policy to include analysis of the potential for differential impacts on women and men. Canada has become a world leader in the field.

There is now a Women's Health Bureau within Health Canada, (the federal ministry), a Centres of Excellence Programme for Women's Health and a Canadian Women's Health Network. These initiatives recognise that gender differences are critical in health and care; and that women were often excluded from

research and treated inappropriately in practice. All include gender-sensitive research, policy and practice in their mandate.

The federal government recently funded a Canadian Research Institute of Gender and Health with a mandate "to support research to address how sex and gender interact with other factors that influence health to create conditions and problems that are unique, more prevalent, more serious or different with respect to risk factors or effective interventions for women and men".

The new institute has funded research on men's issues such as hormone treatment for prostate

cancer, the service needs of elder gay men and Black men's experience of violence as well as many comparative projects such as the role of women and men in unpaid care giving.

Health Canada now recognizes 12 distinct determinants of health, having expanded the list beyond biological and genetic endowments to include gender. Even the traditional focus on reproductive health is shifting. The range of sex issues is understood to be much broader and biology is increasingly

understood as influenced by social contexts.

A gender-sensitive analysis has made a difference, for example, in cardiovascular disease. We know from elsewhere in this report that CVD is a very different in women than men. Protocols are changing in Canada as well as new guidelines for treatment that may show up in outcomes.

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'Health Canada now recognizes 12 determinants of health, having expanded beyond biological and genetic endowments to include gender.'

Sue Laughlin **Scotland bears the standard for Britain**

SCOTLAND has one of the first UK examples of a comprehensive, strategic attempt to address women's health problems from a gender as opposed to a merely biological perspective. The Glasgow Women's Health Policy was first launched in 1992 and re-launched in 2002. At its heart is public involvement. Crucially, it aims to ensure that key issues identified by women – emotional and mental health; health effects of poverty; safety in the home, community and

workplace; sex differences in the presentation of various diseases – are given priority.

A senior manager has been appointed by Greater Glasgow Health Board to oversee implementation within NHS Greater Glasgow. Progress has, however, been partial. Some Trusts have yet to ensure that women's health needs are coherently included in their implementation plans. However, progress on gender-based violence has been substantial and

the effects of abuse integrated in mental health planning and delivery of services for homeless people. A Centre for Women's Health has been created.

So has this strong local precedent, combined with the new Scottish Parliament's commitment to equality, transformed health policy? The answer has to be a qualified "no". Gender remains largely unrecognised as a determinant of health, nor is gender sensitivity recognised as a pre-requisite of

effective service delivery.

The big positive, however, is that NHS Health Scotland, the national public health agency, has commissioned a report on gender and health in the NHS on behalf of the Scottish Executive. It aims to discover how gender might best be integrated into key strategic and operational developments in the NHS.

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THE member states of the World Health Organisation made a political commitment to incorporate a gender perspective into health policies in 1998. WHO's regional office for Europe has a gender mainstreaming unit, whose task is to support the gender mainstreaming policies of the region. Our experience is that many countries have difficulties in translating international political commitment into clear national policy. Member states have particularly asked for the unit's support in two areas. First they want help in identifying gender-specific indicators that may be used to map priority areas for gender specific health policies, Secondly, they need advice on steps that may be useful in achieving

WHO

the different phases in the process of policy making: agenda setting, planning and decision-making, implementation and evaluation of the policy outcomes. Our unit has designed projects to provide this support.

We are beginning to make progress. We have analysed gender specific health policies in five European countries that have made particular progress: Iceland, Ireland, Malta, the Netherlands and Switzerland. The WHO's First International Meeting on Gender and Health was held in Vienna in September 2002. Although few countries have yet begun to implement gender specific health policies, some are planning them and many intend to develop such policies.

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Michael Kimmel **We are our own worst enemy – and women's**

WE are making men's health visible. But before we indulge in "premature self-congratulation", a note of caution. I fear that as we make men's health visible, we may allow gender to remain invisible. It is not gender analysis to say "women get x" and men get y". That approach misses most of the point about gender and health - because the real problem is not the division of resources between men and women. The big issue is masculinity. Gender – the meanings of masculinity, masculinity as ideology – is the critical variable for men's health. Stated simply, the traditional ideology of masculinity is the central risk factor for men's health and the single, greatest obstacle to women's health.

For example, masculinity is the chief reason why men do not seek health care as often as women. Men perform self-examinations, seek preventive screenings and pay attention to diet and substance abuse far less often than women. Why? As the health researcher Will Courtenay writes: "A man who does gender correctly would be relatively unconcerned about his health and well-being in general. He would see himself as stronger, both physically and emotionally than women. He would think of himself as independent, not needing to be nurtured by others. He would be unlikely to ask others for help...He

would face danger fearlessly, take risks frequently, and have little concern for his own safety." As one Zimbabwean man put it: "Real men don't get sick".

These attitudes speak plainly from health statistics. In the US, the four causes of death with the highest male to female ratio, the highest differential by sex, are those most closely associated with gendered behaviour, not biological sex: accidents, suicide, cirrhosis (drinking) and homicide.

Let me give just one example of how

damaging it can be to ignore masculinity when thinking about gender and health. Few public health discussions acknowledge that HIV is the most "gendered" disease in the history of Europe and North America. (A gendered disease could in principle affect both women and men equally, but in fact affects one gender disproportionately.) As a result, efforts to reduce HIV infection must confront the association of masculinity with risk-taking by encouraging needle exchange programmes (not sharing

hypodermic needles) and promoting safe-sex health campaigns (since men associate unsafe sex with masculine prowess). The problem may seem different in the economic South – in Africa, Asia and Latin America, HIV cases in women actually outnumber those among men. Yet, even here, masculinity is a critical factor. In sub-Saharan Africa, 60-80 per cent of women infected with HIV have had only one sexual partner. So HIV risk reduction requires men to take responsibility for wearing condoms in

cultures where eschewing birth control and fathering many children are equally signs of male power.

We are not Martians and Venusians, not opposite sexes, but partners – in sickness and in health. But to make gender visible in health care we must transform the meaning of masculinity so all us live happier, healthier lives.

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Ian Banks **It's smart to make use of the way men are**

LOOK at the life expectancy of men and women (page 3) and you will see that men die earlier than women. But look at the ratios between those rates and you find that the variation across countries is dramatic. And that is encouraging. Such statistics tell us that it is not just the Y chromosome or testosterone dictating that men must die early. It is the environment in which men find themselves. This means we can make the situation better.

Alan White has looked at the incidence rate for melanoma in Europe*. There are high rates for women, but right across the continent more men than women die. The

reason: their late presentation to see a doctor about that melanoma.

Such facts should make us question service delivery. Look at the differences between the rates of male and female consultations with GPs (page 2). The rate gradually increases in men compared to women so that, as the prostate starts to enlarge at about 50-55 years of age, the male rate begins to overtake women's.

Because of late presentation, we also find older men using in-patient services more than women. Suddenly the cost implications of men not using primary care services enough become clear. It costs a lot more to keep them horizontal in hospital rather than

vertical in the community.

So what do we do? At the Men's Health Forum, we work with the politicians. We educate not just laymen but health professionals and run campaigns. Instead of criticising men for being mechanistic, we make use of the way men are. For example, the Haynes manual on men's health is modelled on guides to fix your car. It has sold more copies than any other men's health book. .

There are some encouraging signs. For example, we have recently seen Alan White appointed by Leeds Metropolitan University to be Britain's first professor of men's health. We need partnerships, particularly

with the women's health movement. We have learned from that movement's mistakes as well as from its successes. When we talk about men's health, we must also talk about women's health because they are inextricably linked. Prostate cancer makes a lot of women very ill. Cervical cancer makes a lot of men very ill. The two are entwined. We win or lose together.

*"The State of Men's Health Across Seventeen European Countries", Alan White and Keith Cash (European Men's Health Forum 2003)
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Practice implications

CORONARY heart disease is the most common cause of premature death in the UK – 23 per cent in men and 14 per cent in women (43,000 premature deaths in 2001).

Yet we fail to recognise marked differences between men and women in this field with respect to age at presentation, the experience of CHD treatment and recovery and the degree of co-morbidity. The meaning of CHD also differs and their experience of illness creates different needs in terms of health education, treatment and rehabilitation.

Research has tended to focus on CHD as a male disease. So CHD in women may be misdiagnosed and treatment denied or delayed. That said, even this focus on men has neglected what the cardiac experience means for a man.

The National Service Framework (NSF) on CHD, (DH 2000) recognises gender differences, but does not address them. So practitioners provide gender-neutral treatment regimes.

Yet the gender differences are considerable. Women have smaller coronary artery lumens than men, independent of body size, and less collateral circulation. These anatomic

differences lead to an increase in ischaemia during exertion or stress.

US research demonstrates that 69 per cent of women initially present with angina compared with 30 per cent of men.

There are psychosocial differences. Depression is three times more common in women than in men and we know that depressed patients report significantly more episodes of angina and more intense anginal pain.

Vulnerabilities to other illnesses also impact on relative risk of CHD. Men have a tendency to central obesity with greater risk of hypertension and diabetes, which both increase the risk of CHD. Meanwhile, women with diabetes lose their innate protection against CHD.

During an infarction, men and women suffer different symptoms:

women have significantly more nausea or vomiting and men more chest pain, while women report more neck and back pain.

After a cardiac episode, women have difficulty with male-orientated “getting back to normal” rehabilitation. Going back to “house work” may not be an inspirational goal and, whereas a man might take “an easier job”, a woman may struggle to get change within a patriarchal household.

We know that men typically show a willingness to engage with rehabilitation, but this may not be a sign of long-term behaviour change. In women – because of a high degree of co-existing morbidity – we need to work out how to support change in patients for whom CHD is one more problem among many. And then there are possible psychological problems for female partners feeling they must over-see their man’s health post cardiac event.

Considerable public resources focus on reducing the personal and financial costs of CHD. Yet, despite this expense, we question whether men or women are really well catered for.

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THE phrase “sexual health” has appeared in government documents for less than 15 years. So how is it distinctive from “reproductive health” which focuses on pregnancy, childbirth and early dependency, and has historically emphasised women?

Sexual health means avoiding unintended *physical* outcomes of sexual activity as well as negative *psychological* outcomes such as regret because, for example, a sexual experience has been coercive. Sexual health requires mutuality and respect for partners and lifestyles. It also incorporates the positive potential of successful sexual lives.

Services for sexual and reproductive health are still used mainly by women and only reluctantly by men. One problem is a school-based education system that often confuses reproduction with sex, and seldom deals with sex in the context of relationships. So sexual education, which is not part of the National Curriculum, tends not to engage young people, especially young men.

Additionally, many parents are reluctant to discuss sexual issues with their children. Public discourse suggests that talking about sex with young people encourages them to go out and do it. This adds to guilt and shame and a reluctance to use services. There is also growing

advocacy of an abstinence-based approach, although there is no evidence that this is effective.

The Dutch approach to sexual education is more successful than the UK's and suggests that differences between men and women in

sexual activity are not biological but socially and culturally constructed. For example, in the Netherlands, 60 per cent of men selected love and/or commitment as the major reason for their first sexual relationship, compared with just 15 per cent here. There is a much lower level of regret in the Netherlands among women about their first experience of intercourse. Young people begin penetrative activity later; there is more discussion, and use, of contraception, and teenage conception rates are considerably lower.

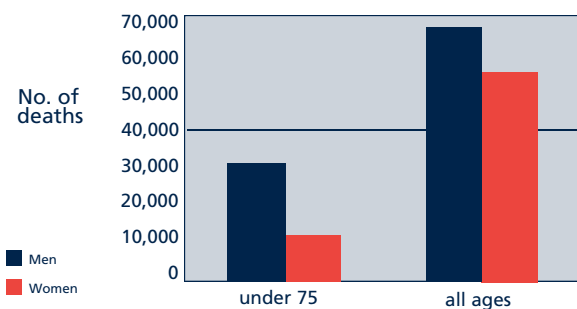
The challenges are to encourage men to respect themselves and others more; enable women to be equal decision-makers; introduce staff training on gender; encourage more discussion in homes; reduce gendered assumptions to improve mutuality in relationships. We need greater openness and to challenge religious and cultural barriers that deny women choice over their own fertility.

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Heart Disease

Sexual Health

Cardiac deaths by age, 2001 (GB)



Practice implications

THE worldwide expansion in tobacco use is mirrored by a worldwide lung cancer epidemic. Sex and gender differences highlight the need for gender specific strategies to reduce smoking and lung cancer mortality.

Whilst male lung cancer mortality rates are generally higher than female rates, male rates in more developed countries have been steady or falling for some time. However, female lung cancer mortality is increasing.

Lung cancer mortality is closely associated with incidence because lung cancer is an aggressive disease with poor survival rates. However, studies suggest women may have better chances of survival than men.

Women appear to have a higher risk of lung cancer than men at the same level of exposure to smoking. Biological factors specific to women, for example, such as hormonal influences may be factors. Some studies have suggested differences between women in their risk of lung cancer associated with age at menarche and length of menstrual cycle. DNA repair may also be poorer for women.

The key gendered risk factor for lung cancer is smoking. There are important differences between women and men in their use of tobacco, including age at smoking initiation, and number of cigarettes smoked. Some differences have decreased - the proportion of women and men who smoke, for example, is now very similar in Britain,

and in the past more women smoked low tar cigarettes. Women may also experience higher exposure to environmental tobacco smoke.

Little is known about gender differences in diagnosis and treatment for lung cancer, but some research suggests common measures of lung assessment, such as airflow obstruction, may be more valuable in diagnosing men. It may also be necessary to develop different screening methods for lung cancer, since men and women may have different patterns of pre-cancerous lesions.

In terms of lung cancer prevention, the single most important factor is reduced tobacco use. Research suggests nicotine replacement therapy is less effective for women: those who smoke have a higher dependence on nicotine, women have a slower rate of nicotine clearance and may suffer more from withdrawal symptoms, for example. Men and women appear to smoke for different reasons with avoiding weight gain and alleviating stress and depression being significant factors for women. The timing of cessation is important – women of childbearing age are more likely to succeed if they give up during or shortly after the menstrual cycle.

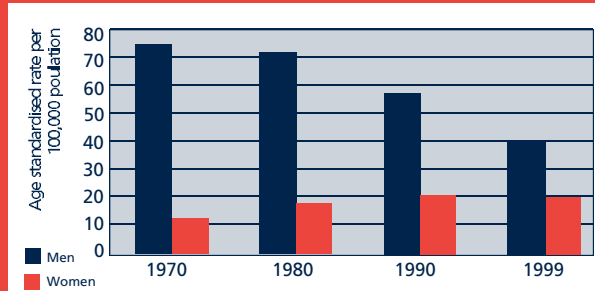
The differences observed with respect to nicotine absorption suggest important neurobiological factors and there are clear sex and gender differences in factors affecting taking up smoking and maintaining the habit

which need further research.

We need gender sensitive research reflecting the bio-social-cultural factors involved in lung cancer, to evaluate gender differences in the value of interventions such as population screening and to introduce gender-sensitive cessation programmes.

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Trends in male and female lung cancer mortality, United Kingdom - all ages



FOR almost 40 years there has been a clear demand from women – and to a lesser extent men – for gender to be taken seriously within the field of mental health. This has yielded an impressive body of literature and significant service developments. But, until recently, this demand has had little impact on mainstream thinking and decision-making.

Yet, gender inequality obviously has significant mental health implications. It should not be surprising since we know that differential access to resources such as money, status and power affects mental health. Power, for example, when abused sexually, physically or emotionally, can damage psychological well-being.

Likewise, expectations of how women and men should be can be damaging. Women labour under expectations that they are emotional and should be concerned about the needs of others. They are expected

to be cheerful, keep it all together, like children, be deferential, intuitive rather than rational, feminine, attractive and slim.

Mental Health

Meanwhile, men are required to be strong, self-confident, decisive, dominant, in control of their lives and emotions and to be providers.

The processes that hide and justify gender inequality can also be harmful. Mental health is damaged in silencing those who try to speak about psychological damage created by inequalities and by blaming victims.

With notable exceptions there are poor levels of gender awareness within mainstream mental health services, which has serious implications for the quality and safety of those services. There are also high levels of dissatisfaction among women service users and staff.

But change is coming. The drivers

include the Commons Health Select Committee that has highlighted blatant inequities in secure care for women and men. The Government's NHS modernisation, equalities and social inclusion agendas also make progress in this field more possible. The Department of Health has supported development of a women's mental health strategy "Into The Mainstream" and in 2003 published its "Implementation Guidance".

Challenges include broadening this developing field more to issues affecting men and using performance management to measure progress and improvements.

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What next?

Lesley Doyal NHS reform

NHS patients are male or female and there are real differences in some of their needs.

Modernisation, making services effective, efficient and evidence-based, requires that this reality is at the heart of the NHS. That means changing the planning of services, through recruitment and management of staff to education and training, delivery of care and audit and evaluation. Otherwise scarce resources are wasted on sub-optimal care, reinforcing existing gender inequalities.

We need action on health statistics.

In current surveys of contraceptive use, for example, women but not men are asked about the methods they use. Little information is collected on the health implications of physical and sexual violence, the latter affecting women more than men. Occupational health data has typically focussed on male experiences, largely ignoring hazards faced by women in paid and unpaid work. The UK and EU lag behind in ensuring that women are properly represented in medical trials. So we lack knowledge about the effectiveness and potential hazards of drugs on women.

We should follow the US, Canada and Australia in ensuring that undergraduate training includes understanding of gender issues. For example, in coronary

care and mental health, practitioners should be able to recognise the different symptoms of male and female patients and respond appropriately. A&E and primary care staff should be trained to deal with gender violence.

Among staff generally, the model that has spread race awareness through the NHS should be mirrored in developing sex and gender awareness. The National Institute for Clinical Excellence should incorporate gender issues into its formal assessment framework so that sex differences in drug effectiveness and toxicity are identifiable. The Healthcare Commission needs more sensitivity to sex and gender issues if it is to maximise improvement in clinical practice.

The Commission for Patient and Public Involvement in Health and the Patients Forum, recognising that women have always had less control than men in NHS decision-making, should develop mechanisms to ensure active involvement of women and men. The Commissioner for Public Appointments similarly has a responsibility to equalise the gender balance on NHS boards.

A reforming approach in all these areas could considerably improve the NHS, cutting gender inequalities in health as well as creating a more effective and efficient service.

Sources: *"Promoting Gender Equality in Health"*, by Lesley Doyal, Sarah Payne and Ailsa Cameron (2003, *Equal Opportunities Commission*)

Siân Griffiths Pele + pubs

THERE is an overwhelming case for making gender awareness an issue at all levels. I would like to see primary care trusts link with local football clubs to promote men's health issues or go into the pub or the workplace, not wait for men to visit a surgery.

I would expect more active consideration of women's needs within the NHS, not just around specific diseases such as breast cancer or around reproductive services, but also general diseases such as lung cancer and heart disease.

We need national role models to place the issue on a bigger stage, following on from, for example, Pele, who has made erectile dysfunction a widely discussed topic. Debate about gender should, like smoking, be part of mass media discussion.

There should be a focus on prevention. So, if we want to promote healthy diets, we could ensure the National Curriculum teaches boys how to cook. Making gender a priority is a responsibility of many other sectors, not just health.

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Julie Mellor Public Sector Duty

LESLEY Doyal's research makes a compelling case for gender analysis to inform the development of NHS practice. This is vital for a modernisation process that ends "the one-size-fits-all approach to public services".

The process should be unashamedly

about equality but in the sense of the Equal Opportunity Commission's strap line: "Women. Men. Different. Equal." To create equality, you have sometimes to take account of difference. If you tackle different health needs better, then you can achieve better health equality outcomes.

The Equal Opportunities Commission welcomes the Government's commitment to introducing a positive duty on public bodies to promote sex equality and tackle unlawful sex discrimination.

A duty to promote sex equality and tackle sex discrimination will make an enormous practical difference to women's and men's everyday lives. Health services would have to make the location and hours of their services accessible to women with childcare responsibilities. Family support services would need to become father friendly as well as meeting the needs of mothers. Primary health providers would have to take steps to encourage men to use their services and get early

diagnosis for health problems.

A duty to promote sex equality would also drive better employment practices, which would help achieve the vital goal of retaining skilled staff in the health service.

Promoting equality for service users and the workforce should be part of the core work of the public sector, not something extra. It is part of providing a quality service.

Julie Mellor is chair of the Equal Opportunities Commission.

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