

# GETTING IT SORTED

## A POLICY PROGRAMME FOR MEN'S HEALTH



Getting It Sorted represents the Men's Health Forum's view of the policy changes needed to improve the unacceptably poor state of male health in England and Wales. The fact that action is urgently required cannot be doubted by anyone who takes note of the statistics that reveal the scale of the problem and who observes the current lack of national and local policies to tackle it.

Fortunately, there has been, in recent years, an increasing recognition of the importance of improving men's health. The Department of Health, the Health Development Agency, health charities and others have started to realise that men's health requires particular attention. The Men's Health Forum (MHF) believes there now exists an historic opportunity to take the decisive action that is needed. This means it is time to stop talking and start work. Good intentions must be translated into policy and practice that will make a difference.

This edition of Getting It Sorted is a shorter but more up-to-date version of that published in June 2002<sup>1</sup>, during the first-ever National Men's Health Week. It does not repeat most of the analysis and statistical evidence contained in the first edition as much of this remains valid and is easily accessible via the MHF's website ([www.menshealthforum.org.uk](http://www.menshealthforum.org.uk)). This edition takes into account the responses made by organisations and individuals to the original publication and develops the new idea that male health is best addressed alongside female health in the context of an approach that "mainstreams" gender concerns. It also proposes a new definition of a "men's health issue".

The MHF is very grateful to all those who took the time and trouble to contribute to the debate that followed the publication of the first edition. This new, sharply-focused version of Getting It Sorted is the definitive statement of the MHF's determination to bring about significant improvements in the health of half the population. In fact, it is clear that no major improvements can be made to the health of all unless we can improve the health of men.

# What's wrong with men's health?

## **Men's health is unnecessarily poor**

There is overwhelming evidence to support the contention that men's health is much poorer than it need be. Many men die prematurely. Average male life expectancy at birth is just 75.6 years. In some parts of England and Wales, and among certain groups of men, it is as low as 71 years<sup>2</sup>. This is a problem - not just for men but also for women, for service providers and for society in general.

## **Men are reluctant users of health services**

Once they reach the age of 16 and their parents stop taking them to the GP, it is commonplace for men to avoid primary care unless they are experiencing significant pain or an illness has become too serious to ignore. Men also make poor use of preventative services. There is - tellingly - very little research evidence in this area, but the reasons for men's under-utilisation of primary care probably include:

- **Difficulty of access.** A man's GP may be based some distance from his workplace and appointments are often available only during normal working hours.
- **Cultural norms.** Many men believe that they should "tough out" illness for as long as possible rather than admit to "weakness". Similarly, it is not unusual for men to be concerned that they would be "wasting the doctor's time".
- **False perceptions.** Primary care may be seen as a service primarily for women and children.

Men's use of GUM (genito-urinary medicine) services also needs to be improved. Relatively few asymptomatic men attend for screening and many men's knowledge of services is low: a survey carried out in 2000 by the MHF in conjunction with the Doctor Patient Partnership found that only half of adult men knew that a GUM clinic provides sexual health advice and treatment<sup>3</sup>.

## **Men's health is under-researched**

Although a great deal of health research has used men as its subjects, it has rarely investigated them specifically as men. In other words, most research, whether clinical or non-clinical, looks at the impact of a particular approach or treatment on a sample of people and does not draw conclusions based on an analysis of sex or gender. 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. Some male-specific health concerns - for example, prostate cancer - are widely acknowledged to have lagged behind in terms of scientific research.

## **There is no "user-led" movement for better male health**

Part of the reason why men's health remains neglected is that men themselves have not argued, campaigned or lobbied for improvements. Few men write to their MPs about issues like waiting times for an appointment at a GUM clinic, for example, or difficulties in obtaining treatment for erectile dysfunction - even though these matters may have serious consequences for the individual. In marked contrast to the history of women's health, most men's health advocates have been health professionals, academics or policymakers, not service users or activists. (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 as reluctant collectively as they are individually to ask for help with their health.

## **Men are viewed negatively by some providers and policymakers**

Male "risk-taking" and men's apparent unwillingness to take better care of their own health have led many in the health services to assume that any attempt to improve the situation is doomed to failure. In its most extreme version, this view of men may lead to them being seen in a general way as unreliable, irresponsible and unwilling to be helped.

## Gender is under-recognised as a determinant of health

Social class and ethnicity have long been accepted as important factors in determining health status. The resultant inequalities are rightly judged unacceptable and significant policy provision has been made in response. Gender, on the other hand, continues to be viewed as a peripheral factor (or simply not viewed at all). Where gender is seen as relevant, it is often believed to be an issue for women but not for men. This lack of awareness is, in part, due to the mistaken belief that differences in health status between the sexes are mostly the result of biology and are therefore inevitable. It is also linked to the perception, again inaccurate, that the huge changes in women's lives over the past 30 years mean that we now live in a "post-feminist" era in which the issue of gender is largely irrelevant. In fact, gender is one of the key determinants of health. In his summary of the current position in the *Independent Inquiry into Inequalities in Health*, Sir Donald Acheson specifically brackets gender with social class and ethnic origin as a key factor in determining health status:

*Inequalities by socioeconomic group, ethnic group and gender can be demonstrated across a wide range of measures of health and the determinants of health<sup>4</sup>.*

In addressing the question of gender more generally, Acheson recognises that there are "gender differences in health that do not appear to be predicated on inevitable differences in biology" and, whilst drawing attention to aspects of health where women are disadvantaged, also notes that "across the whole of adult life, mortality rates are higher for men than women for all the major causes of death". He concludes: "These differences between and within genders have important policy implications". The Acheson Report is fundamental to much present health policy. It is therefore particularly regrettable that Acheson's comments on gender have been largely overlooked.

### Men's Health Facts

Lowest and highest male life expectancy at birth by local authority area (England) 2000 - 2002

Manchester	71.0 years
Blackpool	71.7 years
Liverpool	72.5 years
Tower Hamlets (London)	72.7 years
Knowsley (Merseyside); Middlesbrough	72.9 years
National Average	75.6 years
North Dorset; South Norfolk; New Forest	79.1 years
Purbeck (Dorset)	79.2 years
Rutland; Hart (Hampshire); East Dorset	79.5 years

Life expectancy at birth by health and local authorities. Office for National Statistics Website Release, November 2003

For more statistical information visit [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk)

# Defining a men's health issue

## What is a “men's health issue”?

It is difficult to discuss men's health without a working definition of what properly constitutes a “men's health issue”. The field of men's health is a relatively new one, so it is perhaps not surprising that there are few good, generally agreed definitions. The following, formulated in Australia, has been the most widely used:

*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<sup>5</sup>.*

This definition is extremely helpful in addressing the common misapprehension that men's health is primarily about male-specific problems like testicular cancer or prostate disease. In fact, virtually any condition (with the obvious exception of female-specific conditions) may constitute a “men's health issue” and this definition demonstrates that well. Suicide is a good example: suicide is not a male-specific problem but men are much more likely than women to kill themselves; men have risk factors specific to their gender (e.g. a marked reluctance to ask for help with mental health problems); and men 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).

## What is “male health”?

Before we can accurately define a “men's health issue” however, there must be a shared perception of what we mean by “health”. The problem with the Australian definition is that it appears to be underpinned by a narrowly medical interpretation of health. In particular, it does not encompass the idea of personal “well-being” which has been an important component of many people's understanding of “health” since the World Health Organisation's classic definition of 1948, i.e. that good health is:

*. . . a state of complete, physical, mental and social well-being and not merely the absence of disease and infirmity<sup>6</sup>.*

The Men's Health Forum's own vision of good health draws on the WHO definition for its inspiration but has tried to take into account some of the analytical developments that have occurred in the last 50 years:

*Good male health is a state of physical, mental and social well-being that enables individual boys and men, and the male population as a whole, to meet the demands of everyday life and to realise their aspirations and biological potential.*

The MHF's definition is formulated in the context of “male health” but, strictly speaking, it is not male-specific. There is, in fact, no difference between what constitutes good health for men and what constitutes good health for women.

The Australian definition of a “men's health issue” has the further disadvantage of not addressing the importance of the wider political and social determinants of health, such as economic status, environmental quality and culturally-determined behaviours. Tackling these factors is now widely accepted as central to improving health – indeed, such an acceptance underpins much of the present Government's health improvement strategy. It is also important to note that “men's health issues” must be seen to include matters relating to the health of boys. Male health problems do not start at the age of 16.

## **A new definition**

The MHF is therefore proposing a new definition of a “men’s health issue”. This definition is based on the above understanding of the meaning of “health” and draws on the organisation’s wide experience in recent years of discussing men’s health with clinicians, health improvement professionals, academics, community activists and many others with an interest in the field.

The MHF’s definition uses the term “*male* health issue” to make it clear that the definition should be understood to refer to boys as well as men. This definition is, of course, intended to underpin the recommendations for policy which follow in this document – but we also hope that it will provide a useful contribution to the ongoing international debate and the search for shared values and objectives:

*A male health issue is one arising from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level.*

## Men’s Health Facts

Male life expectancy by social class (UK)				
Social class	1982-1986	1987-1991	1992-1996	1997-1999
Professional	75.1	76.7	77.7	78.5
Managerial & Technical	73.8	74.4	75.8	77.5
Skilled non-manual	72.2	73.5	75.0	76.2
Skilled manual	71.4	72.4	73.5	74.7
Semi-skilled manual	70.6	70.4	72.6	72.7
Unskilled manual	67.7	67.9	68.2	71.1

Office for National Statistics. *Social Trends 33* (The Stationery Office 2002)

For more statistical information visit [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk)

# Why gender is important

Over the past 30 or so years, women's health advocates have argued – rightly, and with some considerable success - that women have been ill-served by a male-dominated health service, and that policies and practices need to change to reflect the specific needs of women. It is now becoming clear, perhaps rather surprisingly, that men have also not benefited greatly from the way the health service has been structured and the way decisions have been made.

## What is “gender”?

The term “gender” is now widely used to express the social and cultural ideas that characterise our perception of male and female. The concept of “gender” is therefore helpful in differentiating this additional layer of meaning from that of the word “sex”, which is commonly understood to refer only to the physical differences between men and women. The word “masculinity” is often used interchangeably with the phrase “male gender” to express this specific idea in respect of men (in fact, “masculinities” is the term now used by many sociologists to take into account differences between different groups of men).

Understanding masculinity 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. Masculinity is also linked to many men's reluctance to seek help – because help-seeking is widely interpreted as a sign of weakness. The importance attached within the prevailing notion of masculinity to the idea of being “rational” also makes many men feel disconnected from their bodies and their physical needs. Many of these traditional attitudes have remained stubbornly prevalent despite their inherent disadvantages for men's health and the social and economic changes that have significantly affected the roles of men and women in recent decades.

This is not a straightforward area, of course. Our understanding of male gender has developed against the background of a long-standing and largely unresolved debate about the extent to which the traditional characteristics of masculinity are pre-determined by biology. Developments in genetics, neuroscience and endocrinology will continue to illuminate and inform this debate and it is essential that these are taken fully into account.

It is of fundamental importance however, that we continue - emphatically - to refute the notion that there is an inevitable relationship between maleness and poor health. Even the relatively small amount of evidence currently available shows that it is possible to change male attitudes and behaviour and create measurable improvements in health.

It is also essential that we are pragmatic enough to recognise that male gender roles have existed for a very long time and that individuals cannot easily choose to discard them. This means that, to develop effective work with men, health policymakers and practitioners must improve their understanding of male gender roles and seek to deliver services aimed at men as they are - and not as some might wish them to be.

Hand-in-hand with this however, must go a commitment to allow and encourage men (and perhaps more particularly, boys) to feel less restricted in their choice of a male gender identity and, within that, to give them the skills to make informed decisions about their health and well-being. Men will achieve the highest level of good health only when they are allowed the freedom to describe their experiences and express their needs - and when services are constructed that explicitly take account of the concerns that emerge.

## What does this mean for policymakers?

It will be evident that an enhanced understanding of male gender would help the development of more appropriate services for men. A simple example might be to recognise that, 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 a useful addition to traditionally-organised primary care services. Health promotion information provided in way that resonates with the mechanistic ways men perceive their bodies might also make a difference. Indeed, this approach underpins the best-selling Haynes' Man Manual<sup>7</sup>, produced in the format of a car workshop manual – a good example of a pragmatic response to men's concerns.

It will also be clear that the interaction between gender and health is not a concern solely for policymakers in health. Cultural expectations of men (and men's expectations of themselves) are fundamental to a whole range of social policy matters, which in turn have an impact on health behaviours and health outcomes. Again, to take a straightforward example, career success for men is often dependent on their tacit acceptance that work commitments must take priority over home life and leisure interests. Such a belief is undoubtedly bad for many men's health and bad for the health and well-being of families. Effective action to improve men's health is therefore dependent on a shift in our attitudes and expectations in respect of men and the male "role". It also requires a willingness to give far greater priority to better male health as part of the wider social and political process.

### Men's Health Facts

Percentages of men above and below desirable weight · (England) 2001

Underweight	4%
Desirable	28%
Overweight	47%
Obese	21%

Department of Health. *Health Survey for England*. (The Stationery Office 2001)

For more statistical information visit [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk)

# Health policy and men's health

## The Department of Health

The Department of Health has, generally, paid little attention either to the specific health needs of men or to the wider issue of gender. This is the case both historically and in its more recent policies and plans. The Department's otherwise commendable *Tackling Health Inequalities: A Programme for Action*<sup>8</sup>, published in July 2003, is a good example. Promisingly, the document claims on its opening page that it "identifies action on a broad front to address the inequalities that are found . . . between genders . . ." In fact, this brief acknowledgement of the issue represents its only mention in the entire document and suggests an unwillingness to acknowledge and act on the analysis of gender in Sir Donald Acheson's *Independent Inquiry into Inequalities in Health*.

The NHS Cancer Plan and the various National Service Frameworks (NSFs) also take a generally broadly "gender-neutral" approach, as do most other current health policy documents. An editorial in the *BMJ* highlighted the particular problems with the NSF on heart disease – a typical example:

*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*<sup>9</sup>.

The National Service Framework for Mental Health is similarly problematic. It states the government's target of reducing the suicide rate by least one-fifth by 2010 but fails to address the relevance of a male:female suicide ratio of 3:1. This issue is dealt with rather better in the subsequent National Suicide Prevention Strategy, but suicide remains a clear example of a failure to engage effectively with an indisputably "gendered" phenomenon.

An awareness of the importance of men's health is not only missing from overall 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. ED is now known to be a marker for undiagnosed cardiovascular disease, so prescribing restrictions that have the effect of deterring men from seeking medical help for their ED may prevent early diagnosis of a significant underlying condition. These rules therefore, not only discriminate against lower-income men, who are much less likely to be able to afford a private prescription, they also undermine wider public health objectives. These concerns are shared by the Independent Advisory Group on Sexual Health and HIV which was set up by the Government specifically to monitor progress and advise on the implementation of the National Strategy for Sexual Health and HIV:

*. . . the current policy for the provision of anti-impotence treatments is contrary to the principles of the NHS and should be reviewed*<sup>10</sup>.

The underlying message of such a policy is to suggest – both to men's health organisations and to individual patients – that men's health issues are not taken as seriously as they should be by the Department of Health.

## Gender mainstreaming

Recent international and national policy developments have created an important new opportunity to construct health policies that take gender issues specifically into account – a process that has become known as "gender mainstreaming". In 2001, the World Health Organisation's "Madrid Statement" urged member states "actively [to] integrate gender mainstreaming into public policies that determine health", emphasising that:

*Mainstreaming gender in health is recognised as the most effective strategy to achieve gender equity. It is a strategy that promotes the integration of gender concerns into the formulation, monitoring and analysis of policies, programmes and projects, with the objective that women and men achieve the highest health status*<sup>11</sup>.

In June 2003, the Women and Equality Unit of the Department of Trade and Industry published *Delivering on Gender Equality*, a statement of policy intention that is both ambitious and unambiguous. It states plainly that:

*The Government is committed to mainstreaming gender equality into all aspects of policy*<sup>12</sup>.

Widespread support for such a policy approach was expressed by many health organisations attending the first UK Gender and Health Summit held at the King's Fund in November 2003. In the same month, the Equal Opportunities Commission published the report *Promoting Gender Equality in Health* which also made a strong case for gender mainstreaming throughout the health service.

There has however, been little concrete evidence so far, of the political will to turn these words into action. The only example in England has been the publication by the Department of Health, in March 2003, of the Women's Mental Health Strategy. The attention paid to gender in this document is certainly to be welcomed but it does not appear, at this stage, to form part of a wider strategic commitment to recognise the importance of gender issues in national policy.

### **Local health policy**

The unwillingness of the Department of Health to show a lead has meant that there has also been little interest in the development of "male-sensitive" policy and practice by health organisations at the local level. Health authorities, as they existed before April 2002, rarely attempted to address men's health (although there were some notable exceptions, such as Worcestershire Health Authority's Health Improvement Programme for Men<sup>13</sup> and Nottingham Health Authority's men's health report<sup>14</sup>). Local authorities have a similarly poor record, with the exception of Stockport Metropolitan Borough Council which has undertaken a review of men's health in its area<sup>15</sup> using the new powers allowing local government to scrutinise local health services.

Primary care, the level to which power and resources has recently shifted during the NHS reforms that established primary care trusts, also has a generally poor record when it comes to providing the type of services that best meet men's needs. The assumption of primary care practitioners has tended to be that "the services are there and men can use them". It is, therefore, perhaps not surprising that the NHS has been described as "a no man's land"<sup>16</sup>. The MHF's objective is that this should not remain the case for very much longer.

### Men's Health Facts

Men's self-reported general health - "bad" or "very bad" by ethnic group

Chinese	5%
General population	6%
Irish	7%
Caribbean	8%
Indian	9%
Pakistani	11%
Bangladeshi	18%

Department of Health. *The Health of Minority Ethnic Groups '99*. (The Stationery Office 2001)

For more statistical information visit [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk)

# The potential for improvement

The potential for improving men's health is clear. Men are not doomed by genetics to an early death. The difference in life expectancy at birth – some 7.4 years - between men in social classes 1 and 5 shows the potential for improvement<sup>2</sup>. The difference in life expectancy between different parts of England reveals a similar picture: male life expectancy at birth differs by 8.5 years - from 71 years in the local authority area with the lowest life expectancy (Manchester) to 79.5 years in the three with the highest (Rutland, Hart and East Dorset)<sup>17</sup>. Life expectancy is just one dimension of health of course, but these statistics clearly show that there is no biological reason why all men should not live at least as long as those in the groups that currently live longest.

## The men's health lobby

There is now an increasing number of specialist organisations pressing for improvements in men's health. 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. Other male-focused organisations include the Prostate Cancer Charity, the Sexual Dysfunctions Association (formerly the Impotence Association), the Orchid Cancer Appeal and the British Prostate Group. The Health Development Agency, QUIT, the Institute of Cancer Research, the World Cancer Research Fund are among those also paying more attention to men's issues as part of their wider work programmes.

There are now some 200 national and local organisations in the UK undertaking work of some kind on men's health<sup>18</sup>. The smaller, local projects however, are often subject to unreliable, inadequate, short-term funding - and their vulnerability is demonstrated by the regularity with which they disappear from the radar screen of the MHF's database. Nevertheless, they demonstrate that enthusiasm and expertise does exist and could - and should - be built upon.

One particularly significant development was the launch, in March 2001, of the All Party Parliamentary Group on Men's Health<sup>19</sup>. This Group, chaired by Dr Howard Stoate MP, has members from all three main parties and has been extremely active in considering the key issues and contributing to the ongoing debate. Since its inception, it has addressed a variety of issues, including young men and suicide, prostate disease, alcohol misuse, obesity, hypertension and sexual health. MPs have also supported numerous Early Day Motions on men's health issues and tabled questions to ministers.

The pharmaceutical industry has also recognised the importance of tackling men's health. This reflects the industry's commitment to improving public health, not least through health advice and promotion aimed at the general public, as well as its more expected involvement in the 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, contributed to this process.

## Men do care about their health

One of the key lessons from projects that have succeeded in working with men effectively is that men are, in fact, much more interested in their health than is usually assumed. In the right environment, men are surprisingly willing to talk about their concerns, to request information and to ask for help. The Sexual Dysfunction Association's telephone helpline is a good example of this: it receives thousands of calls a year from men about ED, one of the most difficult health issues for men to talk about. Similarly, over 200,000 men have, to date, responded to a media campaign, recently fronted by the great Brazilian footballer Pelé, through which they can receive confidential information about ED. The very large number of visits to the UK's only comprehensive and dedicated consumer-oriented men's health website, [www.malehealth.co.uk](http://www.malehealth.co.uk), reflects men's willingness to access health information if it is provided in a way with which they feel comfortable.

Projects working with men in pubs, clubs, the workplace and even shopping centres have also found that men will use services if they are provided in an appropriate way. One pub initiative, established in Walsall in 1997, was developed by a practice nurse who had previously failed to encourage men to attend a “well man” clinic based in a GP surgery. In three days, over 100 men attended, of whom almost three-quarters had at least one previously undiagnosed long-term health problem<sup>20</sup>. A men’s “MOT” clinic run by nurses at a south London supermarket during National Men’s Health Week in June 2002 screened 55 men in a single day<sup>21</sup>. When Worcestershire Health Authority and Bovis co-operated to run health checks for male construction workers as part of European Health and Safety Week in 2001, 89 out of 200 workers signed up for a free, confidential check<sup>22</sup>.

### **Where do we go from here?**

We stand merely at the starting point of a long-term venture. It is nevertheless, already evident that new attitudes and approaches by health providers can make a significant difference (although, at the same time, we must not forget that robust and sustainable improvements in men’s health will depend on more than shifts in health policy alone). Support will come from a strong, and growing, international movement that is already pressing for better health for men. This movement is, by and large, professionally-led but great encouragement can be drawn from early indications that “ordinary” men do indeed have an interest in their own health. Once better understood, this interest has the potential to provide the foundation for genuine long-term improvements. Men, emphatically, are not the obdurate, indifferent group they are sometimes perceived to be. The Men’s Health Forum believes that there now exists an historic opportunity to take a decisive leap forward in improving men’s health. The goal must be nothing less than the achievement of optimal health and well-being for all men.

### Men’s Health Facts

Male deaths from suicide and undetermined intent by age. Rates per 100,000 population (UK)

Age	1976	1986	1996	2002
15-24	9.8	12.8	15.0	13.3
25-44	15.1	20.4	23.9	24.1
45-64	20.9	22.6	17.3	17.9
65 and over	24.0	26.3	17.3	13.5

Office for National Statistics. *Social Trends 34* (The Stationery Office 2004)

For more statistical information visit [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk)

# Using the Ottawa Charter framework

The framework outlined by the World Health Organisation in its Ottawa Charter for Health Promotion of 1986<sup>23</sup> has never been bettered as a means of both analysing the need to improve health and of structuring the action required to do so. The framework comprises five guiding principles for nation states seeking to improve the health of their citizens. We have chosen the Ottawa Charter framework as the best means of expressing and structuring our own recommendations for the kinds of actions necessary to improve the health of men and boys in England and Wales, and the recommendations on the following pages are grouped accordingly. Our interpretation of the Charter's principles, in the particular context of our objective to improve the health of men and boys, is outlined below:

- **Build Healthy Public Policy**

Historically, the greatest leaps forward in population health have depended not on improvements in clinical practice but have resulted from public policy in non-medical fields (improved water quality, better domestic hygiene, changes in industrial practice, safer transport networks and so on). Men and boys have much to gain from a recognition of the relationship between legislative action of this kind and better health. A concerted - "joined-up" - effort to improve male health would involve changes, for example, to education policy, employment policy, the criminal justice system, family law and so on, as well as the more obvious initiatives that could be taken within the health sector.

- **Create Supportive Environments**

All the evidence suggests that the health of men and boys is inextricably linked to the settings in which they lead their day-to-day lives. This applies at the overarching level of community and the physical environment, as well as at the more specific level of school, workplace, social setting and so on. It may be particularly important for men - whose reluctance to engage with conventional health services has been consistently demonstrated - that we establish structures for health improvement at the places where they spend much of their time.

- **Strengthen Community Actions**

We accept that there is, at the moment, no prospect of a mass movement of men emerging to demand better health. At the same time, we cannot hope to improve the health of men without consulting men, learning from them and supporting those efforts that are being made to stimulate debate and action. This is particularly true of groups of men (e.g. black and minority ethnic men, young men, older men). The Men's Health Forum believes strongly that "ordinary" men do care about their health and that it is a vital component in bringing about improvements that we work to engage them in the process of change.

- **Develop Personal Skills**

Developing the capacity of individual men to improve, maintain and monitor their health is vital. Learning of this kind is a lifelong process, and the skills required are different in different circumstances and at different life stages. From pre-school onwards, we should be delivering information and advice in a way that is consistent with men's and boys' view of themselves and of the world in which they live. This is not, therefore, just a matter of traditional "education" - it is also about, for example, ensuring that individual men have the social skills necessary to utilise services effectively, the self-confidence to request and accept help, and the ability to cope with changes in physical and mental functioning.

- **Re-orient Health Services**

We must work towards a future in which priority equal to that presently given to treatment services is given to the enhancement of good health and the prevention of illness. Since men are badly affected by all the major causes of preventable illness and death, a change towards an approach which favours pre-emptive action would not only be visionary, it would be of enormous benefit to men, especially those men whose health is the very poorest.

## 1. Building Healthy Public Policy

- 1.1 Unless there are clear and obvious reasons for not doing so, every policy document produced by the Department of Health should reflect the Government's stated commitment to gender mainstreaming and, within that context, should cover men's health as a specific issue. Gender and 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.
- 1.2 Targets must be set for the achievement of key men's health goals. There would, of course, need to be detailed discussions about which areas of health were amenable to such an approach but potential examples might include suicide, cardiovascular disease, traffic accidents, obesity levels, smoking and alcohol consumption. In many cases, specific targets for men could be derived from the targets already set for the population as a whole.
- 1.3 The Department of Health should strive to ensure that health concerns specific to men (notably prostate health, ED and other sexual and reproductive health problems) are given the same priority as concerns that are of proportionate relevance to the whole population.
- 1.4 Health Improvement and Modernisation Programmes must be specifically required to address men's health issues as part of a consideration of gender as a determinant of health. Health Action Zones, Education Action Zones, Neighbourhood Renewal Schemes, Healthy Living Centres, Local Strategic Partnerships and other similar multi-agency initiatives should also have a specific brief to tackle men's health problems.
- 1.5 Primary care trusts should be required to complete an assessment of men's health needs as part of their health inequalities work. Each PCT should also be required to ensure that it has a member of staff with dedicated responsibility for the improvement of men's health.
- 1.6 Local authorities should be encouraged to address men's health issues in partnership with their local PCT(s) and the various other agencies with which they work in delivering local services. As providers of leisure, education, housing, environmental and social services, local authorities have a potentially enormous role to play in developing local health initiatives for men, especially those in disadvantaged groups.
- 1.7 All government departments should consider the health implications for men of their policies. Measures intended to tackle social deprivation are of critical importance, since there is good evidence that higher employment levels and a move towards greater social equality would produce significant benefits for men's health<sup>24</sup>. Greater priority should be afforded at all levels to the support of family units (and not just traditional families) since stable relationships are known to be protective of men's mental and physical health, and may be similarly so for boys. In particular, there should be much greater recognition of the importance of fathers, not least because children's (and perhaps more particularly boys') emotional health has been shown to be linked to a positive relationship with their father<sup>25</sup>. It is also essential to recognise that working conditions are one of the most important determinants of men's health - developments in employment policy should always be tested against their impact on the health of men.

## 2. Creating Supportive Environments

- 2.1 Healthcare services – especially primary care services – should be provided in a way that is both convenient to men and consciously “male-friendly” (e.g. opening hours outside working hours, male-interest magazines available in waiting areas, information displays aimed at men, etc.). If such services could be persuaded to consider men's needs more fully, it seems likely that other practical ideas, as yet unforeseen, would follow in due course.
- 2.2 The existing evidence suggests that men are more likely to use services that are quick and convenient. More primary care services should be offered in non-traditional settings. NHS Walk-In Clinics are already proving to be more attractive to male patients than GP surgeries<sup>26</sup> and this aspect of their use should be specifically monitored and, if appropriate, built upon.

- 2.3 High street pharmacies are presently under-developed in terms of their potential to offer information, advice, and guidance for self-treatment. They are also known to be significantly under-utilised by men. Pharmacies may have particular value in terms of delivering services to men and their potential to do so should be explored.
- 2.4 There is a growing body of evidence suggesting that men will respond to outreach services that are offered in places where they already meet and feel comfortable – for example, pubs, social clubs, sports venues and, most particularly, workplaces. The Scottish Executive has instituted an important initiative in this area of provision with its plans to provide a national network of male health checks in community settings – England and Wales has much to learn from this initiative and should monitor it closely.
- 2.5 Men's access to confidential and anonymous sources of health advice (e.g. helplines, websites, etc.) should be encouraged as a matter of policy. Evidence suggests that men may prefer this kind of service and, importantly, that such services may act as a "stepping stone" towards men's use of primary care.
- 2.6 Healthcare professionals should seek to avoid stereotyped notions that disadvantage men and discourage men from using services (e.g. "men are better able to cope with pain"; "men should be brave in the face of distressing news about their health"; "men bring illness and injury on themselves by their behaviour").

### 3. Strengthening Community Actions

- 3.1 Health providers at a local level must make a particular effort to hear from "ordinary" men. The various new consultative processes, such as Patients' Forums, are very welcome here, but it is widely acknowledged to be less easy to involve men in community engagement exercises. Unless there is a dedicated effort to listen to men's experiences as service users and to seek their views about the kinds of services they would like to see, we will continue to develop services that are under-utilised and ineffective. We must therefore actively ensure that men are encouraged, enabled and supported to participate.
- 3.2 Men are not a homogenous group. There is a clear need for the development of a national strategy to improve the health of black and ethnic minority men for example. Young men and older men have particular health problems associated with their time of life that differ from those of the population as a whole, and gay men's health must be seen as broader than HIV and AIDS. We need to engage with communities of men with specific needs in order to better develop appropriate and effective policy and practice.
- 3.3 National Men's Health Week<sup>27</sup> (NMHW), held annually in June, is now an established and successful mechanism for engaging with "the man in the street". It has the proven ability to involve a wide range of professionals in local initiatives aimed at delivering advice and information. It has also had some success in involving local community groups and, in the longer run, may offer the means to discover local advocates or "champions" for men's health. NMHW should therefore be supported as strongly as possible in order to allow it to achieve its maximum potential.

### 4. Developing Personal Skills

- 4.1 Health and social care professionals whose work involves supporting families with small children should be trained and encouraged to discuss with parents the importance of allowing and enabling their boys to develop the skills of "emotional literacy".
- 4.2 Schools should be encouraged to develop policies and structures that allow boys to acknowledge vulnerability and to feel comfortable about asking for help. In this context, schools should ensure that homophobic and sexist attitudes are challenged. These ideologies artificially limit the boundaries of "normal" male behaviour and hinder boys' capacity to see themselves as needful of support in taking care of their physical and mental health.
- 4.3 PSHE (Personal, Social and Health Education) programmes in schools should include a component encouraging boys to take greater interest in health, with a practical focus on using health services. An important and related issue is the increasing evidence that boys may derive greatest benefit from sex education where it is delivered using a gender-specific approach. There is no doubt, in any event, that sex education for boys is in need of improvement.

- 4.4 Men should be encouraged and enabled to become involved as fathers. Ante-natal classes, parenting classes (where they are offered) and other forms of education and family support should include specific components for fathers. There may be scope for a specific national campaign encouraging fathers, rather than mothers, to take their children – particularly their boys – to routine health care appointments.
- 4.5 There is widespread consensus that some aspects of poor male health are directly associated with men's greater propensity for risk-taking. We need urgently to develop a greater understanding of the relationship between masculinity and risk-taking. To that end, investment in a dedicated research or evidence review programme is recommended. In the meantime, we need to develop programmes which aim to help boys and young men make sensitive and sensible judgements about risk.
- 4.6 The ability to seek help – and to accept it when it is offered – is a social skill. Service providers should recognise that it is not a skill that all men possess and should aim to develop ways of working that minimise the discomfort that some men feel when they engage with health and other support services.
- 4.7 Investment is urgently required in initiatives that aim to challenge and change male attitudes and behaviour where these have a detrimental effect on the health and well-being of others. This especially so in the area of violent and anti-social behaviour, including domestic violence. Investment here would benefit the men concerned, as well as victims of violence and society as a whole.

## 5. Re-orienting Health Services

- 5.1 All health-related research should seek to take gender into account much more than it currently does. Unless there are good reasons for not doing so, research should always consider whether differential results for men and women have gender-related explanations – and hence whether gender-specific responses might be required.
- 5.2 There is an urgent need for health promotion initiatives specifically targeted at men (rather than a continued reliance on a population-wide approach). The suspicion is that many groups of men are regarded as intractably difficult to reach by public health planners. Where resources are short and there is pressure to deliver “what works”, this inevitably militates against developing new ways of working with men. As we have previously noted, where there have been examples of good practice, they are often small scale and dependent on the enthusiasm of interested and dedicated individuals. All too often, such projects are subject to unreliable, inadequate, short-term funding. In the absence of national objectives for the improvement of men's health, PCTs must choose to develop a more committed and structured approach to the issue at a local level. Where local projects are of proven worth, PCTs should seek to achieve sustainability and should ensure dissemination to other areas.
- 5.3 In order to support health promotion initiatives targeted at men, specialist training and the construction of a sound evidence-base of “what works” should be developed. In fact, training in men's health must become part of the core curriculum for health professionals of all kinds.
- 5.4 A number of other services currently do not take men's needs into account as well as they might. Many experts believe that depression in men is under-recognised by mental health services, for example, and although the great majority of drug and alcohol misusers are male, there has been little work on the relationship between masculinity and addiction. Men's health is a relatively new area of work and there is currently a dearth of knowledge, skills and experience at all levels. We should be aiming to create a climate in which there is a recognition throughout the health and broader public services that good health for men requires policies and provision tailored to take account of men's specific needs, concerns and experiences.

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## About the Men's Health Forum

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

**Policy development • Research • 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**

The Men's Health Forum's mission is to provide an independent and authoritative voice for male health and to tackle the issues affecting the health and well-being of boys and men in England and Wales. Our vision is a future in which all boys and men in England and Wales have an equal opportunity to attain the highest possible level of health and well-being. The Men's Health Forum believes male health problems should not be tackled by re-allocating resources from female health or shifting attention away from female health.

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