

Hazardous Waist?

Tackling the epidemic of excess weight in men



NATIONAL MEN'S HEALTH WEEK 2005 POLICY REPORT



EXECUTIVE SUMMARY

The current prevalence of overweight and obesity in the national population represents a public health problem of unprecedented seriousness. Finding ways of tackling the problem effectively will be vital for the future health of both sexes - but the situation is of more pressing importance for men in the straightforward sense that many more men than women are currently at risk of developing weight-related disease. Already two thirds of men in England and Wales are overweight or obese compared to just over half of women. If present trends continue, more than three men in every four will be overweight or obese by 2010.

For physiological reasons, overweight men tend to accumulate fat around the abdomen. Abdominal fat is strongly associated with one of the most damaging consequences of obesity, *metabolic syndrome* (see definition on page 4). According to the World Health Organisation definition of the condition, men are significantly more likely to suffer from metabolic syndrome than women. Men also have higher rates of the cancers most commonly associated with obesity (excluding those that only affect women) and are more likely to die earlier in life from heart disease or stroke, conditions which are markedly more common in those who are overweight or obese. Excess weight also causes or exacerbates numerous lesser health problems of varying degrees of seriousness and has recently been associated with a higher risk of dementia in old age. Furthermore, at its present level of prevalence, male overweight and obesity is very damaging to the national economy in terms of years of life lost, working days lost, and in terms of the cost of caring for those affected.

The pattern of the prevalence of excess weight differs between men and women. There is a critical period in men's lives (when they are in their

late twenties and early thirties) when they are at greatly increased risk of gaining weight - women tend to gain weight more evenly across the lifespan. The pre-disposing factors for becoming and remaining overweight or obese also vary between the sexes. Men know less about diet than women and are more likely to drink alcohol to excess. Men are more likely to be physically active than women - but most are nevertheless nowhere near physically active enough to gain a health benefit. Men are less likely to be concerned about becoming overweight, more likely to fail to notice that they have gained weight, and more likely to deny that they have a problem once they are overweight.

There is very little developed knowledge about how to engage with men on the issue of weight and very clear evidence that most of the present support systems are failing to work with men effectively. The Action Plan at the end of this document calls for five measures to be implemented with great urgency. In summary these measures are that:

- It must become widely recognised that "weight is a male issue too".
- It is essential to develop a strong research base.
- "male-sensitive" approaches are needed immediately - especially in primary care and health promotion.
- Work with boys is critical to reducing overweight in adult men in the future.
- Government must implement a cross-cutting strategy to tackle this problem for both men and women. This strategy must take account of the differences between the sexes.

Explanatory note

Terms used in relation to overweight and obesity

Three indicators of overweight and obesity are in common use:

1. Waist circumference

There is an established correlation between raised waist circumference and poorer health prospects. Waist circumference in men is considered to be “raised” when it is 102 cms or over and in women when it is 88 cms or over. The most important factor to note however, is that health risk increases in parallel with increasing waist circumference – for example, in men, a waist circumference of over 94 cms is a very accurate predictor of increased risk of cardio-vascular disease¹ and a waist circumference of over 100 cms is similarly accurate in indicating the risk of type 2 diabetes². For this reason, the recording of waist circumference is in increasingly common use as a monitoring tool in primary care. Simply measuring around the waist as a method of gauging risk to health has the additional advantage of being easily understood by the general public.

2. Waist-to-hip ratio (WHR)

WHR is an alternative means of assessing central obesity. WHR is calculated by dividing waist measurement by hip measurement. A man's WHR is considered to be “raised” when division of his waist measurement by his hip measurement results in a figure exceeding 0.95. A woman's WHR is considered to be raised when the same calculation results in a figure exceeding 0.85. This indicator is not used in this document but may be encountered in some of the reference material.

3. Body mass index (BMI)

Weight relative to height is measured using the BMI scale. An individual BMI score is established by dividing weight in kilogrammes by height in metres squared. The calculation is a complex one but “ready reckoner” tables are widely available. A BMI of between 25 and 30 is described as “overweight”; a BMI of over 30 as “obese”. These definitions apply equally to men and women. The risk of a number of weight-related health problems is known to increase from a BMI of 25 onwards, becoming of particular seriousness beyond BMI 30. BMI has the drawback in some cases that a muscular physique (rather than excess fat) may misleadingly raise BMI to risk levels because muscle is heavier than fat.

BMI is a long established measure of health risk and most existing comparative data (e.g. link between weight and heart disease, link between weight and cancer) is expressed by reference to BMI. For this reason, BMI is the measure used most frequently in this document, despite the increasing interest – which the MHF encourages – in the importance of waist circumference as an indicator of risk (see 1 above).

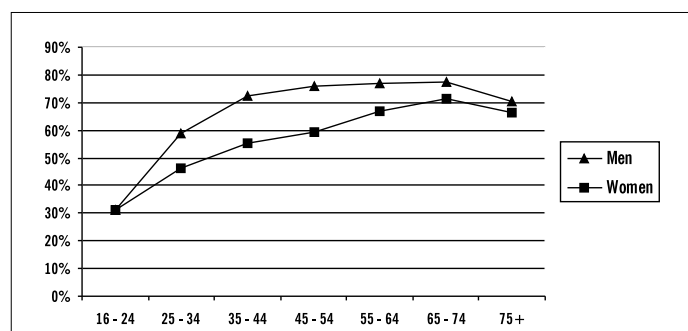
1. Introduction

Contrary to popular belief, more men than women in England suffer from excess weight. The most recent statistics, published in 2004, show that two thirds (65.4%) of English men have a BMI of more than 25 compared to just over half of women (55.5%). Roughly the same proportion of men and women are obese (22.9% and 23.4% respectively)³.

Likewise, the average waist circumference of English men grew by 3.8 cms between 1994 and 2003, from 93.8 cms to 97.6 cms – an increase of 4%⁴. 31% of men now have a waist circumference of over 102 cms⁵.

Male overweight increases with age but not markedly so beyond the 45 – 54 age group, by which time 76% of men are overweight or obese. The critical age period is that between ages 25 to 34, during which period the proportion of men with a BMI of more than 25 almost doubles from 31% to 59%⁶. The prevalence of excess weight in women increases much more gradually over the lifespan.

Proportions of the male and female population with BMI of 25+ by age



Source: *Health Survey for England 2003* (The Stationery Office, London 2004)

Overweight on the present scale is essentially a phenomenon of recent decades. Levels of obesity in men in England have trebled since 1986 and are increasing at a much faster rate than obesity rates in women⁷.

A recent World Health Organisation study of 40 countries found that the UK had the eighth highest rate of obesity in men (compared with the eleventh highest for women)⁸. It is predicted that, if present trends continue, more than three quarters of the UK male population will be overweight or obese by 2010 (more than one man in four will be obese)⁹.

Unlike most indicators of poor health, excess weight in men does not show a very distinct social class gradient, although men in social class 1 are the least likely to be obese (20%)¹⁰.

Figures from the most recent year available (1999) show that the prevalence of obesity in men from Bangladeshi (5.4%), Chinese (6.2%), Indian (11.9%) and Pakistani (12.6%) communities is lower than that of the general male population (18.9% at that time)¹¹. It should however be noted that the health risks associated with excess weight are known to occur at lower BMIs in many Asian populations¹² and that the WHO now recommends that the “cut-off points” should be set differentially for population

groups of different Asian origins¹³. At 20.4%, the prevalence of obesity in Afro-Caribbean men is similar to that of men in the population as a whole¹⁴.

Overweight and obesity among children and young people is also increasing. The Health Survey for England 2002, which had a particular concentration on the health of children, found that 30% of boys aged under 15 are now overweight or obese by the customary BMI measures applied to adults (although if the alternative, international classification system designed specifically for children is applied, this figure falls to 21.8%)¹⁵.

2. Physical activity and diet in men

Weight gain at an individual level, has only one simple cause – an excess of energy intake over energy expenditure. Energy is measured in calories and is taken into the body in the form of food and drink. Energy is expended in all forms of human activity (even sleeping burns calories) but expenditure increases in proportion to the level of vigorousness.

Men tend to be more physically active than women but even so, even in the the youngest age group, less than 50% of men undertake enough physical activity each week to derive a positive health benefit. Overall, one man in five is effectively inactive.

Nos of days p.w. of men's participation in at least 30 mins of activity of at least moderate intensity (Great Britain)

Age	19 - 24	25 - 34	35 - 49	50 - 64	All ages
1 or 2 days p.w.	21%	12%	20%	30%	21%
2 or 3 days p.w.	14%	21%	27%	28%	24%
3 or 4 days p.w.	17%	21%	19%	18%	19%
5 days p.w. or more*	49%	46%	34%	24%	36%

* = Recommended level
Source: Office for National Statistics: *National Diet and Nutrition Survey Volume 5 (2004)*

The energy intake required to meet the average requirements of particular population groups was estimated by the Committee on Medical Aspects of Food Policy (COMA) in 1991. These average requirements are expressed as EARs ("Estimated Average Requirements"). The EARs for men are as follows¹⁶:

Men, by age	EAR (kcal per day)
19 - 59	2550
60 - 64	2380
65 - 74	2330
74+	2100

Surprisingly, given the prevalence of overweight and obesity, across all age groups, men average an energy intake of only 92% of the EARs¹⁷. There is however, significant variation in energy intake between individual

men - for example, for men aged 50 – 64, the range is from 1110 kcals per day to 3409 kcals per day¹⁸.

It is very important to note however, that surveys which rely on self-reporting of energy intake – that is to say, practically all such surveys – are accepted to be subject to an under-estimation rate of up to 25%, with overweight subjects more likely to under-report their energy intake than people of normal weight¹⁹.

Similarly, men's reported average daily fat intake is just one percentage point above the recommended maximum of 35% of energy from fat²⁰. Men do however have a higher intake of saturated fat ("bad fat") than the recommended safe level, deriving almost 14% of their energy intake from saturated fat, compared to the recommended level of 11%²¹. High intake of saturated fat is directly related to a higher LDL cholesterol level (see later) - a major risk factor for heart disease.

Men also have an energy intake from "non-milk extrinsic sugars" (i.e. effectively, added sugar) that is in excess of the recommended maximum level (14% against 11%)²².

Although eating a diet high in fruit and vegetables does not necessarily prevent weight gain, such a diet is correlated with a reduced risk of heart disease and several cancers and it is reasonable to suppose that men eating less than the recommended levels of fruit and vegetables are at higher risk of overweight and obesity.

On average men eat 3.2 portions of fruit and vegetables each day. Only 22% of men eat the five portions associated with a diet that is known to be beneficial for health²³. 6% of men aged under 25 eat no fruit and vegetables at all²⁴.

It must also be observed that 27% of British men drink more than 21 units of alcohol each week, and around 8% drink more than 50 units²⁵. A pint of beer is usually around two units of alcohol and contains roughly 180 calories. A man drinking (say) two pints of beer each day (28 units per week) is therefore consuming the equivalent of one day's energy requirements each week in beer alone.

3. An "obesogenic" environment for men?

Most specialists in the field believe that the overarching causes of overweight and obesity at the population level are much more complex than the cause at an individual level would seem to imply. Consequently, the problem is extremely difficult to tackle effectively.

The western world has an abundance of food. Modern manufacturing processes and the twin commercial imperatives of keeping production costs low whilst making food taste as appealing as possible mean that much of this food is supplied in an energy-dense form (high in fat and high in sugar). Mass advertising campaigns exhort people to eat foods of this kind and some biological research has even suggested an inborn preference for high fat and high sugar foods²⁶ – a characteristic that may potentially be more marked in men²⁷.

High fat, high sugar foods are popular with children. The ethical issues associated with directly marketing such foods to children have been the subject of a great deal of public debate in recent years. A review of the research literature commissioned by the Office of Communications (OFCOM) noted that several studies have found that the food choices of adolescent boys are more likely to be affected by advertising than those of girls²⁸.

Along with these changes to food supply, the developed world has experienced massive technological change over the past century. These changes have resulted in unprecedented shifts in the pattern of work, transportation and communication.

American studies suggest that the population-level increase in men’s BMI began in the late nineteenth century when the amount of physical effort involved in work began to decline. Physical work gradually became less demanding and fewer men were required to be engaged in it. This continuing shift towards sedentary occupations for men was paralleled by a fivefold increase in obesity between the beginning and end of the last century²⁹.

This effect may be particularly marked for men in the UK where working hours are the longest in Europe. 27% of men with full-time jobs in the UK work more than 48 hours a week (compared with 11% of women) and 11% of men work more than 60 hours a week³⁰. Long working hours are not only, in most cases, hours spent in sedentary activity, they also severely limit the time and energy available for physical activity in leisure time.

4. The risks to men

It is well established that excess fat is more damaging to health when it is carried around the abdomen³¹.

Sex is the most important determinant of exactly where on the body excess fat will accumulate. Overweight men commonly gain abdominal fat while women accumulate fat around the hips and thighs. It is often said that overweight men tend to be “apple-shaped” and overweight women tend to be “pear-shaped”.

Excess abdominal fat is sometimes also referred to as “central obesity” and for a range of physiological and biological reasons, is particularly associated with the interlinked group of symptoms that together constitute *metabolic syndrome*³².

Metabolic syndrome (presence of 3 or more of the following symptoms)
Obesity, especially central obesity.
Insulin resistance (type 2 diabetes)
High blood pressure (above 140/85)
High triglyceride levels
Low levels of high density lipoproteins (HDL or “good” cholesterol)

Metabolic syndrome greatly increases the risk of developing heart and circulatory problems - it

approximately triples the risk of death from coronary heart disease and doubles the risk of death from cardiovascular disease³³. This group of risk factors also makes up a “causal web” - that is to say, each of the individual risk factors increases the risk of developing others of the risk factors.

The link between obesity and type 2 diabetes is particularly strong. In the 1950s, approximately 200,000 people in the UK were diagnosed with type 2 diabetes. The figure now stands at 1.8 million, with 100,000 new cases diagnosed each year. The over-riding reason for this increase is the parallel increase in overweight – a BMI of over 30, for example, increases the risk of developing diabetes by 10 times³⁴. Diabetes is, broadly, equally prevalent in men and women. (It is much more common in people of Afro-Caribbean and Asian origin - but probably for different underlying reasons)³⁵.

Waist circumference alone may be a highly effective predictive measure for type 2 diabetes and hence for metabolic syndrome. A recent Swedish study offered very clear evidence that type 2 diabetes is uncommon in both men and women with a waist circumference of under 100 cms. Beyond that point, the prevalence of diabetes increases very markedly³⁶.

There is no internationally agreed definition of the exact components of metabolic syndrome, and two different definitions are in common clinical use*. Use of the “ATP III” definition gives a broadly similar prevalence in men and women (21% - 22% for both sexes) but using the World Health Organisation definition suggests a markedly higher prevalence in men; 24.6% of men having the condition compared to 17.8% of women³⁷ (figures for the Republic of Ireland).

The links between overweight and obesity, increased blood pressure and higher levels of low density lipoproteins (LDL or “bad” cholesterol), are also well established - in particular central obesity increases the concentration of the most damaging form of LDL cholesterol³⁸.

Raised levels of LDL cholesterol and increased blood pressure increase the likelihood of heart disease and stroke. High LDL cholesterol is a major risk factor for heart disease and according to the British Heart Foundation is responsible for nearly half of all deaths from heart disease³⁹. High blood pressure increases the risk of stroke by seven times⁴⁰.

By the same token, tackling one element within this group of interlinked risk factors (i.e. weight) has the effect of reducing the level of risk from the other factors – for example a reduction in weight of 10 kgs is estimated to reduce LDL cholesterol by 10%, triglycerides by 30% and to raise HDL cholesterol by 8% - with a concomitant reduction in the risk of stroke or heart disease⁴¹.

Obesity is also strongly linked with significantly greater risk of several cancers (obesity is second only to smoking as the most important preventable risk factor for cancer). Obesity is most strongly correlated with increased risk of colorectal cancer, oesophageal cancer and kidney cancer⁴². All three of these latter cancers are much more common in

men than women⁴³. Prostate cancer, although it is not linked specifically to weight gain, is known to be strongly associated with a diet that is high in fat, high in sugar and low in fruit and vegetables⁴⁴.

An important longitudinal study has very recently found a strong link between obesity and overweight in mid-life and an increased risk of dementia in old age. The increased risk across both sexes is 74% for those who were obese in mid-life and 35% for those who were overweight. The study suggests that this link may be less marked in men than women but it is nevertheless a further clear deleterious consequence of excess weight⁴⁵.

Excess weight is additionally, a very common - but effectively unquantifiable - cause of low back pain, breathing difficulties (e.g. sleep apnoea) and permanent damage to weight-bearing joints like the knees and hips.

It is estimated that 14,000 male deaths each year in England are directly attributable to obesity⁴⁶. This constitutes around 5.5% of all male deaths⁴⁷. Many of these deaths occur before retirement age, a dreadful toll on family life.

The number of directly attributable deaths however, represents only a fraction of the premature deaths to which excess weight and its consequences are a contributing factor.

Analysis of information gathered during the Framingham Heart Study in the USA suggests that weight-related disease will cause a 40 year-old male non-smoker with a BMI of between 25 and 30 to lose, on average, 3.1 years of future life expectancy by comparison with a normal weight non-smoker of the same age. An obese 40 year-old male non-smoker loses 5.8 years (an obese 40 year-old male smoker loses 13.7 years)⁴⁸.

* During the preparation of this report (April 2005), a third definition of metabolic syndrome has been proposed, by the the International Diabetes Federation. This definition can be viewed at the IDF website at www.idf.org.

5. Men's attitude to weight and "what works" with men

Virtually all industrialised countries have a highly-developed and widely understood network of support systems for women who want to lose weight. This network encompasses elements as diverse as the routine expectation of empathy and encouragement from friends and relatives, ready access to "female friendly" advice from the mass media, multi-national companies running nationwide chains of weight loss classes, and "calorie-counted" foodstuffs in every supermarket.

This firmly established socio-cultural context may have resulted in a vicious cycle which disadvantages men. That is to say, men do not regard attempting to lose weight as a "male activity" and the consequent lack of demand has discouraged the development of a "male-friendly" infrastructure of support - whether that is from social networks, commercial providers or the NHS.

The knowledge base about men's attitude to weight, and how to work with men is extremely limited. There is a dearth of formal literature on the subject.

It is commonly held among health professionals that men are less likely to be worried about excess weight than women - and a recent NOP survey of public attitudes appears to bear this out. No significant differences were recorded between men and women in terms of the perceived disadvantages of being overweight in relation to health (around a fifth of both sexes believing that poor health is the most worrying consequence of overweight) but 42% of men compared to 27% of women answered that being overweight "wouldn't bother me at all"⁴⁹.

A series of focus groups conducted in Dorset in 1995 as part of the planning for a men's weight loss programme found similarly that men over 40 believe that to gain weight as one gets older is "natural" and does not mean that one is "not fit". Men were also found to believe that a pre-occupation with weight loss was a "women's thing".⁵⁰

Gender stereotyping tends to associate "bigness" in men with good health and physical attractiveness. This may give some men a false perception of their own weight. Around half of men who are actually overweight may consider themselves to be normal weight (the reverse of this proposition is true for women). Likewise, overweight men are much more likely than overweight women to consider themselves physically attractive⁵¹.

A detailed psychological study of overweight Swedish men aged 51 similarly suggested that, although poorer physical health was experienced by all men in the study group, simple overweight (by BMI) was positively correlated with relatively high levels of self esteem. Within this overall effect however, men whose excess weight had resulted particularly in excess abdominal fat, were more likely to suffer fatigue and to experience depressive symptoms. (This study hypothesised that social stress might, by biochemical means, actually increase the likelihood of abdominal obesity over a more general distribution of fat)⁵².

Examples of effective practice

The Men's Health Forum is currently working in partnership with BT to pilot a nationwide weight loss programme aimed predominantly at male employees, which should in due course, yield a good deal of practical knowledge. This programme is based broadly on the "Keeping It Up" programme which ran in workplaces in Dorset from 1995 to 2000⁶². South Sefton PCT has also run a successful lifestyle programme - "Tommy the Trucker" - aimed at lorry drivers (almost exclusively men) visiting in the Mersey Docks⁶³. There are also other examples of approaches that have worked well with men but that are not widely known such as the Bradford Health of Men project's work with refuse collectors⁶⁴ and the Braunstone "Beer Belly Busters" Club in Leicester⁶⁵. Because of the shortage of effective interventions and the lack of publication of those that there are, it is important that progress is made on practical project work, evaluation and dissemination.

A study focused specifically on the nutritional knowledge of Scottish men found “glaring gaps” between what men knew and what they needed to know to make even the most basic decisions about healthy eating in accordance with official recommendations – in particular, men were very confused about the fat content of some foods and did not realise that the advice is to eat more starchy foods⁵³.

Perhaps the most comprehensive understanding of men’s attitude to weight however, has been developed in Australia where the national “GutBusters” “waist loss” programme - aimed exclusively at men - enrolled 100,000 men between 1991 and 2002.

The necessity to adapt its programme in the light of its developing expertise resulted in GutBusters gaining an acute insight into men’s attitudes to weight and weight loss. Among other findings, GutBusters’ experience has suggested⁵⁴:

- Men are often “in denial” about their weight.
- Men’s most serious limitation in losing weight is lack of basic knowledge about how to do it. Men enjoy gaining knowledge and will act systematically on what they learn – an “engineering approach”. Likewise, men prefer being given information to being offered “counselling” as a support system.
- Men may prefer to take on their weight problem alone and privately – the conversion of GutBusters from a group-based programme to a personal correspondence programme resulted in an immediate increase in participation.
- Physical discomfort (e.g. digestive problems) may be a greater motivation for men than concern about body image.

There is extremely strong evidence within the UK that these kinds of male attitudes are not only problematic in themselves, but that they are directly reflected both in the way services are offered and the way services are taken up. (This is against a background in which broad popular prejudices against both men and women who are overweight are already believed to affect detrimentally the way such people are perceived and treated by health professionals)⁵⁵.

The national *Counterweight* programme⁵⁶, is a multi-centre practice nurse-led obesity management project being conducted in seven regions of the UK. Since 2000 it has been offering structured programmes to patients in 80 general practices.

A computerised audit of almost 120,000 medical records in 26 of the participating *Counterweight* GP practices revealed that male patients were less likely than female patients ever to have been routinely weighed in the surgery (57.0% against 69.2%) or to have had their BMI recorded (57.7% against 70.6%)⁵⁷.

An analysis of 1256 patients taking part in *Counterweight* programmes across 58 of the participating practices in 2004 found that only 26% of

those attending the programmes were men - despite the service being equally available to both sexes⁵⁸. (Men who did take part lost weight as effectively as women).

Similarly, Recommendation 357 from the Health Select Committee’s 2004 report on obesity⁵⁹ - that NHS organisations should consider partnerships with commercial slimming organisations – has been enthusiastically embraced by a number of PCTs⁶⁰. However the most structured pilot programme so far to use this approach achieved only 12% participation by men⁶¹.

This kind of data and the kinds of attitudinal studies highlighted earlier in this section hint at a complex relationship between maleness and excess weight that is as yet little explored. It may well be that developing a more sophisticated understanding of this relationship is the key to discovering successful strategies to help men achieve and maintain a healthy weight.

Men and weight: the context for the debate

There has in recent years been a number of important analyses of the problem of overweight and obesity in the population as a whole – for example the examination in 2003 by the National Audit Office of the economic consequences of obesity, *Tackling Obesity in England*, and the report of the Health Select Committee in 2004 – but it is certainly not unfair to say that none has given particular consideration to the relationship between maleness and weight gain. Policy initiatives demonstrate a similar lack of attention to this issue. The recent *Choosing Health* white paper for example, is to be commended for its commitment to increasing physical activity and participation in sport, and to promoting healthier eating - indeed on its commitment to the future development of a co-ordinated range of measures aimed at tackling obesity - but it is silent on the need for “male-sensitive” policy and practice. NICE (National Institute for Clinical Excellence) guidelines on the management of obesity are due in 2007 but it seems unlikely at present that they will take anything other than a similar view.

The most encouraging recent development has been the Department of Health’s sponsorship of a major Men’s Health Forum conference on men and weight, *Hazardous Waist?* taking place in June 2005. The Department has also supported the publication of the *Haynes HGV Manual*, a book on weight issues for men designed in the format of a car maintenance manual, and written by the Men’s Health Forum. It is hoped that these developments will mark the beginning of a greater emphasis being given to this issue, which is demonstrably central to any future planning on tackling the problem of overweight in the population as a whole.

Action Plan

The present levels of overweight and obesity in men constitute nothing less than a public health emergency that will continue to get worse unless decisive action is taken in the immediate future. Already two thirds of men are overweight or obese. If current trends continue it is estimated that within five years three men in every four will be so.

The consequences of this situation both for individual men and for society as a whole should be regarded as wholly unacceptable by health practitioners, and by decision-makers across the whole spectrum of public policy.

The Men's Health Forum calls for the implementation of the following five actions as a matter of urgency:

1. Politicians, policy makers, practitioners, the media and the public must recognise that weight is a male issue too.

The popular assumption that weight loss is predominantly a women's concern is one of the crucial reasons for lack of progress on this issue. This assumption almost certainly results in poorer services for men and underpins an unhelpful degree of resigned acceptance among health professionals. Most of all, it perpetuates a myth which affects men themselves and may indeed help to explain why excess weight is so much more common in men than women. It is important however, that any such shift in perception does not rely on the premise that the most important reason for losing weight is to achieve a popular ideal of physical perfection. The idealisation of body-shape has undoubtedly had damaging consequences for women - not least in its association with eating disorders.

2. Men's attitudes to weight and weight loss need to be more fully understood.

It is clear that the existing, broadly "unisex", approach is failing men. Unless there is recognition that helping men to achieve and maintain a healthy weight requires a "male-sensitive" approach then men will continue to gain weight and remain resistant to support services. The lack of existing knowledge in this area means that achieving such an understanding will require investment in a comprehensive and dedicated research programme. As well as exploring men's attitudes and considering how best to work with men, such a programme could aim also (for example) to answer questions about why so many men tend to gain weight in early adulthood and look at the role of alcohol in male weight gain.

3. There must be investment in new "male-sensitive" approaches, particularly in primary care and health promotion.

Although working with men on weight issues is not a well-developed field, there is some practical experience here and there that offers a basis for beginning to tackle the problem. It is important that projects that work effectively with men are properly evaluated and that good practice is disseminated. There is an increasing belief among those who have worked to improve the health of men in other fields,

that men can be persuaded to take their health seriously provided they are approached in the right way. It is arguable that a step change might be achieved by simply making routine health checks (weight, waist circumference, blood pressure, blood cholesterol etc) more widely and easily available (i.e. not just in clinical settings) and by promoting that availability in a way that will encourage male take up.

4. It is essential to develop work on weight issues with boys in pre-schools, schools and community settings.

This is vital, not just because of the increasing levels of overweight in children, but also because the establishment of a healthy lifestyle before adulthood is likely to reduce the risks of later becoming overweight. Initiatives such as the provision of healthier school meals and a greater emphasis on physical activity will clearly make a difference. It seems probable that acting to reduce advertising of "junk" foodstuffs direct to children would also be helpful. As in the case of adults however, attention must also be paid to attitudes and behaviours specific to boys and to developing interventions that are more likely to appeal to them.

5. A cross-cutting national strategy on overweight and obesity is urgently needed.

Such a strategy should focus on men and women separately. It is short-sighted and demonstrably ineffective to concentrate solely on solutions targetted at individuals, important though these are. Lifestyle programmes and pharmaceutical interventions are essential components of the way forward - but the problem of overweight can be tackled effectively only by "joined-up" solutions. Such an approach should focus directly on the prevention of overweight and obesity, not on co-morbidities. Most importantly, the strategy should take central account of the differences between the sexes in order to benefit both men and women. In the case of men, such a strategy should (for example) encompass action on work/life balance; link strategies on alcohol consumption with action on weight; and encourage employers to develop opportunities for staff to become more physically active and eat a healthier diet.

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The mission of the Men's Health Forum (MHF) 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.

We aim to achieve this through:

- Policy development
- Research
- Providing information services
- Stimulating professional and public debate
- Working with MPs and Government
- Developing innovative and imaginative projects
- Professional training
- Collaborating with the widest possible range of interested organisations and individuals
- Organising the annual National Men's Health Week

The Men's Health Forum (MHF) makes comparisons between men's and women's health only when it is unavoidably necessary to do so. We do not advocate shifting attention away from female health or re-allocating resources from women to men. Moreover we do not believe that women's health should function as a "gold standard" for men's health – the MHF is committed to improved health for both men *and* women.

The Forum's mission, vision, values and beliefs statement can be read in full at:
www.menshealthforum.org.uk.

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