

Men and health: a literature review

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Executive Summary

The aim of this review is to critically examine literature about men and their health status in order to inform considerations about men's health in New Zealand.

Most of the literature has been written in the past 20 years, with the majority since the mid 1990s. It covers descriptive reports on the biological status of men's health; comparative studies on men's and women's health; philosophical and sociological analyses of masculinity and the male role; health disparity analyses; impact of health professional action on men's health, and original research on interventions to improve men's health.

As in other Western countries, the health status of New Zealand men is poorer than that of New Zealand women. Pakeha women live 5.2 years longer than Pakeha men and Maori women live 4 years longer than Māori men. Pakeha men live about 8 years longer than Māori men. There are also differences in the incidence of and death rates from certain disease states.

While the apparent disparity between men and women's health is not disputed, there is little agreement on whether or how to address this. The extent to which biological differences between men and women affect health is debated. There is agreement that the health status of men is linked and shaped both by the nature of social organisation with accompanying socially defined roles, and also economic opportunity which negatively impacts on particular groupings of men. However, it is unknown which of these factors impacts most on men's health and if and how this can be addressed.

Men are not a homogenous group, and health status varies according to a number of factors most-notably including socioeconomic status and ethnicity. Interventions designed to address these factors have largely not been evaluated. The literature signals the need for more original research to clarify these factors. Suggested research should include work on understanding men's health beliefs; behaviours which facilitate help-seeking, and identifying possible failures in the current health service systems. Masculine roles and ideologies (including those of male health professionals) are most likely to play a part in discouraging men's help-seeking.

There is variation in the interpretations applied to men's apparent difficulty in accessing health services. Some see this as a mismatch between available services and traditional masculine roles that emphasise emotional self-reliance and control. If this is the case, the solution is either to 'change' the man to fit the existing services or to change the services to make them applicable to men. However, men's lack of help-seeking can also be viewed as a result of social construction. In this case society would need radical change to encourage an attitude that it is 'OK' for men to care for themselves and actively seek health care.

There is agreement that the wider determinants of health must be taken into account, including policy relating to employment, education, housing, social welfare, and justice. Access to health for underserved populations must be improved. In groups of men with increased vulnerability to illness, there needs to be more attention on promoting healthy lifestyles and improving timely access to

affordable health care. Policy should aim to address how men's behaviour and lifestyles contribute to their immediate and long-term health needs. Those involved in local delivery of health care should consider how men can be specifically targeted so their health care requirements can be identified and addressed.

This review concludes that there are unresolved issues around men's health. Factors other than biological difference have a significant effect on men's health, particularly those imposed by society's norms for the male role. Health services appear to be slow in addressing these issues and few change models have been shown to be successful. This highlights the need for further research in several areas to provide a foundation for effective men's health work.

Comment: This repeated para from above.

Men have a lower life expectancy than women, and there are enormous costs associated with premature death and disability that impact families, employers, and society as a whole. Men play a critical role in families as fathers and sons providing care and support to other family members. As members of the workforce, they are employers and employees whose health and wellbeing affect productivity and economic well-being. Improving the health of men through early detection of male health problems and timely treatment of disease can result in reduced morbidity and mortality (leading to) benefits for men, families and society. Then, if one is to improve the health status of men first and foremost is the need to reduce greatly the burden of excess mortality and morbidity suffered by the poor.¹

1.0 Introduction

An original version of this literature review constituted one component of ‘The Men’s Health Project’ which was undertaken in 2002-3 by the Department of General Practice at the Wellington School of Medicine and Health Sciences. The literature review was designed to inform the Men’s Health project group about the background, current issues and thinking in regards to men’s health. It also provided a description of interventions undertaken to address men’s health needs predominantly in the primary care area.

The aims of The Men’s Health Project were to:

- undertake focus groups with a number of peer review groups in the Wellington area to explore what general practitioners (GPs) and practice nurses think about men’s health in general and their perceptions regarding barriers to men’s health care
- put into place an intervention, if required, at GP practice level with the practices represented in the focus groups
- undertake a preliminary examination of New Zealand men’s attitudes towards health and primary care
- provide information from the above to inform the Cancer Control Strategy and /or the National Health Committee and/or other policy stakeholders
- describe possible health care interventions acceptable to men and consider their feasibility.

A report of this project will be available shortly on

<http://www.wnmeds.ac.NewZealand/academic/GP/research/TheMensHealthProject.pdf>

In November 2004, the National Health Committee contracted the Department of General Practice, Wellington School of Medicine and Health Sciences to update the literature review to inform a men’s health needs analysis being undertaken for the Minister of Health.

1.1 Background

Writing on the general entity of ‘men’s health’ began to appear in the literature in the early 1980s. There is no generally agreed-on definition of what constitutes the term ‘men’s health’ with many writers describing what it does *not* constitute and not

defining what it does. The lack of an agreed-on definition has been highlighted as one of the barriers to health professionals addressing men's health as an issue of concern.²

A definition which has been put forward by the American men's health forum and cited in Rich and Ro states:

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. (pg 1)¹

The United States Institute of Medicine (IOM)³ have advocated the use of a definition of health being a *state of wellbeing with the capacity to function in the face of changed circumstance*. Rich and Ro suggest that taken together, these definitions take account of the way men's health is expressed in functional, wellbeing and disease orientations.¹

Many of the writings on men and their health focus predominantly on the comparison between the health of men and women. This focus is seen as unfortunate as it “...sets us on the path of comparison which sometimes leads to competition and rivalry” (p4).⁴ (Paradoxically in a number of health research studies, gender is rarely mentioned, even when it could be a significant factor.^{4,5} This phenomenon has been described as ‘gender blindness’ or ‘gender invisibility’.²) Generally speaking, the scope of writings on ‘men's health’ focuses on men and their health needs, or, on why men don't address their health needs and/or attend health care providers and/or on initiatives that might address this issue.

1.2 Aim of review

The aim of this review is to examine literature about ‘men's health’ particularly looking for literature which critically examines existing health care models and describes alternatives. There are particular bodies of literature in relation to specific groupings of men which are only briefly addressed in this literature review, in particular ‘gay men’, men with HIV/AIDS, and men with disability or chronic illness. The review includes a summary of the key issues relating to:

- Men's health in New Zealand
- The status of men's health
- Men, masculinity and health
- Young men and their health
- Initiatives to improve men's health including a description of:
 - Workplace initiatives
 - Community initiatives, including one-off initiatives and multifaceted programmes which provide a number of different services or target particular groupings of men
 - Primary care initiatives including discussion about the influence of the gender of the patient and/or the GP and the discussion about health screening

- Stand-alone initiatives that utilise a primary care philosophy of practice.

1.3 Scope and depth

This review of the literature will provide a broad contextual understanding of men's health including a brief overview of the general state of men's health and contributing sociological factors. The review is comprehensive rather than systematic, and is limited to literature available in New Zealand.

Articles or books were retrieved following literature searches of Medline, CINAHL, Embase, Te Puna, and psycINFO databases. Bibliographic references were identified from other works as well as references recommended by colleagues. An internet search of men's health websites was undertaken as well as tracking websites identified from other sources.

The literature reviewed comes predominantly from medical and nursing journals with some literature coming from social science publications. An internet search demonstrated a considerable amount of media targeted particularly at men. A selection of this information was downloaded. National and international government (and similar) reports when able to be sourced have been included in the review.

Database searching for literature on 'men's health' is not straightforward. 'Men's health' is not a MeSH term (whereas 'women's health' is). Initially literature was located using combinations of subject headings including 'men', 'gender identity', 'health', 'risk taking', 'self concept', 'pilot projects', 'health policy', 'health care reform', 'primary care', 'health promotion', 'health education', 'health services accessibility', 'attitudes to health', 'health behaviour', 'health compliance', 'risk status', 'social class', 'social characteristics', 'ethnic groups', 'social values', 'lifestyle', 'primary prevention' and 'health seeking'. Each set of results from the searches was scanned and works chosen on the basis of a relevant abstract, or where no abstract was available, the title of the work. The search was refined and re-run at the end of 2004 and all literature published since 2003 were identified, abstracts scanned for relevance and the data available in New Zealand retrieved.

2.0 Men's health in New Zealand

2.1 Life expectancy

Current figures (released in 2002) show New Zealand men can expect to live 75.2 years and New Zealand women 80.4 years, a gap of 5.2 years. Māori men can expect to live to 68 years and Māori women 72 years, a gap of 4 years.⁶ The gap between women and men's life expectancy was 4.1 years in 1950-1952 and reached a high of 6.5 years in 1975-1977.

There was a period of rapid gain in Māori life expectancy in the three decades after World War II. However, between 1980 and 2000 disparities between Māori and non-Māori increased significantly. Non-Māori life expectancy increased rapidly in this time but Māori life expectancy increased little. The gap in life expectancy between

Māori and non-Māori increased from six or seven years, to about nine years. Life expectancy estimates released in 2004 from Statistics New Zealand suggest Māori life expectancy has started to improve with the difference between Māori and non-Māori life expectancy narrowing from 9.1 years in 1995-1997, to 8.5 years in 2000-2003.⁷

2.2 Causes of death by gender

A summary of trends from the New Zealand Health Information Service 'Mortality and Demographic Data 2000'⁸ (the most recent 'Causes of Death' data, is provisional 2001 data, see Appendix A):

- There were 26,723 deaths in New Zealand in 2000, a decrease of 5.3 percent from 1999
- There were 13,817 male deaths and 12,906 female deaths in 2000
- Māori accounted for 9.7 percent of total deaths in 2000 (2583 deaths), while Pacific peoples accounted for 3.2 percent of deaths (861 deaths)
- Males had a 55.2 percent higher age-standardised rate of death than females in 2000 (512.0 and 329.9 deaths per 100,000 population respectively)
- The Māori age-standardised rate of death (720.1 per 100,000 population) was 87.3 percent higher than the non-Māori age-standardised rate (384.5 per 100,000 population) in 2000
- Cardiovascular disease, which includes ischaemic heart disease, hypertensive disease, and cerebrovascular disease was the leading cause of death for men. This was followed by cancer.

Selected trends:

Cancer

- There were 7620 cancer deaths in 2000 (4120 males and 3500 females)
- Leading causes of cancer death included cancer of the lung, cancer of the breast, colorectal cancer and cancer of the prostate.
- Māori males had an age-standardised cancer death rate that was 51.3 percent higher than the non-Māori male rate, while the Māori female age-standardised rate was 82.1 percent higher than the non-Māori female rate
- Lung cancer was the leading cause of cancer death for Māori in 2000
- There were 622 deaths from female breast cancer in 2000, accounting for 17.8 percent of female cancer deaths
- There were 594 deaths from prostate cancer in 2000, accounting for 14.4 percent of male cancer deaths.

Ischaemic heart disease

- There were 5973 deaths from ischaemic heart disease in 2000 (3269 male and 2704 female)
- Māori males had an age-standardised ischaemic heart disease mortality rate that was 88.6 percent higher than the non-Māori rate, while the Māori female

age-standardised rate was 121.0 percent higher than the non-Māori female rate.

Cerebrovascular disease

- Cerebrovascular disease was the third leading cause of death in 2000, with 2668 deaths
- Māori males had an age-standardised cerebrovascular disease mortality rate that was 7.1 percent higher than the non-Māori rate, while the Māori female age-standardised rate was 55.6 percent higher than the non-Māori female rate.

Other causes of death such as accident (2.9% (M) compared to 1.3% (F)) and intentional self harm (2.7% (M) compared to 0.6% (F)) showing very different gender associated rates.⁸ In 2001, the all-ages sex ratio for suicide in New Zealand was 3.3 male suicides to every female suicide. The youth suicide (15-24 year) ratio was 3.7 male suicides to every female suicide. The rate of suicide for Māori males was 20.7 deaths per 100,000 population compared to the non-Māori rate of 17.7 per 100,000 population.¹⁰

Table One**Major causes of death – numbers and percentages by sex, 2000**Source: *'Mortality and Demographic Data 2000'*

	Male		Female	
	No.	%	No.	%
	3269	23.7	2704	21.0
Hypertensive disease	85	0.6	134	1.0
Other forms of heart disease	535	3.9	708	5.5
Cerebrovascular disease	1048	7.6	1620	12.6
Cancer	4120	29.8	3500	27.1
Cancer of the colorectum & anus	(571)	(4.1)	(563)	(4.4)
Cancer of the trachea, bronchus and lung	(860)	(6.2)	(546)	(4.2)
Prostate cancer	(594)	(4.3)	-	-
Breast cancer	(2)	(0.0)	(622)	(4.8)
Stomach cancer	(186)	(1.3)	(123)	(1.0)
Pneumonia and influenza	147	1.1	200	1.5
Diabetes mellitus	408	3.0	394	3.1
Chronic obstructive pulmonary disease	769	5.6	571	4.4
Transport accidents	403	2.9	170	1.3
Falls	111	0.8	140	1.1
Intentional self-harm	375	2.7	83	0.6
Assault	32	0.2	22	0.2
All causes of death	13,817	100.00	12,906	100.00

↑

2.3 Trends in mortality rates

Between 1951 and 1996, death rates declined by three quarters among infants and children (decline of infectious diseases) and there were small decreases in other older age groups. In the last two decades the greatest relative improvements have been in middle age (45-65 years), (despite a male peak because of ischaemic heart disease through to the mid 1970s), and older age (65+ years). Young people from 15-24 years have shown the least relative improvement (predominant cause of death is by accident).¹¹

Table two summarises the major causes of death in New Zealand and compares the 1996 and 2000 figures

Table Two: Major causes of Death¹²

	Male		Female	
	Rate per 100,000 population			
	1996	2000	1996	2000
Ischaemic heart disease	185.0	143.8	90.6	74.3
Stroke	50.9	45.2	46.8	41.6
All other cardiovascular disease	38.4	32.0	30.0	25.4
Breast cancer	-	0.1	28.5	23.9
Lung cancer	43.6	37.6	20.2	20.0
Chronic obstructive respiratory disease	45.8	35.9	22.8	19.7
Colorectal cancer	28.8	25.0	20.8	19.0
Diabetes	15.0	18.0	10.5	12.3
Dementia	7.6	8.2	9.0	7.3
Motor vehicle accident	20.6	16.0	8.1	7.1
Aortic aneurysm	11.1	10.5	6.5	4.7
Suicide	23.7	20.9	6.1	4.3
Stomach cancer	8.6	8.1	4.5	4.1
Prostate cancer	23.9	25.2	-	-
All other causes	215.9	203.0	163.8	141.5

2.4 Prevalence of chronic disease in New Zealand

A 'Portrait of Health: key results of the 2002/03 New Zealand Health Survey' looked at the prevalence of disease by gender and ethnicity in New Zealand. Prevalence is defined as a measure of the proportion of people in a population who have some attribute or disease at a given point in time or during some time period. Prevalence includes both new (incident) and existing cases of disease.¹

Key trends have been noted where they were influenced by gender and are summarised below:

Heart disease:

One in 10 adults reported that they had been diagnosed with heart disease. Heart disease is caused by a combination of genetic and environmental factors. Modifiable risk factors for heart disease include high blood cholesterol, high blood pressure, tobacco smoking, weight and obesity, physical inactivity, diabetes, high blood homocysteine and inadequate fruit and vegetable intake. In males the prevalence of heart disease was highest in Māori, followed by European/Other, Pacific and Asian ethnic groups. In males there was no significant difference in the prevalence of heart disease between New Zealand Dep 2001 quintile 1 (least deprived) and quintile 5 (most deprived) although the prevalence of heart disease increased. Among adults diagnosed with heart disease males were significantly *more* likely than females to receive medical treatment (aspirin, other medication, bypass surgery or angioplasty).

¹ New Zealand Guidelines Group definition http://www.New Zealandgg.org.New Zealand/templates/dsp_popup_glossary.cfm?glossaryword=prevalence accessed 31/12/04

Stroke

One in 48 adults reported that they had been diagnosed with stroke. Stroke is caused by a combination of genetic and environmental factors. Modifiable risk factors for heart disease include high blood pressure, high blood cholesterol, tobacco smoking, high alcohol intake, overweight and obesity, physical inactivity. In both males and females the prevalence of stroke was higher in Māori, than non-Māori. In both males and females, the prevalence of stroke was higher in the most deprived New Zealand Dep quintile although this did not reach statistical significance. In males, non-Māori were *more* likely to receive medical treatment for stroke than Māori although this did not reach significance.

Diabetes

One in 23 adults reported they had been diagnosed with diabetes. Diabetes is characterised by raised blood glucose due to insulin deficiency (type 1) insulin resistance (type 2) or both. Diabetes is an important cause of morbidity and mortality, including cardiovascular disease, blindness, kidney disease and vascular insufficiency of the legs. The major risk factors for type 2 diabetes are obesity and physical inactivity. In males the prevalence of diabetes was significantly *lower* in the European/Other group than in Māori and Pacific ethnic groups. In both males and females, the prevalence of diabetes was about four times *higher* in New Zealand Dep2001 quintile 5 (most deprived) than in quintile 1 (least deprived) and these differences were statistically significant.

Asthma

One in 5 adults aged 15-44 years reported that they had been diagnosed with asthma. The cause of asthma is unknown but once developed it can be triggered by allergens, respiratory infections, exercise, cold air, tobacco smoke and other pollutants. In both males and females, the prevalence of asthma was significantly higher in the Māori and European/Other ethnic groups than in Pacific and Asian ethnic groups. Among adults diagnosed with asthma, males were *less* likely than females to receive medical treatment.

Chronic obstructive pulmonary disease (COPD)

One in 18 adults over 45 years reported that they had been diagnosed with COPD. Emphysema and chronic bronchitis are the most common forms of COPD. The main risk factor is smoking. In both males and female, Māori were slightly *more* likely than non-Māori to receive treatment for COPD although these differences were not significant.

Cancer

One in 20 adults reported that they had been diagnosed with cancer. Collectively, cancers account for a quarter of deaths with the major sites being lung, colon, breast and prostate. In both males and females the prevalence of a cancer diagnosis at any one time was *slightly lower* in New Zealand Dep2001 quintile 1 (least deprived), than in quintile 5 (most deprived), although these differences were not significant.

Serious mental disorder

One in 40 adults reported that they had been diagnosed with a serious mental disorder. There were no significant differences in serious mental disorders between males and females.

Risk and protective factors

A number of factors were surveyed including identified high blood pressure, identified high cholesterol, adequate vegetable intake, adequate fruit intake, physical activity, regular physical activity, sedentary lifestyle, weight or obesity, abdominal obesity, adult weight gain, weight cycling, hazardous drinking, current smoking, passive smoking, marijuana use in the past 12 months and regular marijuana use. Key prevalence trends were noted where they were influenced by gender and are summarised below and in Table 3.

- Males were significantly *more* likely than females to be physically active
- Males were significantly *less* likely than females to eat the recommended number of servings of vegetables and fruit per day
- Male drinkers were *more* than twice as likely as female drinkers to have potentially hazardous drinking behaviour, the 15- 24 year age group being most at risk. The prevalence of past year alcohol use was significantly higher in New Zealand Dep2001 quintile (least deprived) than in quintile 5 (most deprived). Prevalence for hazardous drinking was slightly higher in New Zealand Dep2001 quintile 5 than in quintile 1 although this did not reach significance.

Table Three: Health Risk behaviours¹²

	Total population	
	Male (%)	Female %
Body mass index		
Underweight	2.6	3.6
Overweight	38.0	47.9
Obese	19.0	21.2
Tobacco smoker		
Non-smoker	50.2	57.2
Ex-smoker	26.3	20.6
Smoker	23.5	22.1
Hazardous drinker		
Hazardous drinking	27.1	11.7
Physical activity		
Physically active: at least 2.5 hours per week on one or two days / week	78.9	70.3
Physically active: at least 30 minutes per day on five days of the week	56.9	48.3
Vegetable and fruit consumption		
Eat at least three servings of vegetables per day	62.7	71.3
Eat at least two servings of fruit per day	43.9	64.1
Eat at least three servings of vegetables and two servings of fruit per day	30.9	49.6

2.5 Men's health-seeking behaviour in New Zealand

Health-seeking behaviour was surveyed and key prevalence trends where they were influenced by gender are noted below:

- Males were significantly *less* likely than females to have visited a GP in the last 12 months
- European/Other males were significantly *more* likely to have visited a GP in the last 12 months than Māori or Asian males
- Both males and females aged over 65 years were significantly *more* likely than adults aged 15-24 years to have seen a GP in the last 12 months. Up to age 44 years males were significantly *less* likely than females to have seen a GP in the last 12 months
- Males were significantly *less* likely than females to have a usual GP (males tended to attend different GPs)
- The mean number of GP visits to a GP in a year was significantly *lower* in males (3.5 visits) than in females (4.3 visits). In both males and females, there was no significant difference in the use of GP services between New Zealand Dep quintile 1 (least deprived) than quintile 5 (most deprived), although males in quintile 5 (most deprived) were *more* likely than males in New Zealand Dep quintile 1 (least deprived) to report an unmet need for a GP (needed to see a GP, but did not see one)
- Māori males are *more* likely to have seen more than one GP, followed by European/Other, Pacific and Asian males although these differences were not significant
- Māori males were *less* likely than Māori females to visit a Māori health provider ²
- The most common reasons for seeing a GP were for a short term condition, routine check-up, chronic condition, injury or poisoning. A higher percentage of males, than females attended for routine check-up and for injury/poisoning. (Note: There were a significant number of additional GP attendances by females for contraception, cervical smear and maternity care allowing the opportunity for preventive care and relationship building with a GP or other health professional)
- Females were significantly *more* likely than males *not* to be charged for their last GP visit, while males were significantly *more* likely than females, to be charged \$50 or more
- Pacific males were most likely to report an unmet need for a GP, followed by Māori, Asian and European/Other males although these differences are not significant. Adult males in New Zealand Dep quintile 5 (most deprived) were more likely than adults living in New Zealand Dep quintile 1 (least deprived) to report an unmet need for a GP although the difference was not significant.
- Males were significantly *less* likely than males to have used a telephone helpline
- Males were significantly *less* likely than females to have used a service at, or been admitted to a public hospital as a patient in the last 12 months. (These

² One in 7 Māori adults visited a Māori health provider in the last year. It seems that providing a culturally appropriate service alone is not enough to overcome the generic issues that males have seeking health care. It may be the Māori health provider services may need to target men in other ways to improve attendance. Pacific males and females attended Pacific health providers in equal numbers.

prevalence figures did not isolate visits for maternity care and therefore do not accurately reflect accident/surgery/illness visits).

- There was no significant difference in the proportion of males and females using private accident and emergency clinics. (Note: this is dissimilar to other countries)
- Māori males were significantly *more* likely than European/Other and Asian males to not collect one or more of their prescription items in the last 12 months
- Males were significantly *less* likely than females to have seen a dentist or dental therapist in the last 12 months.

2.6 The association between socio-economic factors and health

In 2004, the Public Health Advisory Committee released *The Health of People and Communities*⁷, a Report to the Minister of Health. The report examined the relationship between socio-economic status and health, and concluded in the Foreword to the report, that ability to achieve good health and a long life reflected differences in socio-economic status and ethnicity. The health of ‘poor’ men is mentioned as being of significance in the opening pages, however neither ‘poor men or men’ are specified again as a specific category in the document:

*Inequality in health outcomes is considerable. New Zealand men on low incomes have twice the risk of premature death than men on high incomes. Being Māori further increase the risk of death across all socio-economic categories. (p1)*⁷

Comment: Barb would have something to say about this.

The association between socio-economic factors and health outcomes is noted to be significant and preventable: “...*determinants of health impact differentially on sectors of the population, resulting in health inequalities. These health disparities are preventable and therefore should not be considered acceptable*”. (p20)⁷

A summary of key factors identified by the report are included below. (*Where the text refers to population or people, it is possible in the context of this literature review to read ‘men’*). While the most significant disparity in health outcomes occur in Māori and Pacific people and this is discussed at length in the document, it is notable that the commentary in the section on health makes limited reference to the health outcomes of *poor* people (and *poor* men) as a specific entity:

- Explanations which may describe why the health disparities below occur include epidemiological explanations (risk factors and disease), macro-economic and social structure explanations (social and economic change) and differences in access to, and quality of, health care services
- There is a lack of evidence on the associations between the determinants of health and Māori health outcomes which limits knowing how to address these. Also, there is very limited evidence related to the differential effects of policy interventions, many of which seem to have improved the health status of the well-off, rather than the at-risk. It is noted in the report that research undertaken so far on risk factors which have an impact on health has not

addressed lifestyle issues and behaviour out of the social and economic context of peoples lives

- The Māori population has a younger age structure and together with lower levels of education and less skilled workforce, have a lower median income than non-Māori. Māori workers on average earn 80.5% the hourly rate on non-Māori. Māori in all income categories have worse health than non-Māori, meaning there are variables independent to income, operating above the effect of income (high-income Māori death rates were 2.25 times higher than high-income Europeans; Māori on high income have a 40% higher death rate than low-income non-Māori)
- Pacific people have similar age and income structure to Māori, however have an additional stress in being expected to make a regular monetary donation to family, in the island of origin
- Low income over a long period has greater impact on health outcomes than a short timeframe; however short-term poverty in early life can have life-long consequences on health. Children who live in extreme poverty over time are likely to have the poorest health. Māori in the 1990s were twice as likely to be in poverty as Pakeha/European, and Pacific peoples were three times more likely to be in poverty. One in three children lives in poverty in New Zealand. 49% of Māori children and 42% of Pacific children live in economic hardship; 21% of Pakeha children live in economic hardship
- Disabled people are over-represented among poor people and are twice as likely as non-disabled people to be unemployed
- Well-educated people have better health than less educated people; generally people with the worst health have low educational levels.³ Māori and Pacific people are less likely to have attended pre-school than Pakeha or Asian children. Māori were less likely than other ethnic groups to leave without a qualification. A disproportional number of the lowest literacy achievers are Māori or Pacific people
- Housing affects health. Many Māori and Pacific Islanders because of housing costs, live on the fringes of cities and face higher travel costs and longer trips to and from their workplaces. They spend higher proportions of their income on rent (and overcrowding is said to result from these costs)
- Access to New Zealand primary care is subsidised, but in the majority of areas is not free (although this is changing with the roll-out of the Primary Care Strategy with 'access' funded health care services being offered free or at significantly reduced cost). It has been noted that the cost of primary care in New Zealand is higher than in other countries. Primary care acts as a

³ Low educational status contributes to the cycle of disadvantage because people do not have the occupational or financial advantages associated with higher educational attainment and/or are unable to navigate the health care system and locate the resources that they need. *A poor man's plight: Uncovering the disparities in men's health*, Rich & Ro, 2002

gatekeeper to other health and disability services. Cost is known to be a barrier in accessing general practice health care for those with below-average incomes, particularly those with children, who as a result may take their children to hospital for (free) assessment and treatment of non-emergency conditions. Māori adults were twice as likely as non-Māori to have gone without health services because of cost (anecdotally, men are more likely to forgo health care in lieu of their partners and children)

- Cost is not the only barrier; there is increasing evidence that there is differential access to health care between ethnic groups. New Zealand examples include Māori females being less likely to be screened for cervical cancer; Māori males and females receiving fewer cardiac interventions (despite higher mortality from cardiac disease) and Māori males and females generally having higher mortality rates from cancer after diagnosis.⁴

The report concludes with a number of recommendations to the Minister of Health. The recommendations are in line with the report introduction, which states that social and economic factors are the main determinants of health and therefore the solutions would lie in changes in social and economic policy. Recommendations of significance to men and boys are noted to include:

- **Recommendation 1**: Adopt a goal of improving health of all, without distinction for ethnicity, social or economic position, to the same level as those with the best health.
- **Recommendation 3**: Aim to reduce child poverty by at least 30% by 2007 and make continuing improvements until child poverty is eliminated from New Zealand.
- **Recommendation 4**: Assign to an appropriate Government body' whole of Government' responsibility for co-ordinating policies and monitoring effects on health inequalities.
- **Recommendation 6**: Require the routine reporting of data on socio-economic status ethnicity and health at national and district health boards. This should include analyses by socio economic status within ethnic groups (*author adds should include analyses by gender*)
- **Recommendation 7**: Fund research for identifying policy interventions that reduce health inequalities and to better understand the causal paths linking socioeconomic status, ethnicity and health (*author adds gender*).

⁴ Rich and Ro in *A poor man's plight: Uncovering the disparities in men's health* (pg 14) cite considerable research which supports "the notion that providers unconsciously consider race when making treatment decisions in the applications of expensive technologies". The Institute of Medicine suggest that two sets of factors influence these disparities assuming all populations have potentially equal access; the first being the health care systems including cultural barriers fragmentation of health care, and systems of health care prioritisation; the second resulting from the clinical encounter where providers may be biased against poor men or men of diverse ethnicity; greater clinical uncertainty when assessing poor men or men of diverse ethnicity and beliefs held by the health care provider about the behaviour of health of poor men or men of diverse ethnicity.

3.0 The status of men's health

Despite having many of the social determinants of health in their favour, men have higher mortality for all 15 leading causes of death and an average life expectancy 5-7 years shorter than women.¹³ Additionally there is a male excess of premature death in most major disease states.¹⁴ There are also significant between-country differences in both male/female life expectancy and male/female incidence of certain diseases. For example there is an 11-year difference between male and female life expectancy in Estonia and virtually no difference in Turkey; the death rate for ischaemic heart disease in males varies between 215 per 100,000 in Ireland to about 60 per 100,000 in France (www.emhf.org/resources.stats.htm).

With an international trend of falling birth rates there is a decline in the numbers of young men; in Italy, for example, there are almost as many older men as young men.¹⁴

3.1 Elements that contribute to the differences between men's and women's health

Despite the significant differences between the health and life expectancy of men and women, there are limited factors proven or suspected to cause this difference. There are five broad elements¹⁵ which may contribute to understanding the difference between men and women's health, however the degree to which each affect health has not been able to be estimated:

1. Biological/genetic differences between men and women
2. Social and ethnicity differences and structural inequalities
3. Behavioural differences linked to different social expectations of men and women
4. Men's health-seeking behaviour, and use of and access to the health services
5. Health professionals care of men

1. Biological/genetic difference

Sex differences result in differences in body function, but how does this impact on health? Biologically determined gender health differences are said to begin with the inherent vulnerability of men particularly at conception and pre-birth. The human male is more vulnerable than the human female throughout the whole lifespan^{16, 17}, with sex differences in health status reported to be greatest between 15 and 65 years.¹⁸ Boy's growth, because they are the faster growing sex, is more severely affected if there is a shortage of food during pre-birth or childhood development, and more sons than daughters die in the womb and during childhood.¹⁹

Over the lifetime there is evidence that biology plays a part in determining health differences. Women are thought to have neuro-endocrine, cardiovascular⁴ or haematological²⁰ (and for men urinary-genital²¹) protective factors for at least some stages in their lives (the IOM report *Exploring the biological contributions to human health: does sex matter?* provides extensive background to this issue). Men are also thought to be susceptible to the hormonal influence of testosterone which may result in increased vulnerability to cardiovascular disease and stroke and also promote aggressive behaviour, increase risk taking resulting in injury and death.¹

Biological difference is also demonstrated in the gender variation of disease presentation. Around 40% of all male deaths under the age of 75 years are from circulatory diseases and over two thirds are due to coronary health disease (circulatory diseases in males are about 60% higher than in females).¹⁵ Around 30% of male deaths under 75 years are caused by cancer, with prostate cancer being the most common male cancer.²² Although estimated lifetime risks of developing cancer are 1:3 for both men and women, the risk in dying before 65 years is about 1:6 for men and 1:8 for women, (as well as possible biological differences men are said to be slower to notice symptoms and delay seeking treatment after symptoms are noted).¹⁵

Gender rather than biological difference plays a part in influencing factors which cause ill-health. In Australia, males are more likely to be overweight than females (59% compared with 48.1%) and they have a predisposition to deposit fat centrally thus lowering insulin sensitivity and raising cardiovascular risk¹⁴; and significantly more males than women smoke daily (23.4% compared with 16.2%). Thirty five percent of males who drink alcohol consumed alcohol at levels considered to place them at risk; males aged between 18-24 years were most likely to consume alcohol at an 'at-risk' level.²³

Authors agree that there are distinct biological differences between men and women¹⁴ but it is difficult to attribute the extent to which this contributes to differences in health status. Many believe these to be more related to lifestyle changes²⁴ and late presentation for health care rather than biology.^{25, 26}

2. Social and ethnicity differences and structural inequalities

Social status impacts on life expectancy. In the United Kingdom (UK), men of social class 5 (low social class) live 7 years less than their social class 1 (high social class) counterparts (www.had-online.org.uk). In Ireland, in 1996, it was noted that there were clear occupational class gradients in mortality rates amongst men in relation to circulatory diseases, cancers, respiratory diseases, suicide, injuries including road traffic accidents, and poisonings. Unskilled men were twice as likely to die from disease as 'professional' men, and eight times more likely to die from an accidental cause. Smoking behaviour is believed to be a major influencing social class differential in increasing the risk of ischaemic heart disease. Homelessness, poor housing, damp housing and household overcrowding is believed to be likely to lead to increased respiratory ailments and alcohol abuse, which is 280% higher in the lowest occupational class than the highest occupational class, being linked to certain cancer, mental health disorders as well as falls, suicide, homicide and accidents.¹⁵ Certain diseases are linked to socioeconomic deprivation occurring at different stages in the lifecycle in childhood and adulthood. Coronary heart disease²⁷ is strongly determined by both childhood and adult factors and starvation in a mother's prenatal diet is linked to type two diabetes.¹⁹

Ethnic difference impacts on life expectancy of men. White American men live seven years longer than African American men and white American men live eight years longer than indigenous American men.²⁸ African American men are more likely to die of serious chronic illness than white men; 40% of African American men with heart disease die prematurely almost double the rate for white men.²⁸ The gender mortality differences in some indigenous peoples are greater than non-indigenous peoples with

American Indian and Alaskan native male to female ratio mortality rate from heart disease being 1.4:1; from accidents 2.3:1 and from suicide 4.1:1.²⁹

Disparities in health care are defined as *racial or ethnic differences in the quality of healthcare, that are due to access related factors or clinical needs, preferences and appropriateness of intervention.*³ In the past, writers explained differences in life expectancy and incidence in disease states as being predetermined by racial or ethnic difference; therefore health differences were accepted as unchangeable. However now this viewpoint is rarely expressed³⁰ and is not accepted internationally.⁵ A growing body of literature on health disparities suggest a number of factors causing differences in life expectancies with some saying that racism is the major cause of health disparities.¹

The following commentary is informed by international literature, which frequently uses the term ‘people of colour’, to speak of people of other cultures and not specifically about indigenous races although it may include them. This is a term that is not in common use in New Zealand and there is no equivalent phrase. It is difficult to determine whether ‘people of colour’ has the same meaning when applied in New Zealand to indigenous or ethnic populations, where disparities occur, such as Māori and Pacific men. In this document the term ‘*diverse ethnicity*’ is used as an equivalent.

Determinants have been identified both nationally³¹ and internationally¹ which cause health outcome differences. These factors include race and ethnicity, income and poverty, housing, education, and occupation. The following section will focus on social and economic determinants which have direct impact on the health outcomes of male populations of indigenous or men of diverse ethnicities. Other factors will not be discussed in detail in this review and the reader is directed to two comprehensive documents which draw together what is known about how these determinants affect population health “*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*”³ and men’s health in particular “*A poor man’s plight: uncovering the disparity in Men’s health.*”¹

In countries where individuals are expected to have medical insurance to adequately access health care it is known that low-income men including indigenous and diverse ethnic populations are more likely to be uninsured. Immigrant men³² and/or past inmates of the justice system also appear to avoid seeking health care. Other factors include:

*Perceived hostility, racial stereotyping and discrimination in the health care system; fear of adverse consequences with regard to immigration status; language barriers; a shortage of primary care facilities and medical personnel in lower-income neighbourhoods; an inadequate number of minority physicians and a lack of cultural competence across the health care provider community.*²⁸ (p 710)

A recent Institute of Medicine (IOM) project reviewed over 100 studies that assessed the quality of health care for various racial and ethnic minority groups (holding

⁵ There is evidence to suggest racial or ethnic differences in response to certain drug treatments such as enalapril in heart failure.

constant, variations in insurance status, patient income and other access-related factors).⁶ They concluded that minorities are less likely than ‘whites’ to receive needed services, including clinically necessary procedures, screening tests or preventative health practices,³³ and that two sets of factors cause health disparity: the health care system and the clinical encounter. They stated:

Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patient’s insurance status and income, are controlled. The sources of these disparities are complex, are rooted in historic and contemporary inequities and involve many participants at several levels including health systems, their administrative and bureaucratic processes, utilization managers, health care professionals.... Stereotyping, biases and uncertainty on the part of health care providers can all contribute to unequal treatment.. Clinical encounters are characterised by high time pressures, cognitive complexity, and pressures for cost containment hence the likelihood that these processes will result in care poorly matched to minority patients needs.³

Cultural/linguistic barriers, fragmentation of health care systems and prioritisation systems⁷ are examples of health care systems factors influencing disparity. Factors influencing the clinical encounter include: bias against minorities, greater clinical uncertainty when interacting with minority patients and belief or stereotypes which the clinician holds when considering the behaviour of the patient. Time pressure, fatigue and information overload can cause well-intentioned clinicians who are motivated to be non-prejudiced to unintentionally apply stereotypes to people of diverse ethnicities.^{34,35}

The IOM believe that clinician education about these three factors is one of the most important tools in an overall strategy to eliminate health care disparities. Similarly Burgess et al suggest a number of educational processes including ‘perspective taking’ to highlight the experience of others or deliberately attempting to reverse racial bias, as being effective (some of these processes appear to have similarity with Cultural Safety education designed by Irihapeti Ramsden³⁶).³⁵ Other measures advocated are fostering greater diversity in the health professions including increasing the numbers of cultural community health workers and the formation of multidisciplinary teams to deliver health care. Also important is the building of consistent relationships with (culturally and linguistically tuned) primary care providers to address mistrust of health systems, especially if primary care providers are prepared to advocate for individual patient health care resources. Patient empowerment-education is also important in increasing knowledge about the clinical encounter and patient role in patient decision-making.

A patient’s negative experience of the factors identified by the IOM increases mistrust of the health system, health care providers and institutions in general. This mistrust influences interactions men may have with the health system on subsequent occasions. Internalised racism may exacerbate risk behaviours, distort health beliefs

⁶Many of studies also controlled for potential confounders such as racial differences in severity and stage of illness, co-morbidities, facility where care was received, public/private status and age and gender.

⁷ In New Zealand Clinical Prioritisation Assessment Criteria (CPAC) used by clinicians to govern access to elective surgery. These are known to be influenced by patient ethnicity.

and may alter the concept of manhood. There is some evidence that men of diverse ethnicities are more likely to refuse recommended services, adhere poorly to treatment regimes, and delay seeking health care even more than white men.³⁸ Nihilism can result, particularly in young men. Nihilism is described as a life of horrifying meaninglessness, hopelessness and lovelessness resulting in adverse mental health, self destructive and criminal behaviours.¹ As a result of all the above factors, men are said not able to contribute to capacity within the workforce, their communities or families.³⁷

It is believed to adequately address these factors, men of diverse ethnicity must be represented at all levels of health care delivery in order to represent their constituency groups.³⁴ As well, men need access to community based health services (primary health care) which are located as close as possible to where people live, work and play and as well, men need preventative health services, health information and education³⁸; and that services should be designed with attention to social and cultural differences.²⁹ Services should address the needs of people in all states of health; the fully well, those who are unwell because of illness which is treatable or curable and those with chronic illness or disability.³⁷ (See Section Five for further discussion on initiative to meet men of diverse ethnicities health needs)

3. Behavioural difference

Males are generally raised in society to have one dominant view of what constitutes a man. Men are acceptable if they are strong and distant and have a high tolerance to physical and emotional pain, and are physically strong. They are traditionally the 'providers' for the family. Risk taking is a means to prove manhood.¹

It has been said by Harrison and Dignan (1999) (cited in Lloyd p 5³⁹) that the male gender culture in many aspects is pathogenic rather than protective of health and the majority of negative aspects can be categorised under the rubric of 'lifestyle choices and occupation'.⁴ There are a number of 'popular' reasons given about the status of men's health. These include:

- Men are known to undertake self-harming behaviours to a higher degree than women including excessive alcohol intake, inadequate/inappropriate diet, and potential and actual suicidal behaviour⁴⁰
- Men are employed in more hazardous occupations than women and undertake physical activities that are more likely to result in accidents. Some men also have significant problems with controlling anger (including that resulting in domestic violence) and engaging in unlawful activities (In Ireland the total number of convictions for males were around eight times higher than for Females.¹⁵)
- Men's propensity to risk-taking behaviour and sense of immortality and immunity from accident or disease⁴¹ is said to be linked to their testosterone levels⁴².

⁸ Micro-aggression small racial insults experienced on a daily basis by people of diverse ethnicities, and have an aggregate effect that is equivalent to or greater than so called macro-aggression, such as beatings or lynching. Chester Pierce in Rich and Ro. *A poor man's plight: Uncovering the disparities in men's health*, 2002

It is unfortunate that some of the popular beliefs about what are described as the negative factors (masculine traits) contributing to men's poor health are not recognised as having potential to be harnessed for positive effect. Traditional male behaviours such as having a keen interest in taking part in sport, self confidence, independence, ability to stay-on-task are all characteristics which can be mobilised to promote health or recovery from illness.⁴ Risk-taking activities such as fire-fighting, disaster/rescue response, exploration activities and paid employment in high-risk workplaces are activities recognised to benefit society.⁹ Injuries resulting from such activities are morally acceptable and culturally legitimated within social and occupational worlds¹⁵, however men represent 90% of job fatalities.⁴³

Because of social rather than biological factors men (including indigenous men and men of other ethnicities⁴⁴), experience or perceive health and health problems in a different way than women⁴⁵⁻⁴⁹, and their perceptions of the importance of their health needs appear to be different from that of health professionals and/or health policy makers.⁵⁰ An Australian study examining the health needs of men showed men's *perceived health needs* contrasted with national health policies (although men's needs were not dissimilar from women's *perceived health needs*). In 2000, men's perceptions of their greatest health needs were stress, cost of medical care, and money problems, (women's greatest health needs related to stress, overweight and money problems). However in contrast, Australian national health priorities in 2000 were cancer, mental health, injury, cardiovascular disease, diabetes and asthma. A recent study on gender differences in heart failure found that men experienced physical and social restrictions to be the most difficult consequences from health failure whereas women found restrictions in supporting family and friends to be the most difficult.⁵¹

There has been a prevailing belief that women are at greater risk of developing illness^{18, 52} and in particular certain illnesses, for example mental health concerns.⁵³⁻⁵⁵ As a result of this view, women's health concerns are said to have received greater public attention and action than men's health. It is not uncommon that literature focusing on the relationship between gender experience and health focuses solely on the experience of women.⁵⁶ There is a lack of clarity about whether or to what degree women have increased illness morbidity, causing them to consult doctors more regularly.^{52, 57-60¹⁰} In the past, men's rates of help-seeking were considered 'normative'; if men sought help less frequently than women, women were over utilising the services⁴ and men were using the services at the right amount.⁶¹ However, in contrast, a recent study found women's self ratings of their health are more informed and that they obtain services at a sufficient level in order to address potential problems determined through self assessment (a 'normative' level)⁶²; whereas men delay seeking health care.^{9 63}

4. Men's health seeking behaviour and use of health services

Men generally have higher rates of admission to hospital⁶⁴ (this is not so in New Zealand), but are known to be reluctant users of primary health care and attend GPs significantly less frequently than women⁶⁵⁻⁶⁷. They also take less sick leave from

⁹ This is not to say that women do not take part in these activities as well.

¹⁰ Health screening and health promotion activities may account for some of the additional consultations which occur at particular stages in a woman's life.

work than women⁶⁸ and lack awareness as to when they should attend for screening. In the United States, men attend doctors three times less often than women.⁶⁷ In Ireland 66% of men and 82 % of women had consulted their GP in the previous year.¹⁵

In the Australian BEACH (Bettering the Evaluation and Care of Health) Men's Health study²³ fewer men than women consult primary care practitioners. Of the 103,674 consecutively collected encounters, 44,308 encounters were with male patients and 59,366 with female patients. There were certain differences in consultation rates according to age ranges with males being more likely to consult between 0-14 and 45-74 years, although overall there were fewer male consultations in every age group from age 15 onwards.

Men are said to be inhibited from consulting GPs because of a lack of understanding about the process of making appointments including negotiation with female receptionists, inappropriate opening times, being unwilling to wait for appointments, feeling uncomfortable in a predominantly female environment, a general lack of trust in the health system including issues of confidentiality, a fear of being judged by health care staff and a lack of knowledge of the language to use about their bodies.⁶⁹ In comparison, women are considerably more familiar and comfortable in health environments because of their more frequent attendance for preventative health care (contraception and maternity care) and through accompanying children for healthcare visits.

Consultations to the GP are said to be driven by certain factors including interference with work patterns⁷⁰ and the need to have an obvious physical symptom before consultation⁷¹. As a result, men present later in the course of an illness. When men do eventually consult¹¹ they appear to be inhibited from telling the doctor the extent of their health concerns^{17, 67} (especially if they are not physical⁷¹), bring fewer problems to the consultation than women, have shorter consultation times²³, focus predominantly on health problems which are work-related or could impact on work²³, and are said to fear possible physical contact occurring during examination by their doctor.⁷²

Many clinical treatments and evidence-based guidelines do not acknowledge the impact of gender difference.⁷³ Male clinical presentation in certain diseases may be different in comparison to females. A commonly cited example is that of depression, which is less frequently diagnosed (and treated) in males. When men are depressed they are said to be more likely than women to rely on themselves, to withdraw socially and/or to try to talk themselves out of the illness.¹⁵ Men may also perceive the health risks of certain lifestyle behaviours in a different way than women. Men are

¹¹ Problems relating to respiratory, circulatory, digestive systems and the skin and ear were managed more frequently in male consultations and specifically back problems, diabetes, lipid disorders and general check-ups were undertaken. Less frequently (than women) managed, were problems relating to the neurological, urological and genital systems, specifically depression, genital check-ups and urinary tract infections. Further analyses in the Beach study showed higher rates of male consultations relating to problems associated with the endocrine and metabolic systems and related to the eye, with social problems being managed less frequently than with females. Hypertension was managed less frequently in males than females.

less likely than women to perceive drug taking as a health risk, with male users outstripping female users at a rate of 2:1.¹⁵

A recent study examining gender differences in health-seeking behaviour showed that men's health-seeking behaviour in comparison to women, is linked to a deficit in understanding about health and as a consequence men are less likely to address existing health problem or obtain sufficient health services.⁶² However men are amenable to positive media representations of men's health (including healthy lifestyles initiatives) but this information is not necessarily accepted passively but through an internal negotiation process⁷⁴.

Men are said to be reactive rather than proactive in making use of preventative health care maybe because self-care practices have become culturally perceived as 'feminine', limiting their acceptability to men.¹⁵ Self-directed preventative care is not commonly undertaken by men with health screening often being imposed by pre-employment checks or requested by GPs for follow-up after an illness, rather than initiated by men themselves.¹⁵ Also there is an absence of a preventative health care ethos in the current delivery of general practice care or knowledge about what men should be screened for.⁷⁵ Men are not socialised into a health culture from an early age and are less likely to develop the confidence to seek preventive help. Men are also less likely to recognise that their symptoms arise from a physical or mental illness.¹⁵

Young men tend to consult for acute (injury related) problems. From the age of 45 onwards, the rates of male consultations increase, however the health problems managed are those of chronic illness. It is surmised that this is the case because of low GP utilisation up until middle age with shorter consultations, mean less preventative health care is undertaken. Coupled with high-risk health behaviours in youth, this results in negative health outcomes in later life.⁷⁶

A study examining older (over 55 years) men's health including motivation, self rated health, and lifestyle behaviours found that 'healthier' men were more intrinsically motivated with regard to their health. The study concluded that promoting self-motivation could be the key to increasing older men's perceptions of health and wellbeing.⁷⁷ A tool has been developed for use by health professionals to assess motivation in older men and for this information to be used in targeting interventions such as mail notifications, media campaigns and peer reminders.⁷⁸

5. Health professionals care of men

Despite the fact that men bring fewer problems to a consultation, potentially allowing the health care practitioner additional time to address other health issues, men do not often receive appropriate preventive care from their doctor when they do consult.^{67, 79} Preventative care initiated by clinicians to males is also not offered at the same rate as for women. Sixty percent of paediatric residents did not teach young men testicular self examination at their annual check-up⁸⁰ and primary care doctors are said to be less likely to detect mental health problems in men⁸¹, (possibly because although functionally impaired they may have fewer of the classic symptoms of mental illness particularly depression⁸²), despite men having considerably higher risk for suicide than women.⁸³

Conversely in some clinical speciality areas doctors may treat men more aggressively and intensively despite women having comparatively equal or more severe morbidity.^{84, 85}

Men report that they generally like and trust doctors and would like them to spend more time discussing health concerns^{66, 67}, however it is said that they would prefer to engage in a model of partnership when addressing health problems.⁸⁶ Primary care doctors are said to have ineffective consultation processes with men^{87, 88} with doctors being seen to hold power and health care being problem based.⁸⁹ Primary care health professionals do not take into account a theoretical framework based on the construction and performance of masculinity.⁹⁰ GPs and other health professionals are said not to be using what is known about male health ideology to make “subtle positive shifts in provider-patient interactions”. Courtenay (cited in Mansfield³²) who is a seminal writer in this area suggests that health professionals in their conversation with men explicitly acknowledge that men may have a difficulty in expressing a health issue or assume men are likely to have symptoms present and ask for confirmation rather than waiting for men to report them.¹²

Men’s health needs are generally met in traditional primary health general practice settings. This model of men’s health care has been criticised as it ‘buys’ into the medical model of health delivery, only attracts the ‘worried-well’ or health conscious, and does not reach the men with greatest health need. Critics recommend using a variety of approaches in a number of different settings and being sensitive to individual difference as well as the local community context and culture.⁸⁹

Men have gender specific health problems⁹¹ such as urinary problems and erectile dysfunction^{59, 92, 93} which GPs may not feel comfortable discussing⁹⁴ and as a consequence may not always address appropriately.^{95, 96} (see also section 4.21 for further discussion on health professional impact on the male consultation).

There are increased barriers for men consulting a doctor when they are on a low income and/or have lesser educational advantage and/or are of a different sexual preference⁹⁷ and/or have a different ethnic heritage⁹⁸ and/or have a disability⁹⁹. There is also an international trend of men living alone with increases in the numbers of divorced and separated men¹⁴. However men without partners are perceived to have additional risks, as men prefer female partners, or mothers, to support their health needs rather than health practitioners^{41, 100} and to prompt their consultation to the doctor.¹⁵ Health outcomes for these groupings of men are known to be poorer.^{67, 101}

Although becoming keener consumers of public media on health and increasing purchasers of health products¹⁰², men are said to have significant knowledge deficits about their bodies and their health¹⁰³. They have ineffective recognition of illness and delay seeking help sufficiently early^{67, 104}. They can also be reserved, embarrassed or shy about discussing particular health issues¹⁰⁵, especially those that relate to social, psychological⁷¹ or genital problems¹⁰⁶. Often they do not believe the doctor will be able to adequately treat their symptoms, especially if they have cancer.¹⁰⁶

¹² This is very different than the usual way that GPs in New Zealand work where the patient drives the consultation and the 15-minute consultation timeframe governs the degree to which the GP will probe for additional problems.

3.2 Expenditure on men's health

International health budget allocations for men's health are known to be significantly less than health budgets for women. In the UK spending on men's health is 10- 15% less than the spending on women's health care.¹⁰⁷⁻¹⁰⁹ In 1994 the US Congress budgeted 1,018 million for women's health care and research, but nothing was allocated for similar men's projects.¹¹⁰ In Australia in 1994 the National Health and Medical Research Council (NHMRC) spent 2.5 million on research into men's health compared to 5.3 million spent on women.¹¹⁰ None of the 12 recently developed *gender specific* standards released by the USA National Committee for Quality Assurance to be used as part of HMO accreditation process pertain to men's health.¹¹¹

Men's health work is new and said to be under-resourced in every country, however there are increasing numbers of projects. Men's health networks are said to be fragmented and intra-national rather than international.¹¹²

3.3 Men's health policy

Men's lifetime health prospects are lower than women's creating an inequality and inequity in health care.¹¹³ A number of countries including Australia^{114, 115} and the UK¹¹⁶ have attempted to address men's health inequity through draft policy formation but have not yet been successful in formalising either its adoption or its implementation.

Medical dominance has been suggested as a barrier to supporting further investigation about men's health. This discourse asserts the predominance of individual bodily pathology, rather than investigating the social processes implicated in the varying health outcomes across different populations. The clash between social constructionist policy and medical frameworks for understanding health is believed to have stalled possible implementation of men's health and well-being policies.¹¹⁷

The UK Government has given the Health Development Agency the specific task of addressing the promotion of men's health and it is developing a number of initiatives as part of this project.¹¹⁶ However, as yet, little is known about which interventions are effective in addressing men's health needs, with writers calling for "a stronger evidence base and creative thinking ... to help engage men of all ages in caring for their own health" (Pg 1813).¹¹⁸

3.3.1 Men's health policy in New Zealand

Currently there is no dedicated men's health policy or agency dedicated to men's issues such as there is for women (Ministry of Women's Affairs). The only substantial New Zealand initiative located relating to men's health work was undertaken by North Health (the former Northern Regional Health Authority) in 1995 and 1996. {Fraser, 1996 #860; North Health, 1996 #826; ¹¹⁹} North Health undertook this project in response to the Ministry of Health 1995/6 Policy Guidelines for Regional Health Authorities that noted that particular groupings of men had significant health needs including:

- Men with chronic conditions including disabilities
- Men of lower socio-economic status
- Men whose lifestyle places them at risk

- Men who have unsafe sex with men
- Māori men, and men from Pacific Islands or other ethnic minority groups, who correlate with the above categories.

The North Health initiative involved undertaking a literature review entitled Men's Health Issues and Strategy¹¹⁹ and from this review developed a discussion document designed to be used a part of a community consultation process. The discussion document 'The Health of Men'¹²⁰ included the following recommendations:

- purchasing of health services which address major risk factors
- primary care service provision for men including access and suitability of health services for men, the variety of services orientated to men rather than women; health promotion for men; population education; school education and young people's programmes
- other potential actions included establishing men's needs and wishes assessment and marketing men's health as a concept and education of health professionals.

Following the release of these documents a community consultation process was undertaken¹²¹ and the resulting community priorities were established:

- to assist motivated groups to establish men's health as a visible entity in the community
- in tandem with enhancing community services, to educate the public health service providers regarding barriers to men's effective use of the health services
- to adopt a branding process to increase the visibility of 'men's health' as an area of significant health concern
- to develop appropriate mental health services for men
- to develop innovative health delivery mechanisms for preventive and primary health care
- to undertake work to ensure young men's access to health services is a positive experience
- to undertake a needs assessment and establish best practice examples for men's health care (use these to purchase for men's health gain)
- to ensure the tone of all future North Health documents emphasises positive aspects of men in relation to their health and does not blame men for their health issues
- to ensure the role of men as fathers is recognised
- to recognise that some groups of men are powerless in the current political environment.

The consultation process was completed about the time that the Regional Health Authority (including North Health) structure was disestablished. It was unfortunate that probably as a result of these changes the men's health initiative did not appear to progress further.

4.0 Men, masculinity and health

In addition to the body of literature on the status of men's health, there is a considerable body of literature relating to the sociology of masculinity, influences on male health and the construction of male health beliefs. A summary of key points will be included in this literature review. The reader is directed to a very useful review which is available in the report '*Boys and young men's health*' published by the Health Development Agency (UK) and available on www.had-online.org.uk. Other useful discussions are contained in the introductory chapter written by Trefor Lloyd in 'Promoting men's health'³⁹ and a chapter in '*Mental health in New Zealand from a public health perspective*' available at [http://www.moh.govt.nz/Zealand/moh_nsf/Files/chap910/\\$file/chap910.pdf](http://www.moh.govt.nz/Zealand/moh_nsf/Files/chap910/$file/chap910.pdf). This chapter also includes an outline of Māori, Pacific and gay men's health issues.

4.1 Philosophical understandings and premises which govern thinking about men and their health

Literature relating to men, masculinity and men's health-seeking behaviour tends to align with a number of different philosophical perspectives.¹²² Overall it is recognised that the health of men is a result of a complex interplay of many factors including biological propensity to certain illnesses, masculinity, role and behaviour.

The *gendered approach*, which seems to be most commonly used by writers on men's health, views men and their health as being a problem (blame and shame perspective^{13, 123}). There is a focus on specific areas of health (or specific men's diseases such as prostate cancer) needing to be addressed^{111, 124}. This is labelled a biomedical reductionist approach as it views men apart from the context of their lives. This approach is also used to argue that in comparison to men's health, women's health is still believed to be disproportionately neglected.⁵⁶ Implicit within this approach (which is also called the social constructionist viewpoint) is the belief that men are socialised to undertake a stereotypical 'macho' role which carries certain expectations, ideals and images⁶¹ and the social practices that are detrimental to males are often the ones they utilize in negotiating power and status.²⁹ Typical social constructionist viewpoints expressed in medical and nursing literature attribute the 'risk taking' behaviour of men as being the cause of men's poor health status.

The second perspective views men, their actions and their health as normal and legitimate without problematising them with policy and health care delivery being developed on a *needs approach*.^{90, 125-127} Prioritising resources according to health need rather than gender moves the focus away from competition between the genders. A similar approach is the *gender-relations approach*¹²⁸ which involves examining health concerns in a wider context of men's and women's overall gender perspectives and as well their interactions with each other. This approach examines more closely the consequences of the men's inability to effectively express emotion which is said to result in anger, rage and depression and longer term development of high blood pressure, heart attacks and cancer.¹²⁹

Lack of understanding about these different philosophical assumptions has led to some writers saying that there is "...considerable uncertainty and confusion surrounding prevailing understanding of men's health (with)... public policy and health research operating on oversimplified assumptions about men and masculinity"

(p247).¹²⁸ Men are not a homogenous group with some groups of men having greater degrees of privilege than others¹³⁰ and others experiencing different responses as a result of health issues⁴⁵. These differentials significantly account for increased morbidity and mortality.^{131, 132}

There are significant differences between the women's and men's health movements. The women's health movement mobilised around the lack of social equality between men and women, whereas men's health lobby groups have not been able to find a common ideological stance. There have been two main camps. The '*men's liberation*' movement which has sought to remove men from forms of oppression such as race and socioeconomic status, and '*men against sexism*' movement who propose that sexism is damaging to men.¹³³ Lobby groups have tended to compare men's health resources (and health outcomes) to women's and lobby accordingly, rather than demand wider social change. They have not gained the diverse and effective leaders and support to challenge both political agenda and dominant masculinist hegemony.¹¹⁷

4.2 What should policy makers take into account when considering men's health?

Writers challenge that more research with men is essential to explore a number of key questions including '*what men believe are their personal health resources*'¹³⁴, '*why men adopt less healthy behaviours than women*', '*why men generally do not have protective health seeking behaviours*' and '*what diverse communities of men perceive as being their needs particularly in relation to health practice and service*'.^{60, 61, 90, 135}

4.2.1 Health professionals and men

Equally important is research to determine how the attitude and activity of professional health workers impacts on men seeking health care. Although it would be logical to assume that the male physician would have an increased understanding of both the health needs of men and 'how men work' they also carry around the "*armour of pretence, and it is as threatening to them for them to go beyond the superficial as it is for their male patients*" p 159¹³⁶. It also limits them in advocating for men's health at a policy level because they accept the denial that men have about their health as an "...attribute of the male client" p205.⁶⁴ The training of medical students has been said to be "...imbued with the macho male culture (which emphasises) ...coping, survival, omnipotence, leadership and medical arrogance" (p1059).⁷⁹ The outcome of such training is said to create consultations which inhibit interpersonal conversations with male patients.⁷⁹ Similarly, research into the practice of education or teaching professionals has demonstrated a negative bias towards boys and young men which has been said to result in the unfair treatment of boys.⁴

The challenge of providing appropriate health care for men extends to nurses as well who are said to support a patriarchal environment "*in which men are ignorant not only of their own emotional and physical health, but also of the ways it limits them*".¹³⁷ Nurses could have a significant (or a specialist^{136, 138}) role in supporting men's health.^{64, 139} Generally the nursing role in primary care is focused on the prevention of illness and maintenance of health (and could specifically target men's health needs) in contrast to the medical role which is diagnosis, pathological findings and treatment of pathologies.¹³⁶

4.2.2 Masculinity and role

It is said that some men believe that seeking medical advice or treatment threatens their masculinity.¹⁴⁰ The male sex role stereotype demands that men be healthy, strong and self sufficient and men's ability to recognise that they may be ill may be masked by the need to maintain the image of strength¹⁴¹. Therefore men may be reluctant to admit physical and mental health needs^{15, 142} and especially so if they think their peers have never experienced a similar health issue.¹⁴³ Reluctance to express 'needs', particularly psychosocial needs directly affects the immune system, as well as resulting in complex behaviours such as anger and hostility, depression and grief, substance misuse and abuse.¹⁴⁴ It has been noted that in the newly independent states of Eastern Europe that male rates of heart disease are increasing in relation to males in the West and that these changes may be as a result of stress related psychosocial factors.¹⁴⁵

Because of the significance of the degree to which the male role affects health and health seeking behaviour, individual health professionals need to be aware of tailoring their approaches and responses to males in a different way than is required with women.³² Using the principles of reciprocity which allows men to maintain status in an interaction by avoiding being in the 'down' position is important as it acknowledges the competing importance of work and family to men.¹⁴³ Also the use of motivational interviewing¹⁴⁶ to explore men's current level of wanting to change, and to explore in a non-judgemental way, the advantages and disadvantages of a particular course of action is more likely to result in a mutually acceptable course of action.¹⁴⁷ This is more likely to be effectively used in a workplace or emergency department setting as the prime difficulty is getting men to attend a traditional primary care setting.³²

Challenges to masculinity and role partly explains why health promotion activities are not always well received by men and why wider socio-structural change⁶⁴ is required in addition to targeted men's health promotion. Health promotion is based on the principle that increasing people's awareness of risks associated with certain behaviours will cause them to make rational and voluntary choices to change their behaviour. However, the 'right choice' is also socially mediated and if one's peers are not in agreement, the person may not choose to modify their risk¹⁴⁰. Asking men to modify their 'risky' behaviour may be requiring them to withdraw from their peer group culture and may result in them rejecting health services.¹⁴⁸

An example of an effective health and safety intervention tailored to meet the needs of (and acceptable to) Alaskan indigenous men (to reduce drowning), was the introduction of a 'float-coat' to replace the (minimal) use of lifejackets. The float-coat not only provides warmth, but is buoyant and unremarkable in appearance. Following successful implementation (and acceptance) of the float-coat, male drownings decreased in Alaska, by approximately 30%.²⁹

4.2.3 Social factors

Social factors, such as money, 'place' in the community and how well you are loved, are as equally important to men as physical parameters of health, and this must be taken into account by health practitioners when considering men's health needs.¹⁴⁹

Brelow et al's long term study of a population in California over a 50 year period determined predictors as to living or dying in the next 5 years¹⁵⁰. For young men the most significant predictor was the loving support of family; for men 20-50 years the most significant predictor was satisfaction with their work; and for men over 50 years the most significant predictor was having a partner that loved them¹³. Similarly a project evaluating nine men's health projects in Victoria Australia determined that men-perceived health concerns were able to be categorised into two main areas:

- lifestyle issues including stress management; relationship matters, parenting, partners; risk taking including work safety; anger management; the meaning of good health and diet
- physiological concerns including cardiovascular issues, cancer (prostate and bowel,) injuries sustained in sport, farm work, traffic accidents and general workplace settings.¹⁴⁹

4.2.4 The importance of paid work

An important factor impacting on men's social view of themselves (and their health) is their role as primary provider for the family. Paid work and its associated stress¹⁵¹,¹⁵² plays a pivotal role in how men perceive their identity. Because of increasing male unemployment and the changed (and increased) role of women as paid-workers over the last 30 years, men are reporting that they feel that they have lesser value within the family environment.¹⁵³

However certain conditions at work can lead to poor health outcomes for men; high work demands coupled with little control over work, and high levels of effort with minimal reward being known to lead to poor health outcomes.⁴³ Men do not appear to manage work stress effectively and do not appear to have developed the same social support networks as women.⁴³

4.2.5 Men and their partners and families

There has been a growing interest in the role of men as fathers within society and the positive or negative impact this has on men's perceptions of themselves.¹⁵⁴⁻¹⁵⁹ Mental well-being is said to decline when men live alone or partially isolated from their families¹⁰⁴ with the role of a (female) partner in watching over the health and well-being of the man diminished. A study of suicide in Ireland showed marital status varied for male and female suicides, with 80% male suicide victims (compared to 46% female) being single, separated or divorced.¹⁵

4.3 What health settings may work for men?

Traditional clinical settings and traditional roles of health professionals may not be helpful for working with men and may inhibit men's health-seeking behaviour.⁴ Non-traditional health workers and those in multi-disciplinary roles such as community workers, trade union representatives, and sports and leisure workers may have more appropriate contacts and skills to work effectively with men. Telephone

¹³ This finding reinforces the information gained in the small qualitative study with men talking about health undertaken by the Department of General Practice in 2002-3 and reported in the appendices *Strong, silent & indestructible? A comparison of health related values between young and older males.*

lines/email/text messaging are appealing because they offer ('virtual') anonymity and are available 24 hours a day.¹⁴ Use of the 'NHS Direct on-line' internet health service, shows that men are using the internet to get information and post queries about their health. Anecdotally men appear more likely to use the Internet rather than discuss problems face-to-face (www.had-online.org.uk). There are increasing numbers of good quality men's health websites available which may appeal to certain groups of men.

4.4 Young men

Adolescence is a time when experiences and behaviours can influence lifelong health practices as well as a time of putting current health at risk. There appears to be differences in how young men and young women develop an awareness of health and health issues. Young women have greater access to information, including popular media specifically developed for them, including information about relationships, emotional and physical health. Boys/young men are more likely to have been taken to the doctor or health services by a female relative than a male relative. As a result health concerns are perceived by young men to be the domain of women.⁷⁹ As a result of these factors and others, there are barriers for young men in developing beliefs about health and in accessing needed health care. This requires specific understanding by health professionals about gender and the social roles that young males are required to play.

4.4.1 Access to health care

In the US, one in five young men experience difficulty getting needed health care, with parental income and insurance status thought to particularly impact on access¹⁶⁰. Confidentiality issues are also thought to inhibit access (not wanting to tell parents of the health problem) and also the personal cost of accessing care if the young man did not want to tell parents of the consultation.¹⁶¹ Although young men believe doctors should discuss sensitive issues with them, in reality this does not always occur. It is notable that young men do not attend general practitioners when they are experiencing emotional distress immediately before a suicide or self-harm attempt, when a risk assessment might have significant impact.^{82, 162} Young men often prefer to speak to doctors alone without a parent or caregiver, but say they are not always offered this option.¹⁶⁰ It is unclear whether young men show a particular preference for a doctor of a particular gender or sexual preference.^{160, 161}

4.4.2 Health care services preferred by young men and youth in general

School based health services are said to be received favourably by youth. In Wellington, New Zealand there have been almost equal male/female utilisation rates of a school health service in a lower socio-economic area.¹⁶³ Health and sex education is more favourably received by young men when a gender perspective is introduced.² Introducing health care at school means boys can learn to look after their bodies and also learn about the social responsibility for taking care of themselves and demanding

¹⁴ This has not been demonstrated in New Zealand although Healthline has not yet been fully implemented throughout the country and telephone helplines have up to now been limited to specific health areas such as well-child through Plunketline, mental health and immunisation. There is anecdotal evidence that the 0800 phone lines advertised in Direct-To-Consumer advertising were well used by men and particularly pacific men. (personal communication Bruce Adlam, 2000)

equal health status to women.⁶⁴ School health clinics can also be used to effectively to teach health promotion and screening activities such as testicular self-examination.¹⁶⁴ Teenage boys who have participated in such education programmes being said to be more aware of their physical selves than those in the 25 to 40 year old age group.¹⁶⁵

The Health Development Agency has published a report that reviews existing projects to promote young men's health (<http://www.hda-online.org.uk>). Overall they found that initiatives need time to be accepted; young men will wait till their peers have tried these initiatives before they go, or else they wait till they are desperate and the fear of the health issue becomes greater than the fear of appearing inadequate. Certain services appeared to hold more appeal to young men. These services included:

- services where access is made easy include phone lines, drop-in centres, or through a sports clubs or similar
- projects with a specific identity (music, cultural, ethnic or community based)
- schemes where attendance is compulsory (prison, school).²

In a recently released preliminary report on secondary school youth health in New Zealand, 94% of New Zealand males rated their health as 'good' or 'better'. The focus of this report was not to make comparisons between male and female students however it was noted that male students reported higher involvement in violent behaviours than the female students. Youth in general identified a number of barriers to accessing health services including not wanting to make a fuss, could not be bothered, not feeling comfortable with the health provider, being scared, and concerns that the consultation would not be kept private. The report concluded the health sector needed to become more responsive to the needs of youth and that youth-specific services promote higher utilisation rates and better outcomes for youth.¹⁶⁶

5.0 Initiatives to improve men's health

Initiatives to improve men's health can be based in the workplace, community settings, or traditional general practice settings. A number of countries have focused on trying to implement community-based programmes in addition to the primary care practice services. In the UK this has been particularly so, as a result of the NHS white paper *The New NHS: Modern Dependable* in 1997. In Australia a number of programmes were initiated following the release of the Draft National Men's Health Policy.¹¹⁵ A number of innovative health care initiatives are described in the literature however it has been said that many of these are often short lived and not properly evaluated. (www.had-online.org.uk)

5.1 Workplace initiatives

Health care initiatives delivered in the workplace are said to have more impact on improving men's health than traditional GP care.^{86, 104} A number of mechanisms to deliver workplace health care have been undertaken. These include preventive care (health risk assessment/screening), workplace health events and employee education programmes.

5.1.1 Preventative health care in the workplace

Preventive care has been undertaken in the context of men's workplaces. This appears to be effective because it is conducted in the safe environment of the workplace, is often topic specific (detection of cardio-vascular disease or diabetes) and the assessment is personalised to the individual.¹⁶⁷ Preventive care initiatives include:

1. workplace education
2. health checks.

1. Workplace education

Employee education programmes have focused on delivering information about a clinical issue, identifying risk and lifestyle factors and having occupational health staff available to follow-up questions and undertake clinical investigations. In one such programme the clinical focus was on male cancer awareness (particularly prostate and testicular cancer). The aims of the educational programme included providing appropriate information about particular cancers and fostering the perception that self-examination and routine screening are important health behaviours. This programme began in a limited number of locations and because of its acceptability to the men involved, it was extended to a large number of workplaces. An evaluation of the programme showed employee awareness regarding male cancers was high, with misconceptions about cancer having been corrected and health-seeking behaviours fostered.¹⁶⁸

The aim of 'workplace events' is to empower people at workplaces to take a more active role in assessing and monitoring their own health. The events appear to be more general than employee education programmes and have included formal education sessions, health workers visiting employees during the day, formal health checks and having posters and educational material available. In calling themselves a health event they contrast themselves to health promotion activities which are described as medically orientated and sporadic in nature.¹⁶⁴ Personnel undertaking workplace events deliberately aim to form relationships with individual men and allow opportunities to express physical and emotional needs.¹⁶⁹

2. Health checks

Health checks offered at health events have included assessment of lifestyle factors that influence health such as diet, exercise, smoking, testicular and prostate awareness, alcohol consumption, stress management, sexual health, blood pressure checks, and cholesterol testing. As a result of one of these programmes, workers requested further information on stress related issues at work, how to reduce fatty food, appropriate exercise programmes and whether chest Xrays were needed for screening. They also participated in developing ongoing programmes for reducing blood pressure and cholesterol.¹⁰⁴

A New Zealand workplace health promotion programme targeted dietary behaviour among male contract workers. The intervention comprised nutrition displays in the cafeteria and monthly 30 minute workshops for 6 months. Key outcome measures at six and 12 months were self reported dietary and lifestyle behaviours, nutrition knowledge, body mass index, waist circumference and blood pressure. The study demonstrated that low intensity workplace events can significantly improve reported

health behaviours and nutrition knowledge however changes in objective measures of risk (blood pressure, body mass index) were variable.¹⁷⁰

5.2 Community initiatives

Community initiatives targeting men have generally arisen as a result of primary care initiatives not seeming to have been successful in attracting men and/or addressing men's health needs. Some writers believe the failure of conventional primary care initiatives is a result of dependence on the medical model of treatment.¹⁷¹

The community initiatives specifically described below are generally reflective of similar initiatives undertaken in a number of countries.

- In the UK since the mid 1990s health checks have been offered in non-traditional settings such as pubs and betting offices over a number of days and/or at differing hours in the day¹⁷²⁻¹⁷⁴ or offered by staff using health buses to travel to disadvantaged areas.¹⁷⁵ As well as the usual physical checks, men have been offered information on relevant health issues (and free condoms). Information has been copied to the man's GP, with men sometimes being given a copy to retain.¹⁷²
- A variation of this initiative has been undertaken in pub settings using both nurses and professional actors. This initiative has involved two visits, the first visit including a series of health checks, with the addition of lifestyle related questions. Information was recorded and returned to men. The second visit involved the health visitor team returning with the professional actors to play a sketch relating to the main health issues surfacing from the first phase of health checks. For example the sketch scenario described in the literature included issues about alcohol and tobacco misuse, chaotic lifestyles and work and family pressure. A second round of health checks were offered following the drama. The initiators of this project believed the value lay in that it allowed men to think about their lifestyle and identify areas where there could be change in a non-threatening, relaxed environment.¹⁷⁴
- A number of initiatives using men's sports clubs as a basis for men's health initiatives are described in the literature. An Australian example of such an initiative is 'ClubSmart' an initiative which provides incentives for sports clubs to develop policies and procedures to promote responsible drinking, healthy food choices, injury prevention and smoke-free environments.⁶⁶ A similar New Zealand example exists with formal partnerships between the Cancer Society and sports clubs.¹⁷⁶ Another UK initiative established a competition between high profile sports teams using a health focus.¹³⁰ Similar initiatives have also been based at men's social clubs such as the 'waist watchers' course at a miners welfare club¹⁷⁷, or 'action days' combining sport, cars and beer with health promotion to counter beliefs among young and middle aged men that overt concern about their health isn't manly. Generally the goals of such initiatives have been to:

- raise awareness of healthy lifestyles with young men especially in the areas of social deprivation, and support development of healthier lifestyles
 - to encourage multi-agency collaboration to ‘effect health gain’ and form part of the cross-organisational strategy for health improvement
 - to create a cost effective and efficient health promotion model
 - to redress inequalities in health by working within local neighbourhoods.
- A variety of different countries describe the initiative of undertaking a MOT (Ministry of Transport) check of men. The analogy of a man’s body to a car, seems to appeal to men who are said to show more interest in maintaining their cars than their bodies. A recently released UK men’s self-help health book (Hayes Men Manual) “...uses humour and straight-forward language in an attempt to encourage men to maintain their bodies in the same way as they would their cars” (www.menshealth.co.New Zealand). Sections of this book are available on the Men’s Health Forum (www.menshealth.co.New Zealand). In Western Australia, men have been offered an MOT check whereby testing blood pressure is likened to ‘checking oil levels’, skin cancer checks to ‘rust checks’, and potential problems with testicles are likened to ‘dirty spark plugs’. A ‘chassis check’ determines whether the man is overweight while ‘fuel and additive checks’ involve questions about alcohol and smoking and ‘shock absorbers’ evaluate mental health risk. The promoters believe this model appeals to men as it raises health issues in a language and framework that men can relate to, making the checks as non-medical and non-threatening as possible.¹⁷⁸
 - Health visitors or community health nurses have significant input into the above initiatives¹⁰⁷ and appear to be acceptable to men who have attended health checks.¹⁷⁹ These health professionals also undertake particular programmes with men either as general men’s health support groups or with particular groups of men such as those with chronic illnesses, eg diabetes. The aim of the latter has been to facilitate the transition of men with a new diagnosis of diabetes to everyday life with the illness.¹⁸⁰
 - A few initiatives have used an empowerment model to enhance community living. One such project focused on working with a group of African American and Latino men through a group forum to foster an empowerment process that supported health promotion and health consciousness. This was said to result in significant health improvements for the community.¹⁸¹

5.3 Health care initiatives for men who are poor or of diverse ethnicity

Socio-cultural factors are known to influence the success of health behaviours of African-American men including kinship/significant others; accessibility of resources; ethno-health belief and an accepting caring environment.¹⁸² Men who are poor and/or are of diverse ethnicity are not averse to using health services, however concerns about daily survival mean that they do not make health a priority. Studies have shown even when health insurance is provided to poor people or those of diverse ethnicities, access to health care does not immediately increase.³³

In 2001, in the US, the W.K Kellogg Foundation began to fund men's health initiatives particularly for poor men and indigenous men or men of diverse ethnicity. Initiatives aim to inform changes in policy at the local level by raising awareness of the health status of poor men and men of diverse ethnicities. They also seek to empower those living in those communities by urging them to become active participants in helping design healthcare systems that will suit their needs. A recent study by Loeb showed older non-white men although having overall poorer health than white men, were prepared to participate in significantly more health screenings than white men, if they were delivered in the community.⁷⁷

W.K. Kellogg Foundation funded pilot programmes include a variety of largely *men-only* services including men's centres and men's health information drop-in services (with information tailored to different ethnic groups). Men's health classes have also been implemented across the United States and are reported to be very successful because they address social and economic factors in addition to health issues thus promoting long term sustainable health gains. *Men-only* services appear to address a significant gender barrier to accessing health care; a man's need to be independent and to conceal vulnerability.²⁹

Another example of the impact of community participation into health care planning was a community survey to prioritise health care planning for men conducted by the Baltimore City Health Department in 2000. The survey included 18-64 year old men and determined the five most needed health services. These included dental care, physical examinations, HIV testing, pharmacy services and eye examinations. In response, a Men's Health Centre was opened and in collaboration with a local fathers and family workplace development centre, provides services including the above, for men who are unemployed or underemployed. This project is currently being evaluated and preliminary findings suggest high acceptability by men. The centre's success appears to be because of its focus on determining/supporting men's place in the family and this may determine how to target other support services for men.¹⁸³

Despite the success of these initiatives they have not resulted in widespread implementation through national policy, or as lobby groups wanted, the establishment of an Office for Men's Health. www.cfah.org; <http://www.wkkf.org>. Overall health systems in the USA have been described as 'patchwork' with certain target groups having strategies created around their health needs. Because of such targeted funding there are still gaps in overall service provision. (Rich and Ro have suggested national strategies to address the needs of poor men and men of diverse ethnicities: see Appendix B).

At other levels the US is attempting to address the issue of disparity in access to health services, and treatment when access is successful. The first initiative of the American Hospital Association is to collect accurate ethnicity data www.hret.org/hret/programs/eliminatingdisparities.html (accessed 30/12/04).¹⁵

In Australia, work relating to indigenous people's health and well-being, has utilised a holistic framework when considering men's health needs. A participatory action

¹⁵ In Wellington, New Zealand this have already been initiated in primary care through the HURA study <http://www.wnmeds.ac.NewZealand/academic/GP/research/> accessed 18/1/05

research process being undertaken with a men's health group in Cairns North Australia has focused on three priority issues identified by men. These include development of greater parenting and personal development skills, relevant education and training programmes that would enhance employment chances, and promotion of Aboriginal tradition and culture.¹⁸⁴

In New South Wales, Australia, a recent report recommended that a number of steps be undertaken to address Aboriginal men's health. These included: addressing men's health through a separate strategy to women's health; employing more Aboriginal men within the NSW health sector; making health service relevant to men, their lives and interests; making services specific to male health issues so that men are more likely to attend; providing incentives for Aboriginal men to be involved; developing services within the terms set down by local men; recognising men's role in Aboriginal society and how that role impacts on the health status of men; addressing the high cost of medication; increasing the number of medical practitioners with an understanding of, and time to deal with Aboriginal men's health needs; and developing an evidence base to improve services.⁴⁴

In New Zealand, Māori male mortality is significantly higher than non-Māori mortality in every social class and for all amenable diseases.^{185, 186} "Māori men score worst of all groups in our population on a number of different indices, and indeed have some of the poorest records in all the world" (p 8).¹¹⁹ It has been acknowledged that cultural heritage has a significant impact on men's health and although there has been some recognition of the need to reduce ethnic differences in mortality in New Zealand men¹⁸⁷⁻⁷, little research has been undertaken to understand the experiences of Māori men in relation to their health needs.¹⁸⁸⁻¹⁹¹

5.4 Written and visual media for men

There are increasing numbers of books available to buy or borrow from public libraries on men's health which target everyday men. Three books available through the Wellington City Library service are the New Zealand Consumers' Institute authored *A Man's Guide to Health*¹⁹²; the Australian authored *Over 50s Men's Health Check*¹⁹²; and *Men inside out*.¹⁹³ All three books acknowledge men's reluctance to seek health care and challenge them to think of their health in the same way that they might care for their car!

Also available in libraries and easily obtainable through retail outlets is *Men's Health* magazine which is solely about men's health and *FHM* magazine which has a large number of high quality (accurate) articles on men's health issues.

There are many health websites available for those who are keen to surf for information including New Zealand health websites such as *Everybody* which includes topical men's health issues <http://www.everybody.co.New Zealand/> (accessed 31/12/04), and also dedicated men's health websites such as <http://www.menshealthnetwork.org/>; and <http://www.nlm.nih.gov/medlineplus/menshealth.html>.

Men's self-help resources, similar to those described above, have been critiqued for presenting the ideology that good health is primarily an individual concern and that good health outcomes are largely the product of individual behaviour. This ideology

is said to appeal to middle class men but is of limited use as a health care strategy aimed at achieving better health outcomes for a wider male population.¹⁹⁴

Men's health, from time-to-time (but never as much as women's health), receives media attention through TV and radio advertising. In recent years there has been targeted advertising about prostate cancer and from direct-to-consumer advertising for medications which address impotence and other health issues affecting men. (Anecdotally the media has been well accepted by men and GPs report that men present requesting advertised medication or tests such as PSA tests etc).

5.5 Men's health nights and health sessions

'Men's health' evenings have been run in a number of countries including New Zealand, where they are organised usually by service clubs and supported by local clinicians. The literature suggests that these have considerable appeal to men, with large numbers of men attending particularly in the older age group, and with men who are professional or retired. Generally speaking, the programme is similar between events with local doctors and/or guest health professionals speaking on various topics and men being encouraged to ask questions either in smaller groups or addressed directly to the speakers. Particular topics of interest have included cardiovascular disease, cancer, men's urological problems and stress. A variation has been described where a men's health night deliberately targeting a community was undertaken. The target area was a rural population known to have had declining profit margins and where a recent health screening programme (run at a cattle market) showed 65% farmers had high cholesterol levels and 30% had hypertension. Instead of presentations by clinicians, display booths were set up offering services such as blood pressure testing; estimating body mass index; advice on diet and weight loss; blood glucose testing; blood cholesterol testing; smoking cessation advice; advice on alcohol and healthy lifestyle; assessment of stress levels and advice on sexual health issues and male cancers. A multidisciplinary team of health professionals were available at a partitioned area in each booth to undertake private consultations and information was passed on to the patients GP, if they had one, with their permission.⁸⁹

An Australian evaluation of men's health nights showed that men felt that as a result of going to the evening they were more likely to attend a doctor, although cost and appointment times remained a barrier to consultation. Men also requested additional evenings covering other health topics.¹⁹⁵ In some case men's health discussion or support groups have arisen from the evening.

5.6 Multifaceted community based innovations to reach men

A number of countries, states and communities have attempted to implement comprehensive models of health promotion and health care. They differ from the projects described above as they contain a number of differing initiatives targeting differing groups of men and are not time limited. Four such models are described below:

1. The Health of Men (HOM) was established in 1997 in Bradford and Aireford (UK) to establish wide ranging innovations designed to deliver health services to men using

existing community facilities, services and groups. These innovations include computer technology applications with interactive websites for supplying or testing health information (www.healthofmen.com), use of laptop computers in drop-in centres to undertake certain physical health checks (such as measuring carbon monoxide levels). Weekly 'drop-in' health clinics in community centres and mobile services in areas not well served with primary care services have been established and offer health checks for men. There is regular input into workplaces where health question sessions are held and health and safety advice discussed with employers, and similarly initiated sessions for boys in primary and secondary schools particularly targeting marginalised youth.¹⁹⁶ In addition, HOM has developed male-friendly resources for men and for professionals working with men/boys (such as teachers). This project has received various grants and has current projects underway. Evaluation has been undertaken by frequent user surveys and feedback/evaluation of events.

2. An allied initiative has been undertaken in North Derbyshire with the development of a comprehensive health promotion programme.¹⁷⁷ This included:

- evaluating ways to involve 14-15 year old boys in classroom discussions about their health and identity
- producing a health video to communicate cancer messages
- antenatal sessions for fathers-to-be
- a parenting course for young families
- a support group for male survivors of sexual abuse
- waist watchers, a weight control group for men held in a local men's club
- a heart health project in a local workplace where men are encouraged to become aware of how their lifestyle impinges on their health. The workplaces have sponsored the time involved for this project in recognition that if men are healthy they are sick less often and do their jobs better.

3. Australia has also attempted to implement a number of comprehensive health initiatives targeting men using the MAN model (www.mannet.com.au). The MAN model is a model of disease prevention and health promotion that seeks to improve and create pathways for men and adolescents to better access the health system.

The model has two main components:

- raising the awareness of men and adolescents about their health status and designing a programme that addresses the issues that they have addressed.
- equipping health care providers including GPs and community health nurses to better respond to the needs of men and adolescents.

The MAN model initiative includes:

- community meetings
- men's health nights
- men's health sessions
- men's counselling
- discussion groups

- parenting courses
- community health networks
- professional development for GPs.

4. Another project begun in 2002 in Ireland, by the Men's Health Forum (a men's lobby group for men), has undertaken several preliminary phases in developing a policy to address the holistic needs of men. These include a men's health consultation day where stakeholders put forward projects which could be implemented at a community level (<http://www.nehb.ie/nehb/news/mensconsday.htm>), a study of men's attitudes towards men's health attitudes and perceptions, and a comprehensive study of Men's Health in Ireland (www.mhfi.org). This recommended the establishment of an advisory group for Men's Health in Ireland and the establishment of a Men's Health Database. It recommended the development of a national policy for men's health relevant for all men in Ireland and increased training and awareness for health professionals and service providers on men's health issues and on working with men as a sub-group (including how to design and deliver effective services for men and including health promotion targeting men).

5.7 Primary care initiatives

Writers who promote men's health initiatives in general practice/primary care do not challenge the (community based health care) discourse regarding the understanding of the causes of men's ill health but seek to promote men to enter the traditional services. The primary focus is aimed at ensuring that existing primary care settings are 'men'^{197, 198}, or 'consumer' friendly.¹⁹⁹ It is unfortunate that there has been limited work undertaken to determine which health professional actions/responses elicit a negative response from men.^{4, 97, 140} In an attempt to address some of the wider issues about men's health the Royal New Zealand College of GPs has published a curriculum topic on New Zealand men's health as part of the vocational education programme.²⁰⁰

5.7.1 Making it work for men; making primary health care men-friendly

Examples of primary care initiatives orientated towards men include offering clinics at 'work friendly' hours, setting up men's health checks targeting 'at risk' men or men of a certain age group, offering the choice of female or male health care professionals, using more information and communication technology such as email and/or text or electronic data collection systems,²⁰¹ and encouraging primary care staff to work in wider community initiatives such as school clinics.¹⁹⁸ Other strategies have also been suggested, which could be used to target men's attendance in primary care (see Appendix C)¹⁴⁹. Personal approaches used by health professionals with men have been considered and recommendations made to ensure these are appealing to men.⁶⁶ These recommendations include:

- ensuring confidentiality
- avoiding judgemental attitudes
- establishing trust with men/boys opportunistically in order that they will learn to trust the GP when a crisis occurs
- GPs and health professionals learning to deal with their own gender related difficulties- dealing with their own health issues

- GPs and health professionals being prepared to be real and show personal vulnerability
- GPs and health professionals making themselves more available
- following up family difficulties
- improving waiting room ambience
- providing appropriate consumer information; considering establishing a lending library
- incorporating new technology such as internet access, email contact
- improving consulting room design
- avoiding language that is negative about masculinity
- establish consultation times friendly to men
- encouraging men to take responsibility for making changes in their lives.

5.7.2 Audit: ensuring primary care is working for men

Audits can be used to determine service delivery gaps for men. Robertson⁹⁰ suggests a framework for an audit of the primary care environment and health professional's interpersonal approach (see Appendix D). The Royal College of Nursing (UK) has also developed an audit tool entitled "Getting it right for teenagers in your practice" to identify youth-unfriendly practices.²⁰²

5.7.3 Health promotion in primary care

There have been a limited number of (published) primary care initiatives undertaken with an emphasis on healthy lifestyle promotion. These include an Irish health promotion programme based in primary care²⁰³ and a cardiovascular risk reduction project based in Scotland.²⁰⁴ In the former, 1000 men enrolled in a number of local practices were invited to attend a programme where they were randomly allocated to one of four health promotion groups (cardio-vascular screening, cancer screening, stress management and general lifestyle advice).²⁰³ Thirty six percent of men contacted attended the programme (similar to the numbers attending health promotion programmes for women). Follow-up evaluation demonstrated minor but significant changes in health status and behaviours. Those attending expressed high levels of satisfaction and preferred interventions with an explicit clinical component (cholesterol testing), rather than lifestyle intervention. Men who attended tended to be married, be of a higher social class and well educated, suggesting that this intervention may not reach socially or educationally disadvantaged men.

An important consideration for this project is the impact of general practitioners in primary care when men have cancer. It is thought that 80% of patients with cancer present in primary care. Early diagnosis of cancer has a significant impact on survival.^{205, 206} There continues to be a heavy involvement with the GP after diagnosis and through to terminal care if treatment is unsuccessful. A study in Glasgow showed patients with cancer consulted a GP twice as frequently in the year after diagnosis.²⁰⁷ Most side-effects from treatment occur in between hospital visits (particularly now that oral chemo therapy regimes are increasing and require less in/out-patient visiting time). As a result the GP has a significant role to ensure patient compliance with anti-cancer therapies.²⁰⁶

5.7.4 Primary care: gender influences

The role gender plays in influencing health professional care has been examined. Some writers believe that the gender of the patient does not influence health professionals' behaviour.²⁰⁸ However others think that if male patients in primary care consultations act in ways considered to be outside of a 'typical male gender construction' (appear overly concerned about their health), they may be made invisible by health professionals^{97, 209}, and their health care minimised.

Comment: Cant think of a better word but there must be one!

Similarly the gender of the health professional¹⁰⁷ or physician^{210, 211} may have some influence on the delivery of health care. Bensing²¹¹ found female patients had a preference to consult a female GP, whereas Bourke²¹² found male and female patients were more influenced by the perception of whether the doctor was 'good' at their clinical work and ability to communicate rather than their gender.

Female GPs have been found to spend more time with patients²¹¹ and in seeking to provide continuity of care^{211, 213}. Bertakis found that female GPs were more likely to deliver preventative services and spent more time discussing family, medical or social factors.²¹⁰ Hall et al found that female physicians conducted longer visits, made more positive statements, made more partnership statements; asked more questions; made more back-channel responses, and smiled and nodded more.²¹³

5.7.5 Primary care and screening

Screening can have positive outcomes other than the early detection of disease. Women through cervical screening (and by often being the regular carers of children) are required to have frequent contact with a health professional and in this way have an opportunity to form a relationship.²¹⁴ A positive outcome of having formed a relationship is the increased likelihood that the woman will consult if a health issue arises. Males who are more likely to present for health screening are older, wealthier, more likely to have dependants, routinely use medical services and have attended primary care in the preceding two years.²¹⁵

A dedicated male cancer research centre has been established in the UK to undertake research into male cancers and promote the development of evidence-based screening programmes²¹⁶. Cancer awareness and detection programmes although long established for women have had almost no equivalent for men.^{168, 217} Certain male cancers such as testicular cancer, the most common cancer for men aged 15-24 are known to be curable if detected early.²¹⁸⁻²²²

It is unfortunate that there has not been the same evidence base to establish screening programmes for men as there has been for women, as this may have facilitated a more regular attendance by men to a health care provider in primary care.²²³ Despite a lack of evidence for many screening tests there are a growing number of screening tools for men for use by health professionals, eg <http://www.ahrq.gov/ppip/healthymen.pdf>.

There is continuing international debate about Prostate Sensitive Antigen (PSA) screening for prostate cancer and there is international variation in how PSA screening is being implemented.^{132, 224-229} There is also uncertainty about what men really want to know about the screening test²³⁰, or how men feel when they have had treatment for prostate cancer (which has a significant risk of causing impotence and/or

incontinence²³¹). In New Zealand, men are advised not to have routine prostate cancer screening²³² although there is considerable continued public debate about this guidance^{233, 234} and health professional practice does not accord with current evidence not to routinely screen.²³⁵ Other countries, such as the US, although offering a routine prostate PSA screening programme, acknowledge the deficiencies of the test (high sensitivity but low specificity²³⁶) and instead encourage men to focus on addressing their cardiovascular risk which results in far higher morbidity and mortality.²³⁷ They also highlight the similarity in the risk factors for both cardiovascular disease and prostate cancer and the methods to reduce risk for both diseases, which are similar. Recent research suggests a correlation between cardiovascular disease and prostate cancer.²³⁸ A 'heart-healthy' diet also seems to be a 'prostate-healthy' diet and clinicians are advised to reiterate and emphasise this and other lifestyle changes including regular exercise to men who are concerned about their risk of developing prostate cancer.²³⁹

Opportunistic health screening by GPs is thought to be one way of ensuring routine screening checks are undertaken regularly. As men do not attend GPs regularly, opportunistic screening can be difficult to address within a routine appointment. There is also lack of agreement as to whether patients approve of such screening. Patients tend to want to address the specific issues that they have sought the consultation for and opportunistic screening practices can lead to dissatisfaction with the GP^{240, 241}. However patients believe (or at least feel neutral) that it is the role of the GP to offer preventive screening care.²⁴² Some writers feel that it is an effective strategy and it is important to at least offer an opportunity for screening when a patient presents for a consultation¹⁹⁸, or to actively recruit patients presenting routinely for a further specific health screening consultation.²⁴³

5.8 Walk-in centres

Walk-in centres led by doctors have been in existence in the United States for about 20 years. In 1999, in the UK, funding was authorised by the NHS for 40 pilot walk-in centres in 30 towns in England. By 2001, 39 centres had been established. The aims of walk-in centres are to provide health information and treatment for minor illnesses and injuries. In contrast to the USA, the UK, NHS walk-in centres are nurse-lead, supported by computer software for clinical assessment and consultations are expected to be longer. Cost-effectiveness has not necessarily been given as the prime goal for the service. A number of evaluation studies have been undertaken since the walk-in centres were established.

An evaluation of the demographic profile of those attending shows that the walk-in centres attract a different population compared to primary care organisations. For example it is known a larger proportion of young men attend walk-in centres. This suggests that the centres provide an accessible and appropriate service for certain population groups.²⁴⁴ A 'before and after' observational study showed that the NHS walk-in centres did not affect the workload of GPs working locally, perhaps because some of those attending walk-in centres were not regular GP attenders.²⁴⁵ A time series analysis showed a reduction in consultations at accident and emergency departments and in local GP practices although the reductions were not statistically significant.²⁴⁶

An observational study comparing the quality of care in walk-in centres with general practice and NHS Direct (a phone-in service) using standardised patients showed that walk-in centres perform safely compared with general practice and NHS Direct for the range of conditions under study. It was noted increased numbers of referrals arise from consultations at walk-in centres and NHS Direct.²⁴⁷ This study has been criticised for not choosing standardised clinical conditions that reflect the complexity of general practitioner care and ignoring the value of continuity of care that general practice is said to provide.²⁴⁸⁻²⁵⁰

Comment: Not sure what this means

A review of the knowledge about and use of 'NHS Direct', a free phone health advice service, showed that fewer men than women were aware of the existence of the service.¹⁶ However among those aware of the service, there were no gender- based differences in use.²⁵¹

5.9 Well-man clinics

Well-man clinics were first established in the UK in 1983²⁵² with similar concepts being offered internationally. Although originally based on the well-women clinic concept, there appear to be few working parallels between these services.¹⁴⁸ Implicit in the philosophy of well-women clinics is service provision '*by women, for women*', however this has not been seen as an imperative in well-man clinics. Additionally, the emphasis on holistic, physical, social, mental and social well-being promoted by well-women's clinics has not underpinned the well-man clinics. In many well-man clinics, there has been a predominant emphasis on the medical model of health care delivery, primarily screening for heart disease and cancer. However, there have been some exceptions to the typical well-man clinics with a limited number of clinics offering a more holistic lifestyle evaluation with an emphasis on education to increase knowledge about men's bodies and their health.²⁵²

A version of the service/checks offered in well-man clinics has also been adopted in primary care/general practice in the form of well-man checks (often offered by practice nurses).²⁵³ Well-man clinics have also been established in some prisons in the UK.²⁵⁴ These clinics focus on offering an assessment of the health of the predominantly young male inmates and establishing baseline data about key clinical indicators including coronary heart disease, cerebro-vascular disease and cancer of the lung and prostate. They also provide health promotion and lifestyle advice. Lifestyle actions are discussed including smoking, alcohol and substance use. From this information a summary health action plan is made and discussion undertaken about possible lifestyle modifications. Although long term gains of lifestyle modification with improved health outcomes have yet to be determined, short term gains are said to have been made including the early detection of hypertension, type two diabetes, renal dysfunction and hyperlipidaemia. There has been positive feedback from men about the increased knowledge about their health and reduced rate of illness. Additional prison-based programmes have included parenting classes for fathers.²⁵⁵

There has been limited formal evaluation of the well-man clinic services. So far evaluation has primarily involved establishing whether or not men were satisfied with the service.²⁵⁶ Men attending said they valued the chance to discuss health issues as well as undertake screening. However there has also been frustration regarding the

¹⁶ New Zealand phone help-lines will need to think about targeted advertising to attract men.

clinics inability to undertake follow-up after screening, with the men attending the clinic having to undertake follow-up through a GP (if the man had one). There was not a strong preference for male staff delivering the service although men valued being offered the choice of the gender of staff attending them. The clinics tended to appeal to men over 35 and those of a higher economic class. The evaluation project identified that the service may not appeal to men of younger age groups or those who are disadvantaged.²⁵⁶

Well-man checks have been critiqued for their underlying philosophy. They are said to have been established according to a 'defect apparatus model' of health, a biomedical framework, which seeks through time-effective interventions to promote optimum physiological functioning and minimise deterioration. Implicit in this model is that well-man clinic boundaries between patient and health professional are created by health professionals. Information is gained and given according to current medical knowledge with the objectives defined by health professionals (and not collaboratively) to prevent medically defined disease and disability. As a result, men are required to be passive, compliant and submissive, but are also required to have control and responsibility over all aspects of health. The underlying philosophy ignores the structural, personal or political influences, which may inhibit control and affirms the current role of government, employers, manufacturers and others in their vested interest in keeping men 'unhealthy'. The ideology of screening being the prime role of well men's clinics is believed to be flawed because:

- there is difficulty in measuring benefit
- there being no clear causal link between risk factors and ill health
- there being no guarantee that screening will lead to health improvement
- there may be a lack of humanism involved in offering mechanistic screening checks
- screening may cause anxiety by giving false positive results or identifying diseases which do not exist.

It has been suggested that well-man clinics in addition to undertaking screening functions should aim to enhance men's ability to control risk-taking behaviours by having a prime aim of fostering a man's ability to direct his own life (using the Prochaska and Diclemente model of stages of change¹⁴⁶).¹⁴⁸

6.0 Conclusion

There is a small but growing and increasingly cohesive body of literature on 'men's health' which has been written predominantly in the past 20 years. However over this period of time there has been limited progress made in both identifying why men and women have different help-seeking behaviour and health outcomes and also in identifying ways to facilitate appropriate health care for men. It is unknown how much biological difference contributes to men's health status. The focus in men's health literature has more been on the 'problem of men and their health' with the tone of the discussion being somewhat ambivalent. There is an attitude of both blaming, yet accepting of men's behaviour as a cause for the current status of men's health.

There are a growing number of publications, which attempt to explore new understandings about the complexity of beliefs about men, masculinity and health. A number of these publications challenge not only health care providers but politicians to acknowledge the difference between the status of men's (particularly men who are 'poor' and/or of indigenous and diverse ethnicity) and women's health and to review the multiple factors which may be contributing towards this growing gap. Such writers do not believe men will be influenced by mortality statistics alone, but instead by practical measures that will improve their lifestyle, based on their own expectations, beliefs and experiences of health. It is believed that society at large would also benefit from interventions aimed at normalising men's help-seeking behaviour and men's expression of soft emotions such as pain and fear.

Internationally there are growing numbers of initiatives being undertaken in the community to address men's health. Despite the lack of formal evaluation it appears that many of these approaches have greater appeal to certain groupings of men, predominantly middle class, white, well-educated men. No one approach appeals to all men. Perhaps this is why integrated multifaceted approaches appear to address health issues and access to health care for the widest groupings of men.

New Zealand does not appear to have kept pace with international thinking on men's health. It has not recognised the status of men's health as a disparity and it appears to have normalised differences between male and female morbidity, mortality and life expectancy (not even commenting on them in a publication to discuss New Zealand health disparities). Thus the current status of men's health is viewed as normative, not needing to be addressed, (except in government policies where the health of Māori men is noted as problematic).

Baseline measures of men's health in key areas should be established and maintained in order to be able to evaluate changes in status over time. Currently this information is amalgamated into routinely collected data and is either not always easy to identify by gender or analysis by gender has not been undertaken. The report Men's Health in Ireland is an example of how this information can usefully be used to portray population differences in the health status of men and women (<http://www.mhfi.org/fullreport.pdf>).

Sub-groups of New Zealand men, who are recognised to be the most vulnerable in terms of health and health care, are yet to have substantial recognition (gay, bisexual and transgender men of diverse ethnicities, non-custodial fathers, and men in the criminal system).¹

There are a number of places where interventions could take place, these include but are not limited to:

1. addressing the issues of socioeconomic and ethnic disparity, especially those that relate to child poverty. Poverty in childhood is known to have lifelong effects on health for which health interventions begun later in life will not be able to reverse.
2. preventative health measures targeting and acceptable to men, and which take into account social/family/socioeconomic/cultural circumstances. Preliminary

research will be needed to determine what these measures may be and where in the community they might be undertaken.

3. fostering socio-cultural change in men's thinking about health and well-being to normalise and enhance male health/help seeking behaviours. This will not easily be achieved with current adult males. It will require changes in the way young males are socialised and educated to think about themselves, their roles and the importance of their health and well being. In addition, females need to be made aware of the significance of their role in fostering men's recognition of their health and well being.
4. re-assessing current systems and places of health care delivery in light of what we know about men's preferences. Initiatives acceptable to men appear to be walk-in centres, phone help-lines, work-based health care, well-man checks, men's health nights etc. Further work is needed to examine which initiatives are acceptable to young men, 'poor men', indigenous men and men of diverse ethnicities.
5. exploring the potential for traditional primary care services to integrate support/input into similar initiatives targeting men in the wider community. This contrasts with the stand-alone well-man clinic initiative which has not sustained its early appeal perhaps because of its emphasis on screening for certain illnesses, when men want to address wider and less specific health concerns.
6. providing health professionals, (particularly male health professionals), with education to inform them about the wider context of men's health issues including the influences of being male on men's lifestyle patterns and health seeking behaviour. Health professionals, particularly those who gate-keep the access to resource intensive treatment for acute and chronic illnesses, need to become aware of their own actions in increasing disparities in health outcomes for men who are poor or of diverse ethnicity.
7. considering the auditing of policies, processes and staff actions, for practices which support health disparity. Health care systems (primary, secondary and tertiary care) currently appear to unconsciously perpetuate health care disparity. Traditional systems of clinical care reinforce existing practices which often discriminate against poor people or people of diverse ethnicity.

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Appendices

Appendix A

Major causes of death – numbers and percentages by sex, 2001.

Source: NEW ZEALAND HIS provisional mortality data for 2001.

	Male		Female	
	No.	%	No.	%
Ischaemic heart disease	3387	23.9	2981	21.3
Hypertensive disease	99	0.7	133	1.0
Other forms of heart disease	550	3.9	700	5.0
Cerebrovascular disease	1035	7.3	1745	12.5
Cancer	4165	29.4	3645	26.1
Colorectal cancer	(607)	(4.3)	(571)	(4.1)
Cancer of the trachea, bronchus and lung	(841)	(5.9)	(593)	(4.2)
Prostate cancer	(592)	(4.2)	-	-
Breast cancer	(2)	(0.0)	(615)	(4.4)
Stomach cancer	(195)	(1.4)	(108)	(0.8)
Pneumonia and influenza	148	1.0	264	1.9
Diabetes mellitus	405	2.9	377	2.7
Chronic obstructive respiratory disease	861	6.1	765	5.5
Transport accidents	377	2.7	158	1.1
Falls	129	0.9	161	1.2
Intentional self-harm	382	2.7	117	0.8
Assault	32	0.2	18	0.1
All causes of death	14,160	100.0	13,968	100.0

Appendix B

National strategies that address the needs of men, poor men and men of diverse ethnicity

Rich and Ro in a study funded by the W.K. Kellogg Foundation¹ put forward a number of strategies to address poor men's health needs; most have direct relevance to New Zealand given the New Zealand disadvantage of not having economy of scale in addressing men's health needs. Although the strategies were written particular for men of colour these can equally apply to men who are disadvantaged in health care and have been adapted to take account of the New Zealand system.

- Strategy 1: Expand health insurance coverage for men * limited relevance for New Zealand health system.
- Strategy 2: Establish enhanced points of entry into health care for men. This is to be implemented by the development of male-focused clinical services with a specific to address the broad needs of men; provide adequate reimbursement and support to institutions that develop such models of care.
- Strategy 3: Increase the availability of community-based screening and services and care coordination (case management). This is to be implemented by the development of community-based screening efforts to address the major health problems affecting men; tailoring these approaches to specific cultural linguistic and socio-political realities of target populations; expand case management for men in health care settings; Linking screening services for men with primary care follow-up not only of men with identified disease but for all men who lack primary care; Partner with community organisations to reach men of colour; develop well trained and culturally competent outreach workers who are equipped to educate men about health issues and help them navigate the health care systems; target health outreach to where men work and live.
- Strategy 4: Enhance the bridge between paediatric care and adult care for men This is to be implemented by education for health care providers regarding young men and adult men's health issues (including issues relating to poor men and men of different ethnicities); enhance relationships between adult primary care providers and adolescent providers; consider development of clinics to serve both adolescent and young men in the same clinical setting with enhanced social service, mental health and health education support; develop shared outreach and health education staff between adolescent and adult clinics.
- Strategy 5: Build a culturally competent workforce. This is to be implemented specifically targeting males at college for health career development training and support them through grants and scholarships; work with Schools of Medicine and Nursing and other health professional disciplines to identify barriers to poor male and males of different ethnicities entering health professional training programmes; have health care system require cultural safety training that incorporates issues of masculinity and other health

professionals; monitor satisfaction of men in the health care system both as patients and providers.

- Strategy 6: Develop a holistic model of health care for men (particularly for poor men and men of different ethnicities). This is to be implemented through men’s health programmes which focus on broadly defined determinants of health such as employment, education and discrimination. Funding should be made available to develop and evaluate integrative and holistic models of health for poor men and men of diverse ethnicities that recognise inequities in the health care system and barriers to access; implement prevention focused activities including fitness, nutrition, preventive mental health and education about social justice in all activities which target men of diverse ethnicities.

Core issues that affect men’s health ¹

Access to services	Meaning of manhood
Navigating through the health care system	Health How to care for your body
Choosing a health care provider	Basic prevention of illness
How to address concerns to your provider	Fitness and nutrition
	Sexual health
Mental health	
Trauma and PTSD	Life skills
Substance abuse	Parenting
Stress reduction	Education
Spirituality	Understanding the culture of work
Employment	Negotiation
	Conflict resolution
Social Justice	
The nature of oppression	
Racism	
Sexism	
Homophobia	
Criminal justice	

- Strategy 7: Focus on decreasing racial and ethnic health disparities for men of colour. This is to be implemented by supporting health care institutions in identifying barriers to utilisation by man of diverse ethnicities; include anti-racism training in cultural safety curricula; incorporate concepts of social justice that explicitly acknowledge racism, sexism and homophobia into health education material and other curricula for men.
- Strategy 8: Address the health issues of the most vulnerable men of colour. This is to be implemented by ensuring the availability of linguistically appropriate providers and interpreters in clinicians serving ethnically diverse populations of men; develop interventions to address health issues on inmates and ex-offenders linking men into primary care before discharge; focus specific efforts for ex-offenders on substance abuse and mental health while

also providing links to employment support, education, family reunification and child support service; focus special efforts on gay, bisexual, and transgender men as well as men who have sex with men.

- Strategy 9: Expand research and data collection on the health of men (particularly poor men and men of diverse ethnicities). This is to be implemented by routinely collecting self-identified ethnicity data. Fund formative research to understand the current attitudes and health behaviours of men and poor men and men of diverse ethnicity, including the use of qualitative methods to understand meanings associated with illness, health care and health utilisation and personal experience in the health system; monitor performance indicators for quality health care including health outcomes for men and poor men and man of diverse ethnicity; develop partnerships between public health agencies and academic institutions to conduct research into the health needs of men including poor men and men of diverse ethnicity.
- Strategy 10: Improve understanding of the role of societal notions of manhood and their effect upon the health of men of colour. This is implemented by developing patient education materials from a conceptual framework that acknowledges societal meanings of manhood; includes questions about attitudes regarding masculinity in risk factor assessments for all men, but particularly for poor men and men of diverse ethnicity.
- Strategy 11: Develop community coalitions of health, public health and social service providers who serve men particularly poor men and men of diverse ethnicity. This is to be implemented by funding support to community based organisations serving poor men and men of diverse ethnicity; establish coalitions and collaborations for organisations to share resources.
- Strategy 12: Develop national, state and local policy agendas for health of men of colour. This is to be implemented by encouraging collaborations between national funders, and local health care providers, work and income and education ministries to address the health needs of men and particularly poor men and men of diverse ethnicity; develop men's health programmes at national and local levels with a particular focus on racial and ethnic disparities; develop targeted communication campaigns to raise awareness of the health issues of men of colour.

Appendix C

Strategies to encourage men to attend primary care or general practice settings ¹⁴⁹

Getting men to come in:

- Show practice has an interest in men's health, through displaying men's health posters and information
- Provide women patients with information on 'men's health' to give to their partners and family friends
- Provide evening clinics and appointment times more easily accessible to men working shifts, commuting or living out of town
- Consider going to where men are for clinics in factories and other workplaces
- Encourage males of all ages to be conscious of their health and how they can maintain and improve it (men from their 40s seem to have received this message)

What to do when the men turn up? Getting men to open up and talk in the consultation

- Provide a questionnaire for men to complete before entering the consultation room
- Establish rapport and build a relationship with the whole person
- Initiate discussion (e.g. How would you rate/describe your own health? Do you have any health or personal concerns troubling you? How does your partner treat you? Ensure you tap into positive life motivations by asking What do you do for fun? How are you going with your hobbies/sports? is a way of identifying possible suggestions for social connections)

Getting men to come back

- Encourage men to book longer consultations to address health concerns
- Explain how to ask for a longer consultation (perhaps offer to adjust fees for preventative activities)
- Give home reminders (urine jar, handout/leaflet, pathology form)
- After explaining the importance of a health check strongly encourage men to make an appointment before leaving the practice that day

Helping men to make changes to promote their health

- Try to relate the need for behavioural changes to current presenting problem eg URTI/chest infection, smoking, stress at work
- Find common ground with the patient to reduce risk and promote health eg what changes to make first
- Work with the patient to assess his barriers to change
- Gain a commitment to change
- Note risk status and management plan in medical record
- Introduce men (not just refer) to relevant community networks/support groups

When they come back

- Be proactive in praise and follow-up of issues raised previously raised/discussed
- Monitor and support changes in health behaviours and risks

Appendix D

Audit schedule for general practice acceptability to men⁹⁰

Walls and notice boards

- Are images of men displayed
- Are there leaflets, posters and other materials relevant to men available?

Leaflets, posters and brochures

- Do the images and text say men are welcome here?
- Are letters addressed to both parents where service involves children?

Assessing men's involvement

- Are men involved as clients or patients in clinics, groups or education you facilitate?
- Are men actively and continually encouraged to participate?

Staff attitudes

- Do you relate differently to men and women as clients?
- Do you feel more comfortable approaching women than men?
- Do you assume men positively want to be involved?
- Do you expect men will be interested in their children's health?
- If a mother and father are present with a child, do you listen and talk to them both?
- Do you value a father's contribution?
- Do you schedule visits to suit both parents?

Recruiting men

- Do you want men to be involved?
- Are you prepared to make the first contact?
- Can you enlist other local health or community professionals to help with recruitment?
- Can women clients be encouraged to help men?
- Can you ask male clients known to you to approach other men?
- Is providing help specifically for men possible in your work context?
- Can you tap into work, trade union, sports, fitness and leisure networks?