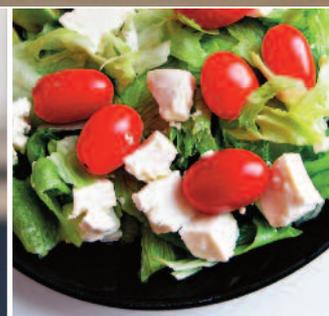
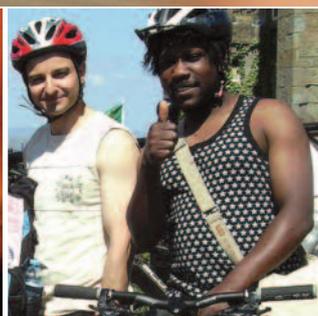
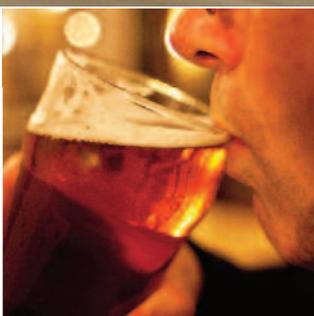


A Picture of Health?



Men's Health and Wellbeing in Bristol

NHS BRISTOL
Men's Health
& Wellbeing



A Picture of Health? Men's Health and Wellbeing in Bristol



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A Picture of Health? Men's Health and Wellbeing in Bristol



Foreword

A Picture of Health? draws on a growing body of research evidence about the key factors which contribute to men's health and wellbeing outcomes. It underlines important aspects of men's health-related behaviour.

Over the next few years, this report will provide an evidence base for the work of health and social care policy makers, service commissioners, health care and public health practitioners in particular. It clearly demonstrates the need for all such stakeholders to become more sensitive to the impact of gender, as mediated by social class, ethnicity and other factors, on the health and wellbeing of individuals and communities.

Increased knowledge and sensitivity will form the basis for a wide range of voluntary, public and private sector partners to work together with communities to address the problems and overcome the challenges identified in this report. Our systematic, sustained and creative efforts can bring a real improvement to the lives of Bristol's men; and to the lives of the women and children affected by men's health and wellbeing



Dr Hugh Annett
Director of Public Health
NHS Bristol and Bristol City Council

1. Introduction

Background

It is recognised that there are inequalities between men and women in terms of health and wellbeing. Men's health is, in general, poorer than women's. Male life expectancy at birth in England is five years less than for females. Additionally, it appears that there are significant health inequalities between men living in different social circumstances, determined by their social class, ethnicity, disability, sexual orientation, religion or belief. There are also differences between men and women in health practices and the way they use health services. Traditionally, men are reluctant to seek help and utilise health services, tending to consult a health professional later in the course of a condition or illness. This delay has a potentially negative impact on their health (Maslen 2010). This combination of factors means that men are disadvantaged in terms of health outcomes. We also know that men are three times more likely than women to take their own lives.

We need to increase our understanding of all the issues that are linked with poorer health and wellbeing outcomes in men in comparison to those in women. We need to know more about why men are more resistant to health promotion messages, why they are reluctant to seek help when in distress, why they find it difficult to come forward with mental or emotional problems and why many men lack social networks (Conrad & White 2010).

Our vision is to become more responsive to men's physical, emotional and mental health needs, based on our increased knowledge and understanding. This will enable us to develop effective health promotion interventions and provide services that reflect men's needs and that men will want to use.



In response to the identified gender health inequalities, the directorate of Public Health, NHS Bristol, has developed Men's Health Initiative which brings together partners from a variety of sectors around one common goal: to develop and implement clear objectives that will help us to achieve our vision.

Purpose of this work

The directorate of Public Health, NHS Bristol, conducted an extensive literature search in relevant, key areas of men's health and commissioned a researcher to produce a men's health report with a detailed summary of the information gathered. The aim of this task is to construct a solid base of evidence to support the Men's Health Initiative.

The objectives are to:

- collate and analyse the men's health evidence base, clearly identifying the issues for Bristol
- distinguish between general health and wellbeing and mental health and wellbeing issues for men
- comment on the gender equality legal requirements for NHS Bristol and its legacy organisations.

This work includes an outline of the context for the Men's Health Initiative, including the policy context, a profile of men in Bristol and specific issues that impact on men's health. The challenges facing health professionals and services are also considered, including sociological and psychological issues such as masculinity, identity and attitude to health; as well as factors that contribute to inequalities in health. An evidence-based analysis of 'what works' is included, summarising national and local interventions to promote men's health and wellbeing, improve outcomes and improve the uptake of services. Finally,

legislation and local compliance are considered, along with recommendations for future commissioning and service development.

This work has been written in a style that is anticipated will be easy to read, to ensure it is accessible to a wide range of readers. Although some technical and research terms are included, these have been explained where possible. The structure is intended to promote ease of reading, with summaries, key points and vignettes to compliment the general text.

The summary at the start of each section provides a short précis of the contents, to draw attention to the basic themes of the text. The key points highlight the most important facts or ideas presented within the text. The vignette is intended to provide a small portrait of an individual or group of men who represent and/or illustrate the topic under discussion, and can prompt the reader to think about some of the issues in more depth. The vignettes may also be useful in group settings to facilitate discussion. On the whole, the vignettes are fictional rather than actual case studies, since the timescale did not allow for the collection of this type of new data.



2. The Policy Context

Summary

Recent, national health policy has paid little attention to men's health issues. Gender inequalities have been primarily focused on women's health. However, the tide is turning and the importance of men's health as an issue for gender inequality is significantly increasing. Two organisations - the Men's Health Forum and the Centre for Men's Health are particularly influential. The Equality Act of 2010 is central to the future of policy developments to address gender inequalities in health related to men.

National policy

There is well established and widely recognised evidence that, overall, men's health and wellbeing is generally worse than women's, although there are some exceptions with particular outcomes. It is claimed that men's health appears to be consistently disregarded within the policy context (MHF 2010a). This is particularly true in relation to inequalities in health and health outcomes.

Over the last decade, the Government has claimed that it has placed equality issues at the heart of its decision making and policy direction. Health inequalities, in particular, have been on the agenda for much longer, initially highlighted by the Black Report (DHSS 1980), and more recently by Acheson (1998) and Wanless (2004). However, it could be suggested that both Government and health services have concentrated on social class and ethnicity as the primary determinants of health inequalities. Gender has mainly been factored into this equation from the perspective of women's experience of health, rather than an understanding of the different issues for both genders. The effect of this is that policy makers have paid scant attention to men's health issues as a characteristic of gender inequality.

An example of this is the Department of Health's report 'Tackling Inequalities: 10 years on' (DH 2009a). This is an influential work on tackling inequalities in health, yet it overwhelmingly fails to acknowledge maleness as a determinant of health inequality. The attention that is given to gender is focused on women and their role in supporting the health of families and children. However, the primary focus on inequalities relates to socio-economic status and ethnicity. Wilkins and Savoye (2009) have noted that inequalities in men's health are directly related to the way services are provided and, as a consequence, should be taken as seriously as other markers, such as ethnicity and social class. This would suggest that the above report is inconsistent as a mechanism to address health inequalities.

The Strategic Review of Health Inequalities in England post 2010 (Marmot 2010) proposes the most effective evidence-based strategies for reducing health inequalities. However, this report has been heavily criticised by a leading men's health organisation – the Men's Health Forum (MHF 2010a), who claim to be surprised that men's health has been overlooked within this policy context. MHF, a charity established in 2001, provides an independent and authoritative voice for male health in England and Wales and tackles the issues and inequalities affecting the health and wellbeing of men and boys (MHF 2010b). Their primary objective is to influence the development of health policy in favour of better male health, and in 2009, they entered into a strategic partnership with the Department of Health.

A similar, key development in the men's health arena was the introduction of the world's first specialist academic department, the Centre for Men's Health (CMH) at Leeds Metropolitan University in 2007. The centre aims to challenge, improve and understand men's health, working in close partnership with health professionals and services, policy makers and service users (CMH 2010).



Both the MHF and the CMH, along with other health activists and groups, have been influential in promoting the men's health agenda and in policy decisions. As a result, several health policy initiatives have included recommendations that focus on men, including the Cancer Reform Strategy (Department of Health 2007a) and the National Chlamydia Screening Programme (Health Protection Agency 2007). Despite these notable exceptions, there has been in general a lack of inclusiveness of men's health as a gender inequality issue within health policy.

Local policy

In the Joint Strategic Needs Assessment (JSNA), NHS Bristol has been effective at highlighting those groups who are experiencing health inequalities, including gender inequalities. The JSNA brings together information about the health and wellbeing needs of men, women and trans people, supporting and informing planning and positive action. The needs of men and women are differently reflected in the JSNA and acknowledgement is given to the need to gain a more in depth understanding of the diversity of gender needs across different groups (NHS Bristol 2010). It is clear that NHS Bristol recognises its obligations in relation to the Equality Act, 2010.

Equality Act 2010

A very useful device for challenging inequalities in men's health is the Equality Act, 2010, which became effective on 1st October. Its power lies in the fact that it is statutory legislation and, therefore, NHS organisations must comply. The Act requires equal treatment in access to public services, regardless of gender, race, disability, sexual orientation, religion, belief and age. The NHS recognises it has an obligation to promote equality in its Constitution (Department of Health 2009b), stating that the NHS has:

'a wider social duty to promote equality though the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.'

Given the evidence base related to men's health and their disadvantage, it would seem that the NHS must, therefore, start to pay attention to the health and wellbeing needs of men and address the key issues surrounding the health inequalities they experience. As well as gender, consideration must be given to the inequalities men face in relation to, ethnicity, age, gender identity, sexual orientation, religion, belief and disability.

Vignette

Ireland and Australia have both developed national men's health policies, designed to address the issue of gender inequality in health care and services (Department of Health and Aging 2010, Richardson and Carroll 2009). These policies also highlight the inequalities in men's health based on other determinants such as socio-economic status, ethnicity and sexual orientation. It is probably too early to establish the effectiveness of these policies. No similar national policy exists in the UK although the inequality issues surrounding men's health issues are beginning to be mainstreamed in other policy documents.

Key points

- In general, there has been a lack of inclusiveness of men's health and wellbeing as a gender inequality issue within health policy.
- Both the Men's Health Forum and the Centre for Men's Health have been influential in promoting the men's health agenda and in policy decisions.
- The most powerful mechanism related to challenging inequalities in men's health is the Equality Act, 2010
- NHS Bristol recognises its obligations in relation to the Equality Act, 2010.



3. The Men of Bristol

Summary

Bristol is a large, urban centre with a culturally diverse population. There are some areas of affluence, but also areas of deprivation. This section gives information that profiles the men of Bristol and highlights some of the issues that are related to their health and their use of health services in Bristol. There are, however, some limitations to the data available and more work needs to be done in this area.

About Bristol

Bristol is England's sixth, and the United Kingdom's eighth most populous city, one of the English Core Cities and the most populous city in South West England. Bristol is also the largest centre of culture, employment and education in the region. Its prosperity has been linked with the sea since its earliest days. In more recent years the economy has depended on the creative media, electronics and aerospace industries, and the city centre docks have been

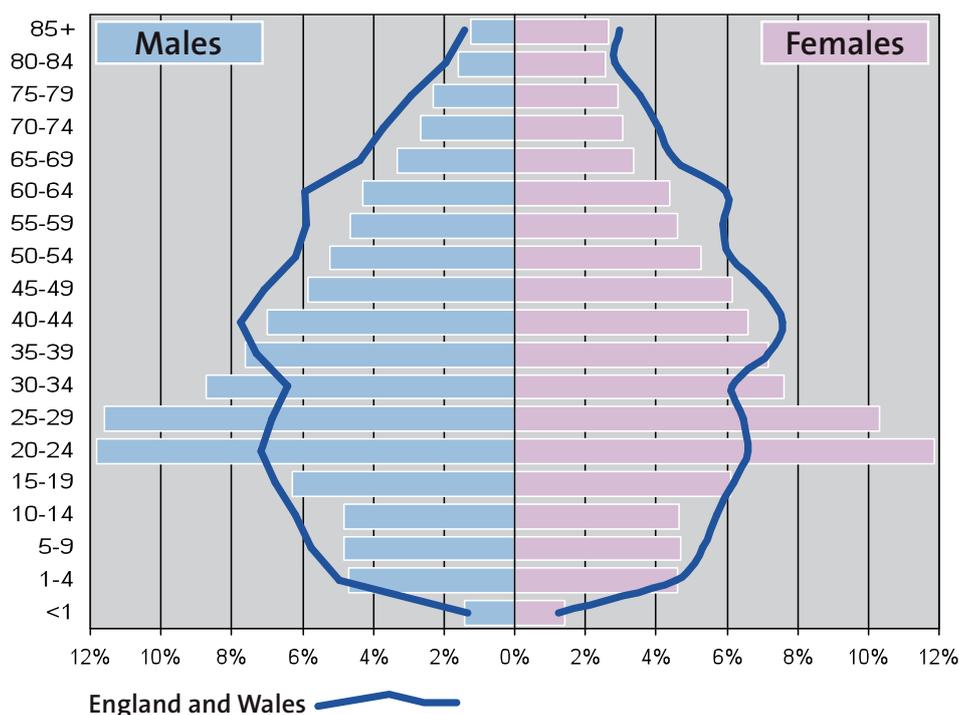
regenerated as a centre of heritage and culture (Norwood 2007).

Bristol's status as a large, urban centre contrasts dramatically with the rest of the South West region, which is relatively rural and affluent. Bristol faces many issues and problems that have more in common with other major cities such as Leeds, Liverpool, Manchester and Sheffield (NHS Bristol and Bristol City Council 2007). For the purpose of measuring deprivation and other factors, Bristol is split into 252 geographical areas called super output areas (SOAs). Thirty five of these areas are amongst the most deprived ten per cent in the country, with two areas that are the worst in the country in terms of education deprivation for children and young people.

About the Men of Bristol

The Office for National Statistics (ONS 2010a) estimated the mid-year 2009 population of Bristol to be 433,087, with almost an even split between males (216,304) and females (216,783) (see table 1).

Table 1: Structure of Bristol resident population, mid-2008

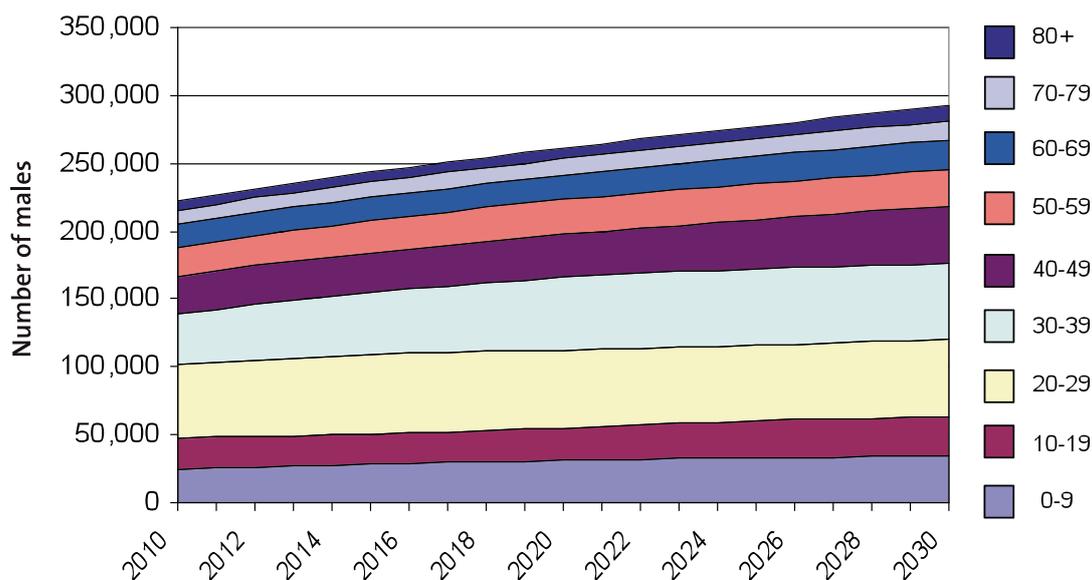


Source: Office for National Statistics, 2009-mid-year population estimates



The 2008-based ONS population projections estimate there will be a 30% increase in the female population of Bristol by 2030 (from a 2010 base) and a larger increase of 37% among men in Bristol (see table 2).

Table 2: Projected growth in the male population of Bristol, 2010-2030



Source: Office for National Statistics, 2008-based sub national population estimates

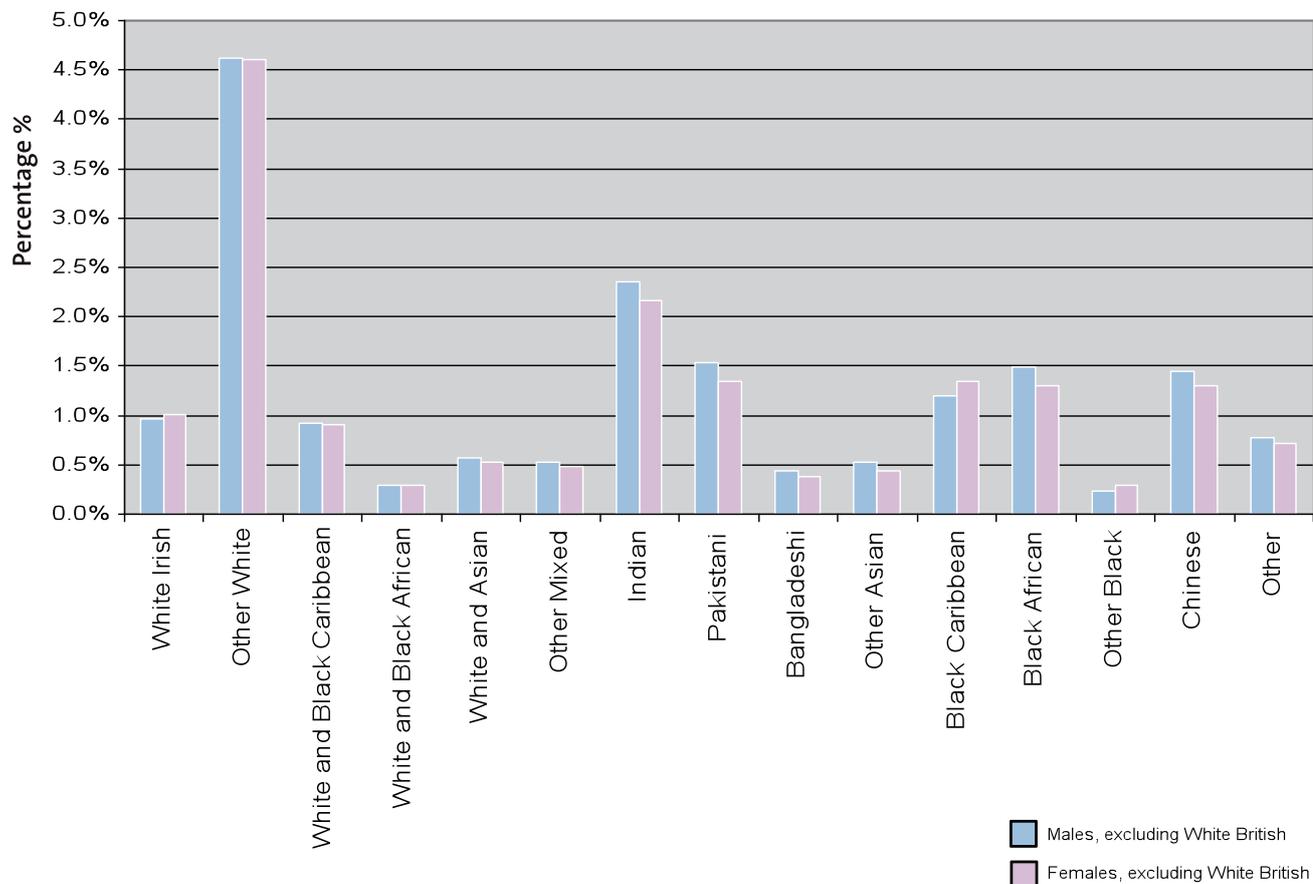
The largest proportionate increase among men is projected to occur in the 80+ age group, with over 70% growth from 2010 to 2030 (approximately 6,300 to 10,900 in 2030). There is also projected to be growth of almost 50% in the 30-39 age group, 40% in the 0-9 age group and 30% growth among 50-79yr olds by 2030.

The Office for National Statistics (2007) estimated that 82.5% of the population of Bristol was White British. Splitting the data by gender reveals 82.1% of men and 82.8% of women in Bristol are White British. The figure below compares the percentage of the male and female population of Bristol that are from ethnic groups other than White British (see table 3).

There are estimated to be proportionately slightly more Indian, Pakistani, Other Asian, Black African and Chinese, and slightly fewer Black Caribbean men, than women in Bristol.



Table 3: Percentage of men and women in Bristol from ethnic groups other than White British



Source: Office for National Statistics, 2007 ethnic population estimates

Use of Health Services in Bristol

The Count Me In survey (Dumper 2010) was carried out by Bristol Community Health to monitor the extent to which its service users were representative of the population of Bristol.

The data obtained is a snapshot of service users gathered over several days during the month of November 2009. All services asked their patients to fill in a data collection form during a limited period. In order to obtain reasonable data, the number of days varied depending on the size of service. Translated versions of the form were made available and posters in English, Arabic, French, Hindi, Polish and Urdu, were produced to explain to patients what was going on.

Participation was entirely voluntary, so the data is not a completely accurate record of who used the services. However, the high numbers who replied makes this valuable evidence. Twenty five services responded, providing replies from a total of 1,898 service users. Read in conjunction with other research, the data offers an indicative profile of the service users, the proportion of the different equalities groups using services and where some of the gaps may be.

A limitation of the data in relation to gender is that it has not been stratified in any way. This means it is not possible to present a picture of the men using the services in relation to other equality characteristics. It would be possible to



return to the original data collection forms and establish the relationships between gender, ethnicity, disability, religion, belief and sexual orientation. However, this is outside the scope of the current work. Despite this limitation, there is some useful evidence about who uses the community health services in Bristol. The data below are presented as percentages of the total responses, unless the number was too small to quantify into a percentage. In this case, only the number of responses is given:

- over half (52%) were of pensionable age, with a third (32%) over 75
- two fifths (40%) described themselves as disabled
- of those that replied, more than half (58%) were female and just under half (42%) were male
- the vast majority (90%) of those who filled in the form were White. 5% identified themselves as Black or Black British, 4% as Asian or Asian British and 1% as dual heritage. Only one person described themselves as Gypsy/Romany
- when asked about preferred language, the overwhelming majority (89%) said English. For spoken communication, Urdu (13), Somali (11), Cantonese (9), French (8), Italian (6), Punjabi (6), Bangladeshi (5) and Polish (5) were most frequently mentioned. For written language, again English was the most requested (1,533); followed by Urdu (13), French (6), Polish (5) and Italian (5)
- two thirds (66%) described themselves as Christian, whilst nearly a quarter (24%) had no religion. Amongst the remaining replies 5% described their religion as 'Other', 69 (4%) identified themselves as Muslim, nine as Hindu, seven as Buddhist, three as Sikh and one Jewish. Also listed were Shamanic, Wicca, and Pagan
- the majority (88%) described themselves as heterosexual. However, 98 (7%) preferred not to say, 34 (3%) said they

were gay/lesbian, 30 described themselves as bisexual and 15 described themselves as having another sexual orientation.

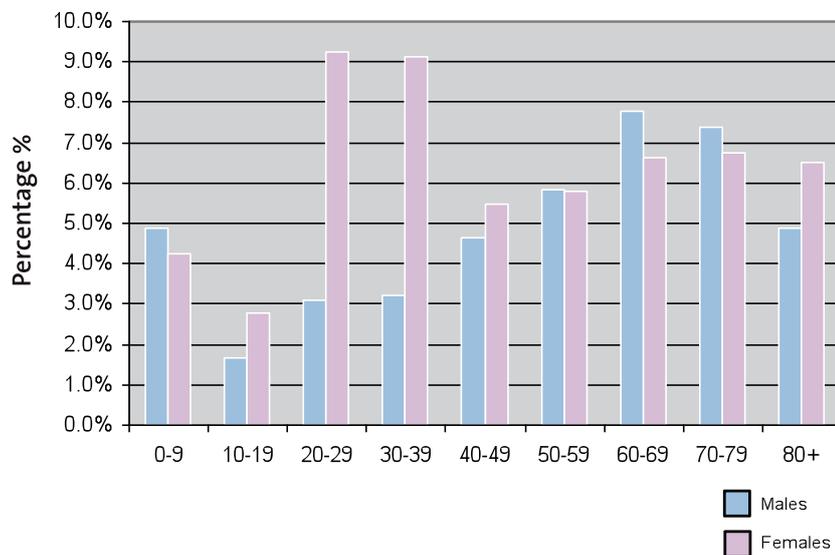
From the evidence of this survey, Bristol Community Health (BCH) reached a number of conclusions. Although these are not specifically related to men they may be useful in informing the work of the Men's Health Initiative:

- it is clear that there are members of Bristol's Black and Minority Ethnic populations that are not being reached, particularly for conditions which they suffer disproportionately from
- there is a need to have greater understanding as to why the BME populations in Bristol are not using domiciliary (community) services in significant numbers
- BCH needs to do more to reach out to the Gypsy/Traveller community
- BCH needs to begin to think about making outpatient services more welcoming to young people
- there is a need to use more diverse methods of communicating with patients, using large font, texts, and targeted languages.

There is also some limited evidence about the use of acute services in Bristol. Table 4 demonstrates that more boys than girls aged 0-9 are admitted to hospital. It could be speculated that this might be in relation to a higher level of accidental injuries, but there is no evidence to confirm or refute this. It is also apparent that men are less likely than women to be admitted until they reach the 50-59 age group. However, this may be attributed to women in the 20-49 year age groups being admitted for pregnancy-related conditions, including giving birth. The higher number of female admissions in the 80+ age group may be attributable to the fact that women live longer than men (van de Venter 2010a).



Table 4: Hospital Admissions by Age and Gender, 2007/08-2009/10 admissions, NHS Bristol



Key points

- Bristol faces many issues and problems that have much in common with other major cities such as Leeds, Liverpool, Manchester and Sheffield.
- The largest proportionate increase among men is projected to occur in the 80+ age group, with over 70% growth from 2010 to 2030 figures.
- 82.1% of men in Bristol are White British.
- There are estimated to be proportionately slightly more Indian, Pakistani, and other Asian, Black African and Chinese and slightly fewer Black Caribbean men than women in Bristol.
- In the ‘Count me in’ survey, 1% of Bristol Community Health service users identified themselves as gay.
- Fewer members than expected of the Gypsy/Traveller community use Bristol Community Health services.



4. A Picture of Health?

Summary

Information about men's health and wellbeing, both nationally and in Bristol, is presented here. A variety of evidence demonstrates that men experience poorer health than women in many areas, and are significantly more likely to die at an earlier age. The main killers are coronary heart disease and cancer. Key issues and lifestyle factors for men are highlighted, including:

- Obesity
- Smoking
- Alcohol
- Substance misuse
- Sexual health
- Work
- Fatherhood
- Men in prison

The impact of gender inequalities on men's mental health and wellbeing is explored in depth, since the evidence reveals that this is a particularly gender-sensitive issue.

Men's general health and wellbeing

There is no doubt that men's health and wellbeing in England is disadvantaged by their gender. Men are more likely to die at any age than women. The average life expectancy of a male born in England is 77.7 years, compared to an average for women of 81.6 years. Men from socially deprived backgrounds have a worse life expectancy than those from affluent backgrounds, on average seven years less, and the gap is widening. In 2001 the mortality rate of those in routine and manual occupations was two times that of those in managerial and professional occupations. In 2008 that ratio had risen to 2.3 (Langford and Johnson 2010).

Within the population of Bristol, there are also similar differences (van de Venter 2010b). Life expectancy for men is lower at 77 years, than for women at 81 years. Disability free life expectancy is also lower for men at 61 years, than for women at 65 years. There are also further inequalities based on socio-economic status. Men from the most deprived areas of Bristol have a life expectancy of up to six years less than men from the least deprived areas of the city.

There are also other aspects of health where men in Bristol experience poorer outcomes:

- more men than women report having a limiting, long term illness and disability
- men are twice more likely to experience bronchitis and emphysema at 65 years and over than women are
- there are more cases of suicide and undetermined death amongst men when compared to women.

Male children in Bristol are not exempt from gender inequalities:

- a higher proportion of boys have physical impairments
- more boys than girls have mental health disorders, including Autism Spectrum Disorder
- more boys than girls have learning difficulties.

The men of Bristol are also more likely than women to have unhealthy lifestyle behaviours:

- fewer men than women eat five or more portions of fruit and vegetables a day
- more men than women are overweight and obese
- more men than women do not use dental services
- a majority of injecting drug users are men (70% men versus 30% women).



The lifestyle and health-related behaviours of men have a significant impact on their general health and wellbeing, particularly in relation to cardiovascular disease, cancer and suicide. This is discussed below within the context of several discreet yet overlapping themes, which all have a role to play in the major causes of death in men.

Specific lifestyle issues and behaviours that impact on men's general health and wellbeing

Obesity

Obesity and the associated levels of healthy eating and physical activity are important factors for health and wellbeing. Obesity is a major public health problem due to its association with serious chronic diseases such as type 2 diabetes, high blood pressure, and hyperlipidaemia (high levels of fats in the blood that can lead to narrowing and blockages of blood vessels), which are major risk factors for cardiovascular disease and cardiovascular related deaths. Obesity is also associated with cancer, disability, reduced quality of life, and can lead to premature death (NHS Information Centre 2010).

In England, obesity is on the increase. Between 1993 and 2008 there has been a decrease in the number of adults with a normal BMI (Body Mass Index). In 1993, 41% of men had a normal BMI; in 2008, the percentage of men with a normal BMI had fallen to 33%. Similar differences were found for women. However, among men, there was a marked increase in the proportion that was obese, from 3% in 1993 to 24% in 2008. This trend is likely to continue. By 2015, the Foresight report (2007) estimates that 36% of males and 28% of females (aged between 21 and 60) will be obese. By 2025 it is estimated that 47% of men and 36% of women will be obese.

In Bristol, 55.4% of men are overweight or obese, compared to 44.5% of women and there are also differences between affluent wards and deprived areas. For example, in Cabot, Clifton and Clifton East, 34.3% of respondents were overweight or obese, but this rises to 62.4% in Bishopsworth, Hartcliffe and Whitchurch Park (Bristol City Council Quality of Life Survey 2010).

Healthy eating and physical activity are closely associated with levels of obesity. The old adage of 'eat less, do more' is commonly cited as a means to overcome weight gain. Unfortunately, the evidence base around what people eat is not strong and what exists will, of course, be biased by participants' self reporting – people tend to avoid reporting negative or unhealthy behaviours.

There is some evidence that suggests there are two principal barriers to healthy eating in men: cynicism about government health messages and a rejection of healthy food on grounds of poor taste and inability to satisfy (Gough and Connor 2006). Fruit and vegetables may fall into this category. In terms of the '5 a day' message, men have been found to be less accepting of the message than women, reporting greater disbelief and a lack of motivation to increase intake (Herbert et al 2010). In 2008, 25% of men and 29% of women reported meeting the Government's '5 a day' guidelines by consuming five or more portions of fruit and vegetables a day (NHS Information Centre 2010). In Bristol, fewer men than women eat five or more portions of fruit and vegetables a day, although 53% of male respondents claimed they met this target (Bristol City Council Quality of Life Survey 2010). There are also differences between affluent wards and deprived areas. For example, in the more affluent areas of Henleaze, Stoke Bishop and Westbury on Trym, 63.7% reported having 5+ portions of fruit or veg per day,



compared to 29.2% in Horfield and Lockleaze (Bristol City Council Quality of Life Survey 2010).

In terms of physical exercise, there is a body of high quality evidence demonstrating that there are marked differences between men and women, as well as other areas of inequality. The Men's Health Forum has introduced a campaign to encourage more men to be physically active (MHF 2010c). As part of this they have reviewed the evidence and found that:

- physical inactivity is directly linked to a wide range of major health problems. These include obesity, cardiovascular disease, diabetes, and several cancers. The risk of developing coronary heart disease (CHD) from lack of physical activity is thought to be comparable to that of smoking
- regular activity has a marked effect on health. Adult men who are physically active have a 20-30% reduced risk of premature death and up to 50% reduced risk of developing major chronic diseases (Byberg et al 2009)
- physically active men are more likely to feel better about themselves and to be less at risk of developing depression
- too many men are inactive. Just 40% meet the Chief Medical Officer's recommendations for physical activity (30 minutes of at least moderate intensity activity on five or more days of the week, Department of Health 2009c). This is based on self reporting and the actual figure is likely to be much lower than this
- activity levels fall sharply with age. About 50% of men aged 16-34 say they meet the recommendations but the levels decline to 44% for 35-44 year olds, 32% for 55-64 year olds and 9% for men aged 75 or over (Department of Health 2009c)

- lower income men are less likely to be physically active. Men in the lowest 20% in terms of household income are much more likely to be inactive than men in the highest 20% (Department of Health 2009c)
- there are also significant ethnic differences: Indian, Pakistani, Bangladeshi and Chinese men are less likely than the general population to meet physical activity recommendations (Department of Health 2005c).

In Bristol, more men than women report exercising five times a week or more, although in total only 35% of men achieve this. There are also some differences between affluent wards and deprived areas. For example, in the deprived wards of Henbury and Southmead, only 26.3% of respondents report taking exercise at least five times per week, compared to 42.3% in the more affluent areas of Bishopston, Cotham, Redland and Cabot (Bristol City Council Quality of Life Survey 2010).

Key points

- Male obesity is on the increase.
- Most men do not reach current recommendations for physical activity.
- Older men and poorer men exercise less than others.

Vignette

J is 52 years old. He works in an office. He used to enjoy playing football, but these days he is a spectator only. J. knows he has put on a few pounds recently, but other than that he feels his weight is okay. In fact his BMI is 37, categorising him as obese. J's wife is encouraging him to loose weight but J says he hates the 'rabbit food' she gives him.



Smoking

Smoking is one of the most significant contributing factors to lower life expectancy, health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease. Reducing smoking is, therefore, a key improvement area within the overarching health and wellbeing of the population.

Nationally, the proportion of men who smoke has continued to decrease since 2008 - this is now at the lowest recorded level, with 21% of the male population smoking, compared to 20% of women who smoke. However, smoking prevalence is higher in deprived areas, with 26% of routine and manual workers smoking (Department of Health 2010a). There is also some evidence that the prevalence of smoking is higher among gay men than in the general population (McKiernan et al 2006).

Evidence has been found that demonstrates there are differences in rates of smoking amongst men from different ethnic groups. In 1999, a survey was undertaken into current cigarette smoking by ethnic group and sex (as part of the larger Health Survey of England into the health of minority ethnic groups). The findings demonstrate that Bangladeshi men were the most likely group in England to smoke cigarettes (44%), followed by White Irish (39%) and Black Caribbean men (35%). Men from each of these ethnic groups were more likely to smoke than men in the general population (27%). Similar proportions of Pakistani (26 per cent) and Indian (23%) men smoked as in the general population. Chinese men (17%) were the least likely to smoke (Stationary Office 2001).

Smoking is the biggest single cause of death and health inequality in Bristol – in some areas of the city, over 40% of the population are smokers. According to the Bristol Health Profile 2010, approximately

25% of the population of Bristol smoke. In men, the rates of smoking are as high as 45% in Filwood and Lawrence Hill and as low as 16% in Stoke Bishop, demonstrating a clear social class division. Early deaths attributable to smoking are significantly higher in Bristol compared to the rest of the South West, with nearly 600 per year in Bristol between 2006 and 2008 in the over 35 age group. Reducing the number of smokers in Bristol is a key factor in changing and improving the health of the population, both now and in the future, (NHS Bristol 2010).

NHS Bristol has had some success with supporting smoking cessation. In 2009/2010 approximately 2,800 men set a quit date, with almost 1,500 reporting that they had quit four weeks later. This compares favourably with female quitters – although more set a quit date, proportionally fewer actually quit. Some differences were noted in terms of social class with the largest group of successful quitters being in routine and manual occupations (Stanley 2010).

There is some evidence that supports gender-sensitive interventions in helping men to quit smoking (Bottorff et al 2008). In this qualitative study, interviews were held with 29 new fathers to identify different ways in which men approached reducing or quitting smoking. Common to all the storylines was the men's reluctance to rely on smoking cessation resources; instead, self reliance, willpower, and autonomy figured more prominently in their narratives. The findings from this study support developing gender-sensitive, tobacco-reduction interventions for fathers who smoke.



Key points

- Smoking in men is now at the lowest recorded national rate of 21%.
- Smoking rates are higher in areas of deprivation.
- Early deaths attributable to smoking are significantly higher in Bristol compared to the rest of the South West.

Vignette

P is retired. He lives in South Bristol and most of his family were employed in the tobacco industry. P started smoking when he was 13 years old. He has tried to quit a couple of times but at the moment he is smoking over 20 cigarettes a day. P is frequently breathless and coughs a lot which wakes him at night. He finds it much easier to sleep in a chair downstairs. His daughter wants him to go to the doctor's for a check up but P thinks he will just tell him to stop smoking, so is avoiding going.

Alcohol

The impact of excess alcohol on health is varied. A Government report into alcohol has summarised the key evidence (Health Committee 2009). Many forms of cancer are more prevalent in heavy drinkers, as are liver disease and high blood pressure. Alcohol use is also strongly associated with acquiring a sexually transmitted infection. Young drinkers in particular are at high risk of accidents and injuries. In terms of men's health, 'problem' drinking is heavily associated with mental illness (from anxiety and depression through to schizophrenia) and personality difficulties, with each driving the other. Heavy drinkers are more than twice as likely to commit suicide as non drinkers. Between 16% and 45% of suicides are thought to be linked to alcohol and 50% of those 'presenting with self harm' are regular, excessive drinkers. There is also the

impact alcohol misuse can have on the health of others, including domestic violence, sexual assault, rape and accidents as a result of drunk driving.

More men exceed sensible drinking guidelines when compared to women (28% of men against 20% of women). Men are also more likely to binge drink than women (21% compared to 14%). Hospital admissions attributable to alcohol have risen in the last decade for both men and women, yet during the same period male deaths attributed to alcohol have risen but have fallen for women (NWPFO 2010a).

In Bristol, the rates of hospital admissions in relation to alcohol are significantly higher for both men and women than the national average, but more men are dying from their alcohol-related condition than women. Alcohol related deaths in Bristolian men are also far greater than the national average for England, yet deaths for women are very similar to national data (NWPFO 2010b).

Key points

- Alcohol-related deaths in men are significantly higher in Bristol than the national average.
- Almost half of all suicides in England are linked to alcohol.
- 'Problem' drinking is heavily associated with mental illness.

Vignette

D drinks every day. He calls into the pub on his way home from work and has a few pints. D separated from his wife two years ago and he is prevented by the courts from having contact with her or their children. As he lives on his own, D feels there is no need for him to rush home. He feels that going to the pub gives him a chance to wind down and catch up with his mates. Usually when he gets home he can't be bothered to cook and his BMI is now 19.



Substance misuse

Men who are misusing substances face many potential health risks. These include mental health and behavioural problems, bloodborne infections such as viral hepatitis and HIV and poisoning or overdose which can lead to death. As well as health risks, drugs can become addictive and lead to long term damage to the body. In addition, there can be a negative impact on family and personal relationships, finances and career. Those who misuse substances may also turn to crime as a means to fund their addiction. It is well known that more men than women misuse drugs, but it is very hard to establish discreet gender differences from the available national data.

The latest Government report (NHS Information Centre 2009a) demonstrates that in 2008/2009:

- 10.1% of adults had used one or more illicit drug within the last year, compared with 9.6% in 2007/08; however, over the longer term, this shows an overall decrease from 11.1% in 1996
- cannabis is the type of drug most likely to be used by adults; 7.9% of 16-59 year olds used cannabis in the last year
- class A drugs, such as heroin, were used within the previous year by 3.7% of adults, compared with 3.0% in 2007/08; over the longer term, this shows an increase from 2.7% in 1996
- a larger number of men accessed treatment services than women (151,064 or 72.7% men, compared to 56,516 or 27.3% of women aged 18 or over)
- there were 5,668 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder; this number is 15.1% less than in 2007/08 when there were 6,675 admissions
- more than twice as many men were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than women (3,997 or 70.5% and 1,671 or 29.5% respectively)
- the total number of deaths related to drug misuse in England and Wales was 1,738 in 2008; 78% of those who died were men
- the most common underlying cause of death (for those related to drug misuse) was from accidental poisoning for both men and women (597 or 78.2% and 166 or 21.8% respectively).

In 2007, the estimated, total number of problem drug users in Bristol was 8,000, approximately 3% of the population (NHS Bristol and Bristol City Council 2007). A joint exercise to measure prevalence of substance misuse was carried out by Bristol Primary Care Trust (PCT), Department of Social Medicine at Bristol University, Health Protection Agency (HPA), South West Public Health Observatory (SWPHO), and the Bristol Drugs Project (BDP). The findings were reported by the director of Public Health in his annual report (NHS Bristol and Bristol City Council 2007).

Population surveys into substance misuse tend to underestimate the number of injecting drug users because of multiple response biases. This study used indirect estimation methods, which collated, matched, and analysed data from multiple local information sources, in order to estimate the number and prevalence of injecting drug users. The estimates indicate that:

- the prevalence of injecting drug users in Bristol lay between 1.3% and 2.2% (i.e. from 1 in 78 to over 1 in 50 adults aged 15 - 54 years living in Bristol)
- the prevalence among men was over 2% and 0.6% to 0.9% among women



- the highest number and prevalence of injecting drug users was among men aged 25 to 54 years
- there were proportionately more women among injecting drug users under 25 years than those aged 25 years or over
- for those injecting drug users under 25 years, there were twice as many men as women; for those over 25 years, there were four times as many
- a higher proportion of women than men injecting drug users may have been in contact with the local data sources used in this study.

Further Bristol data is available which demonstrates that, in 2009/2010, the gender profile of Bristol residents in treatment for drug misuse was 70.7% men and 29.3% women. However, some concerns exist that services are not engaging with as many women as they could, perhaps due to there being more stigma around women with addiction problems, especially if they are mothers (Bristol Drugs Action Team 2010).

Key points

- Cannabis is the type of drug most likely to be used by adults.
- Nearly three times as many men as women access treatment services for substance misuse.
- Almost 80% of people whose death was related to substance misuse were men.

Vignette

T is 34. He has misused various substances for nearly 20 years. For the last ten years he has been injecting heroin. He is able to finance this through his highly paid job. However, it is becoming more and more difficult to maintain his employment in combination with his addiction. T feels unable to enter a treatment programme

because of the stigma associated with his addiction, and the fact that he will probably lose his job.

Sexual health and relationships

The issues around sexual health are complex, not least because sexual health is dependent on sexual activity and this varies considerably amongst different social groups. Measuring sexual identity is tricky, particularly as most estimates are self-reported measures. A recent survey of the UK found that 94.8% of the population identified themselves as being heterosexual or straight, with 1% gay or lesbian, 1% as bisexual or 'other' and 3.3% as 'don't know' or refusing to answer (ONS 2010b). In terms of men's sexual health, this survey is unhelpful as it classes gay men and lesbian women as one group – although their sexual health needs will be different. The Count Me In survey, undertaken by Bristol Community Health, demonstrates a similar profile amongst its service users, although it separates gay men and lesbian women. This survey found the following profile of its respondents - heterosexual/straight (89%), Bisexual (2%), gay men (1%), lesbian women (1%) other (1%) and preferring not to say (6%) (Dumper 2010).

Sexual health is perhaps an area where inequalities in health are difficult to assess, with misconceptions and misunderstanding of the issue and how it impacts on different social groups. For example, it has been well documented that HIV and AIDS are conditions that affect gay men. Indeed men who have sex with men and Black African heterosexuals remain the groups with the highest HIV prevalence within the UK (HPA 2009). However, in recent years, the numbers of heterosexual men acquiring this infection has risen. Recent data shows that the over 50's are at particular risk, and that the proportion who are diagnosed and access HIV care has increased over the past



decade, from one in ten in 1999 to one in six in 2008 (HPA 2009). Age is also a factor in sexual health. At the other end of the spectrum young men, aged 16 - 24 in particular, are at risk of sexually transmitted infections in general (Department of Health 2010b).

The Equality Impact Assessment for the National Sexual Health Policy is a useful document, summarising the evidence base in this area (Department of Health 2010c). It describes how decisions and practices about sex and sexual health are often influenced by individual religious or philosophical beliefs, which may lead to inequalities in relation to health opportunities and choices. A further example given is the inequality in health related to disabled people. Disabled men – like the rest of the population – can choose to have sexual relationships and can have a bisexual, gay or heterosexual identity. Over 85% of disabled people are known to be sexually active (Disability Now 2005). However, data on the sexual health of disabled people is practically non-existent. Disability is not currently included in any of the national datasets on sexual health, as the Information Standards Board (ISB) has not yet agreed a definition of disability.

The Equality Impact Assessment (Department of Health 2010c) is of limited use in relation to ethnicity. It predominantly focuses on the issue of high levels of HIV infection amongst Black Africans, and claims that other issues related to ethnicity are the responsibility of local PCTs. This approach fails to address the issues for men from other ethnic backgrounds.

In the past, men's sexual health has been deemed an important factor in promoting women's sexual health. However, the importance of promoting men's sexual health for their own benefit is now being recognised. An example of this is the

National Chlamydia Screening Programme (Department of Health 2005b). This was introduced in 2006, and primarily aimed at young women, mainly for cost effectiveness reasons. It was only after concerns were raised by men's health organisations and others that the strategy was revised. The Men's Health Forum commented that:

'It may be easier to screen women, but health services have a duty to screen both – not least because chlamydia infection has long-term health risks for men too and because those symptoms that do manifest themselves in men are painful. It is very important that both sexes feel that they have an equal sense of responsibility to the wider community to prevent chlamydia from spreading.' (MHF 2006).

Sexual health is not limited to the avoidance of infection. Other factors are important including sexual abuse, erectile dysfunction and prostate cancer.

Sexual abuse can play an important part in men's health and wellbeing. The British Crime Survey (Home Office 2010) found that 2.8% of men have experienced sexual abuse since the age of 16, with 0.4% experiencing the abuse in the past year. Whilst these figures are small compared to female survivors of sexual abuse (19.5%) the impact of the abuse on the men who experienced it is likely to be profound both in terms of their physical and emotional wellbeing.

Erectile dysfunction can be a serious problem for men, impacting on their emotional wellbeing and their physical health. Recent reviews of the evidence have found strong association between erectile dysfunction and co-morbid conditions such as hypertension, diabetes mellitus and obesity (Nehra 2009, Tamler 2009). There is also some evidence from a systematic review that erectile dysfunction is associated with future cardiovascular events, providing a unique



interventional opportunity to address underlying cardiovascular health concerns in men presenting with erectile dysfunction (Nehra 2009). Prostate cancer may also be linked to erectile dysfunction, although there is some evidence that the type of treatment can impact on post operative function (Briganti et al 2009).

Prostate cancer is one of the most common forms of cancer affecting men, with 10,000 deaths per year. Although occurring mainly in older men, up to 20% of cases occur in men aged less than 65 years (NICE 2008). There is also strong evidence to show that Black African or Caribbean men (regardless of their country of origin) are three times more likely to experience prostate cancer than men from other ethnic groups (Ben – Shlomo et al 2007). The incidence is also higher in higher socio-economic groups, although this may be attributed to higher rates of prostate specific antigen (PSA) testing amongst more affluent men (NICE 2008). At present there is no universal screening for prostate cancer in England, due to the lack of evidence. A systematic review and meta analysis found there to be no value to support the use of screening for prostate cancer with PSA, with or without digital rectal examination (Djulbegovic et al 2010).

The need to examine the sexual health needs of transgender people has also been identified. While it is estimated that the number of transgender people in the UK is relatively low, this is a group that may have particular sexual health needs and they can face discrimination. Mental health problems and addiction are also more common in transgender people than the general population. This is thought to be a consequence of the combined effect of the discrimination and internalised negative feelings (Jones 2007).

It is likely that the main problem facing transgender people is the lack of understanding of gender identity, and

transgender health issues amongst healthcare professionals. Lack of respect from health professionals towards trans people is a major theme within the qualitative literature (Allmark, Salway and Percy 2010). This is an area of great need in terms of an evidence base, particularly as men within this group may face high levels of health inequalities.

In Bristol, higher rates of sexually transmitted infections, HIV and AIDS are found amongst Black Africans. Although only 0.8% of the Bristol population is from Black African groups, they constitute 25 per cent of those diagnosed with HIV. Similar findings have been found nationally (Jones 2007).

Some data from Bristol has been found related to the use of community sexual health services. In 2007/08, just 6% of attendees were men. By 2009/10, this had risen to 8% and is fairly consistent across all ethnic groups. The proportion of male attendees is slightly higher at young person's clinics, at 11% in 2009/10, than at adult clinics. However, even when the services involved are single sex clinics, it is mainly women who attend. For example only 15% of patients attending community sexual health clinics for sexually transmitted infection testing were men, and 23% of those attending for sexually transmitted infection treatment in 2009/10 were men (Harris, D 2010). It has been suggested that this may be because of the way that services are organised. Women may find local (single sex) sexual health clinics a more appropriate location to attend than other options (e.g. the Genito-Urinary Medical clinic at the BRI for both sexes, which men may find more convenient); or it may be that women prefer to use local clinics that also provide other services, such as contraceptive advice.

It has not been possible to find more comprehensive evidence of the sexual health of men in Bristol. This is an area



that requires more detailed data collection and analysis.

Key points

- Young men aged 16-24 years are most at risk of sexually transmitted infections.
- Men aged 50 years and over are at risk of HIV infection, with 1 in 6 newly diagnosed people in 2008 falling into this group.
- Sexual abuse plays an important role in men's health and wellbeing, both physical and mental.
- Erectile dysfunction is associated with future cardiovascular events, providing a unique interventional opportunity to address underlying cardiovascular health concerns in men presenting with erectile dysfunction.

Vignette

K is 55 years old and recently divorced. He was married for 37 years and his ex wife was his only sexual partner. He is now enjoying being single, has had several sexual relationships in the past 3 months. K is not using any contraception as he had a vasectomy 20 years ago.

Work

It is well known that socio-economic status is a determinant of health, with those in poorer circumstances generally less healthy than those in affluent circumstances. In terms of poverty, employment status can be a determining factor, although not all people in work escape living in poverty.

There are marked gender differences in relation to men's and women's employment status and working patterns. National statistics (ONS 2010b) demonstrate that the workforce in the South West region is made up of more men than women (53% of men compared

to 47% of women). Men are more likely to work full time than women (13.9% of working men work part time compared to 48.7% of women. Men are also more likely to be self employed than women (19.4% of men compared to 10.2% of women). Age is also a factor in employment status. Currently 12.8% of the workforce are men aged 65 years or over, compared to 6.9% that are women aged 65 years or over.

In terms of health, of the men who are not employed within the South West region, 32% are unable to work due to long term illness, compared to 16% of women who are not working. Caring for children or other relatives are also cited as reasons for not working, although women are six times more likely to not work due to family responsibilities than men.

In Bristol, data has been found that identifies the percentages of unemployed male claimants of Job Seekers Allowance by ward – the amount of unemployed claimants as a proportion of working age residents. The national figure for England and Wales is 6.8% and in Bristol it is 6.4%. However, 10 wards in Bristol have much higher levels than the Bristol level, including Lawrence Hill (11.5%), Ashley (9.9%), Filwood (9.6%) and Easton (8.5%). By contrast, some wards have much lower levels, including Henleaze (1.6%) and Stoke Bishop (1.1%) (ONS 2010c).

Work also plays another significant role in terms of health. The nature of the occupation may be hazardous and increase the risk of ill health, injury or death. ONS (2009a) provides data about the nature and gender differences in occupationally related deaths. Occupations with a higher rate of mortality are distinctively male-dominated occupations, such as construction workers, mining and quarry work and engineering. Men are also more likely to die from a work-related injury than women. Typical causes include



vehicle accidents, injury by machinery and falls from buildings. Alcohol-related deaths are more common in male caterers, cooks and kitchen porters, as well as publicans and bar staff of both genders. Bristol also has a legacy of tobacco workers whose exposure to cigarette smoking was high. The highest tobacco-related death rates are in wards where employment in the tobacco industry was common (Smoke free Bristol Alliance 2009).

Key points

- Workers in poorer circumstances are generally less healthy than those in affluent circumstances.
- Men are more likely to work full time and be self employed than women.
- Occupations with a higher rate of mortality are distinctively male-dominated occupations, such as construction workers, mining and quarry work and engineering.

Vignette

W is self employed. He works long hours to support his family. His wife doesn't work as they have four young children, one of whom is disabled and needs constant care. When W is not working he helps out with looking after the children and the family home. Recently he has developed a skin condition that is very irritating. He visited the pharmacy and got some cream which helped for a while, but now his skin is sore, cracked and bleeds easily. W thinks it might be caused by some of the chemicals he works with, but feels that he can't afford to take time off work to get it checked out by his GP.

Fatherhood

The evidence about the impact of being a father on men's health is practically non-existent. Almost all the work in this area focuses on the impact of men's health on the health of their babies and children, for example men's depression in the first few weeks of their baby's life is known to lead to disturbances in their children's social, behavioural, cognitive and physical development (Ramchandani et al 2005). However, there is one Danish study that looks at this issue from men's perspectives. This found that up to 7% of new fathers will experience 'male depressive syndrome', demonstrated by emotional rigidity, exaggerated self criticism, alcohol and drug abuse and withdrawal from relationships, amongst other factors (Masden and Juhl 2007). Clearly, much more work needs to be conducted in this area.

Despite the lack of evidence about the impact on health, being a father is an important part of men's identities. The evidence below demonstrates that almost all fathers are involved with the birth of their children and are not absent, as commonly portrayed in the media.

Nationally, the average age for becoming a father in 2008 was 32.4 years, with a majority being between 25 and 39 years. However, a minority of men under the age of 20 and over the age of 50 also became fathers. Overall, 84% of babies were born to parents living together, whether married or unmarried. Of the remainder, a further 9% of births in 2008 were registered jointly by parents living at separate addresses, while only 6% were registered by the mother alone (ONS 2009b).

Out of every 100 babies born in 2008, 34% were registered as having a father in a management or professional occupation and 18% had a father in an intermediate occupation. A further 35% had a father in a routine or manual occupation. Of the remainder, 6% had a father whose



occupation was 'unclassified' and 6% were sole registered by their mothers (and therefore no socio-economic information is available for the father). The number of births registered to fathers in management or professional occupations has increased by 16% between 2001 and 2008, while the number registered to fathers with routine or manual occupations rose by 14%. The largest relative increase in births among the three main socio-economic groups was in births to fathers with intermediate occupations, where numbers increased by 31% (ONS 2009b).

Changes in the number of births to fathers in each group may reflect changes in fertility rates in each group and also changes in the number of men in each socio-economic classification. Further research is needed to improve understanding of the importance of these two factors.

No statistical data is currently available to provide a profile of fathers in Bristol, although this could be collated through the maternity services at University Hospitals Bristol NHS Trust and North Bristol NHS Trust.

Key points

- Despite the lack of evidence about the impact on health, being a father is an important part of men's identities.
- Nationally, the average age for becoming a father in 2008 was 32.4 years, with a majority being between 25 and 39 years.
- Overall, in 2008, 84% of babies were born to parents living together, whether married or unmarried.

Vignette

G is an academic at the local university. His partner is an NHS manager. They met at university when they came to this country to study, and their families live abroad.

After five years of fertility treatment, their first child was born three months ago.

Their little boy is happy and healthy, but recently G has felt very tired, irritable and easily angered. He and his partner having been rowing quite a lot so G is avoiding going home after work, calling at a friend's house and having a couple of drinks. He knows something is wrong, but he is not sure why he feels this way, and doesn't know what to do to feel better.

Men in Prison

Men in prison have high health and social needs, leading to greater inequality in health when compared with the general population. The health and wellbeing of men in prison is generally poor, although many use their sentence as an opportunity to address their health issues. Research demonstrates that prisoners are more likely to use the health services available in prison than those available outside prison (Condon et al 2007). A systematic overview of the literature into the health needs of prisoners shows that they are more likely to have suffered some form of social exclusion compared to the rest of society and there are significantly greater degrees of mental health problems, substance abuse and worse physical health in prisoners than in the general population. Young offenders, older prisoners and those from minority ethnic groups have distinct health needs compared to the prison population taken as a whole, which has implications for the delivery of prison health care, and how these needs are met effectively and appropriately (Harris, Hek and Condon 2007).



A key issue for the health of men in prison is the risk of communicable diseases. Living in close proximity to each other can increase the risk of experiencing an airborne infectious disease, such as seasonal influenza but other factors are at play. For example it may be more difficult for men to access condoms and dental dams to prevent the spread of sexually transmitted diseases. Despite being illegal, the misuse of drugs also occurs in prison and the risk of bloodborne infections may be increased by the lack of access to clean needles and syringes.

The primary health issue for men in prison is their mental health and wellbeing. Some men experience poor mental health which leads them into behaviours that result in a prison sentence. A report from the Prison Reform Trust (2009) reveals that many people who should have been diverted into mental health or social care from police stations or courts are entering prisons which are ill equipped to meet their needs; and then being discharged back into the community without any support. For other men, their mental health is affected by their imprisonment. The suicide rate among male prisoners is thought to be six times higher than among men in the general population. In 2009 there were 57 deaths from suicide amongst male prisoners. However, the most reliable guide to trends is the three-year average annual rate. This currently stands at 86 deaths per 100,000 prisoners and has decreased year-on-year since 2004 when it was 130 deaths per 100,000 prisoners (Ministry of Justice 2010).

HMP Bristol has a capacity of 614, comprising of adult male prisoners and a small number of male young offenders, placed there by local courts. It is also the West of England centre for category B prisoners (those who do not require maximum security, but for whom escape needs to be made very difficult). A

healthcare facility is available at the prison, with full primary care services provided. Prisoners are also able to access local, acute services as required.

In HMP Bristol, there is a higher proportion of younger men (18-39yrs) and a smaller proportion of older men (>40yrs) compared to the general population of Bristol. Of those with a recorded smoking status, 78% of prisoners within the four month period from November to February 2009/10 were recorded as smokers. The estimated smoking prevalence in Bristol is 24.8%, significantly lower than that of the prison population.

542 prisoners had a diagnosis related to drug use recorded at any time during their prison stay (some of which had multiple records/poly drug use). This equates to an overall prevalence of any type of drug use of 31.5%. The most prevalent form of drug use among prisoners at HMP Bristol is heroin/opiate use. Estimates suggest there would be around 100 prisoners at any one time with a record of heroin/opiate use and around 190 prisoners with a record of any type of drug use (or a history of any type of drug use) (van de Venter 2010b).

Key points

- The health and wellbeing of men in prison is generally poor, although many use their sentence as an opportunity to address their health issues.
- Young offenders, older prisoners and those from minority ethnic groups have distinct health needs compared to the prison population taken as a whole.
- The suicide rate among male prisoners is thought to be six times higher than among men in the general population.



Vignette

S came into prison 2 weeks ago. He is on remand, awaiting trial for a serious crime, which he admits committing. His solicitor has said he is probably going to be in prison for a very long time. Prison is much worse than he anticipated and the constant noise means he is unable to sleep. The other prisoners are giving him a hard time because of the charges against him. His family have disowned him and said that they never want to see him again. S feels very despondent. One of the other prisoners – a listener – has approached him to see if he wants to talk about his problems, but S has no intention of telling him anything, fearing it will be spread all over the prison. As soon as he can find the means, S intends to kill himself.

Men's mental health and wellbeing

As well as the above issues, there are some specific health conditions where men experience greater morbidity and mortality than women, which may be attributed to the differences in their lifestyles and health behaviours. Mental health is one such condition with massive gender differences. Mental health and illness, therefore, require special attention.

The social and financial costs of mental health problems are immense. The burden on individuals, families, communities and society as a whole includes the psychological distress, the impact on physical health, the social consequences of mental health problems and the financial and economic costs. Recent estimates put the full cost at around £77 billion, mostly due to lost productivity (Department of Health 2009d).

The gender differences between men and women's mental health and wellbeing are marked, particularly in relation to suicide. The likelihood of a person committing

suicide depends on several factors. These include physically disabling or painful illnesses and mental illness; alcohol and drug misuse; and level of support. Stressful life events, such as the loss of a job, imprisonment, a death or divorce can also play a part. For many people, it is the combination of factors which is important, rather than any single factor (Department of Health 2007b). The evidence base suggests that many of these factors are more commonly experienced by men than women.

On average, men are three times more likely to end their own lives than women, with the peak relative difference occurring between ages 30 – 39 when men are four times more likely to end their own lives. However, another key factor relates to the means people use to end their life. For example, men are more likely to choose violent means such as jumping or hanging. On the other hand, women are more likely to choose non-violent forms such as self poisoning; this means their chance of discovery and rescue is much higher than those who use violent methods (Wilkins 2010). There is also a steep socio-economic gradient in male suicide, with men from the most deprived population groups more than twice as likely to take their own lives as men in the least deprived areas (Kennedy et al 2007).

The types of mental illness people experience also demonstrate gender differences. Women are more likely to experience higher levels of internalising disorders, such as depression and anxiety, compared to men; who have higher levels of externalising disorders such as substance misuse and anti-social disorders (Conrad and White 2010). This is confirmed by Wilkins (2010) who found that suicide, substance misuse, anti-social behaviour, "disappearing" from home, homelessness and a variety of behavioural problems, including personality disorders, are all markedly more common in males.



The healthcare system also plays a part in the gender inequalities experienced by men in relation to their mental wellbeing. Wilkins (2010) highlights the paradox that men are three times more likely than women to take their own lives but only half as likely to be diagnosed with depression.

Branney and White (2010) suggest that there are three main issues in men's mental health. These are:

- conceptions of mental health marginalise the difficulties that men have with emotional and mental wellbeing
- referral and diagnostic procedures exclude many of men's mental health difficulties
- mental health services fail to reach many of the groups where there may be men with mental health difficulties.

The experience of mental health care within minority groups of men demonstrates some stark inequalities, particularly in relation to ethnicity.

'There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community.'
(NIMHE 2003)

Wilkins (2010) has produced a review of the evidence entitled 'Untold problems: a review of the essential issues in the mental health of men and boys', which has been used to inform this next section. This work highlights the inequalities in the experiences of men from Black African or Caribbean ethnic groups. This shows that Black men are up to 33% more likely to be compulsorily detained and treated under the Mental Health Act and up to 70% more likely to have been among those referred to mental health services via the criminal justice system than another referral route. Black men are also more

likely to be among those mental health services' inpatients who have been placed in seclusion at some point during the preceding year. Wilkins (2010) also describes the experience of Black men who are UK born, highlighting the fact that they are more likely to be given a diagnosis of schizophrenia than the general population. Men living in the Caribbean do not share this level of diagnosis, which therefore leads to the suggestion that there may be some specific aspect of the Black British male experience that contributes either to higher incidence or inappropriate diagnosis, or both. There is also some evidence that the incidence of schizophrenia in all BME communities increases in direct proportion to the imbalance between White and non-White residents, e.g. the smaller the local BME community, the higher the incidence of schizophrenia in that community (Wilkins 2010).

Two other groups of men that experience inequalities in mental health have also been identified by Wilkins (2010): gay men and ex-servicemen. Gay men are at increased risk of experiencing poorer mental health than the general population. This may be attributed to a range of factors, including the greater challenges faced by gay men in adolescence such as 'coming out', as well as the homophobic nature of society in general. For ex-servicemen, the issues relate predominantly to post traumatic stress disorder (PTSD) which is more common amongst those with front line experiences, the majority of whom are men. During the past three years, there has been an increased referral rate of 53% for PTSD, including 1,160 new cases during 2008 and over 2500 men admitted for treatment during 2008. Further exploration of these topics is recommended particularly in relation to numbers of ex-servicemen living in Bristol.



It has not been possible to identify data that demonstrates the prevalence of mental illness, stratified by gender, in Bristol. However, one data source, the Adult Psychiatric Morbidity Survey (NHS Information Centre 2009b), was identified and forms the basis of the next section. This may provide an insight into prevalence in general, although this cannot assume to be extrapolated to the Bristol population.

The aim of the Adult Psychiatric Morbidity Survey (APMS) is to estimate the prevalence of mental health disorders among the adult population of England (adults aged 16 and over and living in private households). Assessments of common mental health disorders (including depression, anxiety and phobias), psychosis, borderline and anti-social disorder, Aspergers syndrome, substance misuse and dependency, and suicidal thoughts, attempts and self harm were made by trained interviewers. Screening tools were also used to check for the presence of characteristics of eating disorders, attention deficit hyperactivity disorder, and post traumatic stress disorder.

The APMS has also been carried out in 1993 and 2000; however, the 2007 survey was the first to include people aged over 75 and screening for eating disorders, attention deficit hyperactivity disorder, post traumatic stress disorder and gambling behaviours. There are some limitations to the 2007 survey. For example, it only included those living in private households and, therefore, may underestimate some conditions (e.g. substance misuse/dependence as this is thought to be more likely in those who are homeless or living in social housing). Also, the methodology of using screening for characteristics (e.g. eating disorders, post traumatic stress disorder, and attention deficit hyperactivity disorder) considers the likelihood of having the

disorder, rather than an actual diagnosis or the desire or need for treatment.

The findings demonstrate that, overall, women show higher rates of common mental health disorders than men; however, there are a few groups among certain conditions that buck this trend:

- men aged 16-24yrs and 65-74yrs have higher predicted rates of panic disorder than women of the same age (men = 1.4% and women = 0.8% in 16-24 age group, men = 1.0% and women = 0.1% in 64-75 age group)
- depression episodes are more common among men aged 25-34 than women of the same age range (2.7% and 1.7% respectively)
- obsessive compulsive disorder was found to be slightly more prevalent in men aged 35-44 than women of the same age group (1.2% and 1.0% respectively) and equally prevalent among men and women aged 25-34 (1.5%)
- women are most likely to suffer from mixed anxiety and depression, generalised anxiety disorder or depressive episodes at ages 16-24, 25-34 and 45-54yrs. Men are most likely to suffer from the common mental health disorders between ages 25 to 54 years
- mixed anxiety and depression was found to be more common among 'Chinese and Other' men than women (14.4% and 11.9% respectively). Depressive episodes are more common in Black men than women (5.6% and 1.1% respectively)
- symptoms of obsessive compulsive disorder are more common in Black men than women (4.6% and 1% respectively), as well as in men compared to women from 'Chinese and Other' ethnic groups (2.8 and 1.3% respectively).



In terms of severe and enduring mental disorders, this survey found 0.4% of people (0.3% of men and 0.5% of women) have had signs of a psychotic disorder in the past year (prior to interview). Although the proportion is relatively small, the service and societal costs are high and the impacts on lives affected by psychosis (the individual and family members) are significant.

As with other mental illnesses, the prevalence of psychosis tends to decrease with age, although organic psychoses such as Alzheimer's disease were not included in this survey. Probable psychosis rates are slightly higher in men aged 16-34yrs than women in the same age group (0.4% and 0.3% respectively) and overall rates of probable psychosis are highest for both sexes in the 35-44 age group.

The sample size for psychosis, when split by ethnic group, was small in this survey so the data should be handled with caution. However, the prevalence of psychotic disorder among Black men was found to be significantly higher than other groups.

Key points

- On average, men are three times more likely to end their own lives than women, with the peak relative difference occurring between ages 30 and 39 when men are four times more likely to end their own lives.
- Concepts of mental health marginalise the difficulties that men have with emotional and mental wellbeing.
- Mental health services fail to reach many of the groups where there may be men with mental health difficulties.
- It is recommended that readers who are particularly interested in this issue should read 'Untold problems: a review of the essential issues in the mental health of men and boys' by Wilkins (2010).

Vignette

V has a history of mental illness. Since he was a child he has felt 'different' from others and finds it difficult to fit in. His partner K has just ended their six month relationship. V had high hopes of this relationship and is devastated that K has left him. He is feeling very vulnerable and hasn't been out for over two weeks now. He is neglecting himself, which is unusual as he is normally very fastidious about personal care.

K is relieved that his relationship with V is over. He found it difficult to cope with his fussiness, anxiety and constant checking. K feels that there is something wrong with V but he is not sure exactly what it is. He has heard that a famous footballer has an obsessive compulsive disorder and wonders if this might be V's problem. However, he is just glad that V is no longer his responsibility.



5. Some challenges in promoting men's health

Summary

Every culture or society will have its own, predetermined expectations of what it means to be a man and, consequently, how men should behave. Within most Western cultures the 'hegemonic', or dominant, concept of masculinity is associated with whiteness, heterosexuality, marriage, authority and physical toughness. Combined with inequalities in health, this can cause considerable difficulties for disadvantaged men. This section discusses how concepts of masculinity and psychological aspects of health behaviours can create challenges for health professionals in promoting men's health and wellbeing; as well as for men who try to adopt healthy lifestyles.

Masculinity, Identity and Gender

Masculinities, identities and gender are important concepts in relation to men's health. Gender is the term given to the social construction of roles allocated to men and women. In men, these are commonly known as masculinities and men may identify with a particular, socially constructed role. These roles will vary geographically and change over time (O'Brien and White 2003). Every culture or society will have its own, predetermined expectations of what it means to be a man and, consequently, how men should behave. Men may prefer to invest considerable time and energy in trying to fit this ideology, rather than accept the alternative of being perceived as socially inadequate. Others will not want, or be able to, fit and will be at risk of discrimination simply because they do not conform to the dominant ideology.

Connell (2000) theorised that masculinity is determined by the dominant, or

hegemonic, concept of the socially constructed identity of maleness. Within most Western cultures, the dominant concept of masculinity is associated with whiteness, heterosexuality, marriage, authority and physical toughness (Giddens 2009). There is an expectation that women will be passive and caring but men will be powerful and use that power: physically, economically and politically. Men who do not fit with this concept are vulnerable to inequalities, not only in health, but in all aspects of life.

Despite social pressures on men to conform to the masculinities defined by their culture, there is some evidence that men may reject this view, perceiving other factors to be more important. Sand's research (2008) found that men's perceptions of masculinity differed substantially from stereotypes in the literature. Men reported that being seen as honourable, self-reliant and respected by friends were important determinants of self-perceived masculinity. In contrast, factors stereotypically associated with masculinity, such as being physically attractive, sexually active, and successful with women, were deemed to be less important to men's sense of masculinity. These findings appeared consistently across all nationalities and all age groups studied. It is important to note that, whilst this study was primarily investigating erectile dysfunction, the ratings of constructs of masculinity did not meaningfully differ in men with or without erectile dysfunction; or with respect to men with erectile dysfunction who did or did not seek treatment for their sexual dysfunction.

It has also been suggested that, since masculinity is a dynamic and contextual construct, it can be better understood as one of a number of cultural reference points around which each man organises



and adopts behaviour (Wall and Kristjanson 2005). This means that the cultural influences that are important to each man will affect his views of masculinity and his associated behaviours.

Different concepts of masculinity and male identities can be examined in more detail using the equality strands of age, ethnicity, sexual orientation, religion, belief and disability.

Age

During adolescence, young men will be seeking their male identity and working out what it means to them to be a man. This can be fraught with difficulties, particularly if they do not fit the dominant definition of masculinity within their culture. There is evidence to suggest that alignment with hegemonic masculinity may hinder adolescent boys' psychological health; for instance, by limiting the ways that they are able to express themselves and engage in their interpersonal relationships (Chu et al 2005).

Research by El-Hinnawy (2008) seems to suggest that young men's beliefs about masculinity appear to be fluid, context dependent, and collectively produced. Despite this, the young men in this study conformed to the dominant construct of masculinity, perceiving that being a real man can be defined as a 'father who works to provide financially for his children'. Although there have been societal changes, certain parenting roles continue to be seen as predominantly the responsibility of the father: these are financial provider, protector and disciplinarian (Hauari and Hollingworth 2009).

With increasing age, men may have to face a decrease in their physical strength. There is evidence to suggest that older men will succeed in incorporating actions into their daily lives in a way that does not conflict with their perceived resilience to frailty and weakness. This may even include

actions that involve seeking help for illness or adopting healthier lifestyle behaviours (Tannebaum and Frank 2010).

Ethnicity

Different ethnic cultures will have their own social constructions of masculinity, which are unique to that particular culture. Tensions arise when men who identify themselves with a particular ethnic group find that their group's concepts of masculinity do not fit with the dominant construction of masculinity in the society in which they live.

For example, dominant constructs of Caribbean masculinity are thought to be related to crime, sexual prowess (demonstrated by multiple female partners) and low educational achievement (Geofroy 2007). These constructs do not fit well with the Western concepts of masculinity identified by Giddens (2009) – see above. However, not all will see the negative side of this perspective on masculinity. African Caribbean, working class boys have been found to be perceived as exhibiting a 'cool' masculinity, based around style and fashion, which is different from, but often imitated by, White, working class boys (Frosh et al 2002). Whilst African Caribbean boys can be perceived as 'cool' by their male and female peers, across cultures, teachers and others often perceive these attributes (real or imagined) as threatening. This may also militate against individual academic effort and achievement (Harris, DLG 2010). Clearly, there is a tension between the accepted or dominant constructs of masculinity and the constructs of masculinity within particular ethnic groups.

Sexual orientation

The construction of masculinity embraces heterosexuality as the ideal. This means that those who do not fit with this may experience discrimination. The lives of gay



men are structured by their experiences within a dominant, heterosexual culture and, in particular, by homophobia. There is strong consensus in the research literature that adolescent and adult men who report same-sex sexual orientations, identities, and behaviours are at higher risk of suicide. This may be linked to the nature of the men's adolescent years being defined by a heightened awareness of the development of their gender role. Gender role development is closely tied to dominant cultural ideals of masculinity and heterosexuality and may explain why increased suicide risk is found in men with adolescent, same-sex sexual orientations (Russell and Toomey 2010).

Religion and faith

Religion and belief play strong roles in constructing masculine identity and are usually connected to the home: the influence of religion depends on its relative importance in the family. The religious institution (church, mosque, synagogue etc.) may also be an influential place that teaches how to distinguish "the good from the bad" and enable young men, in particular, to develop their identity and masculinity. Religious elders may reinforce notions of acceptable masculine behaviours that fit with the teachings of the particular faith system. Men who do not fit with the accepted faith notions of masculinity may be ostracised; for example, men who have a same-sex sexual orientation.

Disability

Men who are disabled may experience difficulties in asserting their masculinity. Indeed, within society as a whole, there may be an assumption that masculinity and disability are conflicting identities – masculinity is associated with power and physical strength and disability is associated with frailty and vulnerability. This may lead to disabled men being

feminised and deemed to lack masculine traits. In a society that defines men by their ability to attract sexual partners, to exert control over others, and function without help or assistance, disabled men may struggle to be perceived as "real" men. This undermining of masculinity is widely recognised by health professionals and other therapists and, as a consequence, disabled men are often encouraged to assert traditional masculine identities: for example, by playing sports such as wheelchair rugby or basket ball. In this way, conventional male attributes are recreated into a more achievable form.

The factors of age, ethnicity, sexual orientation, religion, belief and disability are useful ways of exploring concepts of masculinity but there are limitations to this approach. Current, sociological research has moved from a generalised understanding of masculinity to an awareness of the need to focus on multiple masculinities. It is important to remember that men may be affected by multiple factors that influence the kind of masculinities that they construct. Subgroups of men (as well as individuals) have unique health and wellbeing needs. It is important that differences among men and boys are understood if their health and wellbeing are to be improved and specific barriers and risks to health addressed. Therefore, it is not enough to say that different health problems disproportionately affect men. Recognition must be given to the specific needs of communities of men and the complex relations that exist between such communities (Dowsett et al 2010).

A further criticism of hegemonic models of masculinity is that they do not necessarily describe the experiences of the majority of men, or appropriate ideals for all or any men (Lee and Owens 2002). However, an appreciation of masculinities as sets of social practices allows a flexible



model for recognising the role of institutions and organisations in the construction and perpetuation of gendered inequalities in health (Robertson 2008). Caution should be exercised in planning health services for men, to ensure that they do not reinforce or perpetuate stereotypical images. This type of approach may fail to meet the needs it was designed to address.

Masculinities, Identities and Health

There is some evidence to suggest that men feel pressured to engage in actions that may be harmful to their health, in order to appear masculine (O'Brien et al 2009). This is expanded upon by Courtenay (2000) who proposes that men may adopt health-related beliefs and behaviours to demonstrate that they fit the hegemonic masculinity of their culture. These behaviours include:

- the denial of weakness or vulnerability
- emotional and physical control
- the appearance of being strong and robust
- dismissal of any need for help
- a ceaseless interest in sex
- the display of aggressive behaviour and physical dominance.

Exploring the psychology of men's health can help to link concepts about the social construction of gender and masculinities and the behaviours that negatively affect men's health. These behaviours identified by Lee and Owens (2002) include:

- reluctance to seek help for medical and psychological problems
- avoidance of the expression of emotion
- aggressive and unsafe sexual behaviours and attitudes

- a high level of involvement in risky behaviours including drug use, criminal and violent behaviour and physically dangerous sports and recreational activities.

Reluctance to seek help

A large body of empirical research supports the belief that men are reluctant to seek help from health professionals. Men are less likely than women to seek help for problems as diverse as depression, substance misuse, physical disability and stressful life events (Addis and Mahalik 2003). This reluctance can harm their mental and physical health and can make life more complicated for themselves, their friends and families.

However, when examined in the context of masculinities, it is not hard to understand why men experience difficulties in asking for help. To do this, men first need to recognise that there is a problem and then that they need help and, perhaps, will have to rely on others to solve their problem. This conflicts with the ideology of men of being physically strong, in control and self-reliant. It has been suggested that men will not use health services unless the decisions they make around their health do not conflict with their concept of masculinity (Branney et al 2007). The reasons men give for not seeking help are usually framed around the concepts of masculinity that suggest they should be able to cope in the face of problems, deal with pain and not be weak (O'Brien et al 2005). Often, it is only when the health problem becomes so great that it cannot be ignored, that they will seek professional advice. Sometimes, however, even in the face of extreme ill health, some men will deny its existence.

In direct contradiction to this, there is some evidence which proposes that men



do, in fact, seek help for their health-related issues. A literature review of gender-comparative, help-seeking studies does not fully support the premise that men are less likely than women to seek help when they experience ill health (Galdas et al 2005). This review suggests that other variables, such as occupational and socio-economic status, are as important as gender alone. However, this review is also critical of the evidence base as a whole: it highlights the difficulties of comparing men and women as homogenous groups and proposes that the current evidence base is inadequate to inform policy and the provision of health services. It is recommended that the role of masculine beliefs and the similarities and differences between men of differing background require further attention, particularly given the health inequalities that exist between men of differing socio-economic status and ethnicity.

Vignette

H is 54 years old and has a BMI of 34. He has been experiencing indigestion-type pains in his chest for some weeks but these usually pass if he takes it easy. His wife has been telling him to go to the doctors but, although H is quite worried about the pains, he hasn't got round to making an appointment.

H wakes up early one morning feeling tired and a bit sweaty. He gets out of bed to go to the bathroom, feels faint and nauseous, and then collapses. His wife calls for an ambulance but, by the time they arrive, H is in cardiac arrest. Despite the best attempts of the paramedics, they are unable to revive him.

Avoiding emotional expression

As children, boys are discouraged from showing their feelings – “big boys don't cry” is a common saying. Feeling or expressing emotion is in direct conflict with the hegemonic construct of masculinity, where men are supposed to demonstrate that they are strong and invincible. For the majority of men in Western culture, being masculine is bound up with being emotionally strong as well as physically healthy and it is this model of masculinity that they measure themselves against (Conrad and Warwick Booth 2010). Therefore, it becomes very difficult for men to show emotion or to admit that they may have a mental health problem, without compromising their masculinity.

In order to express emotion whilst maintaining a masculine identity, men may release emotion in the form of anger or violence. The most extreme form of violence may be suicide but other expressions, such as homicide or domestic violence, may also occur. The severe nature of these events may be linked to men's reluctance to ask for help. Even men who reject hegemonic ideas that they shouldn't show emotion or ask for help may feel restricted in how they can behave, for fear of the reactions of men who don't (Conrad and Warwick Booth 2010). Unfortunately for men in need of support, those who don't show emotion may include health professionals who are supposed to offer the help required. A recent study has demonstrated that male GPs' own adherence to gender roles may itself influence the doctor-patient relationship (Hale, Grogan and Willott 2010). This highlights the role of institutions, such as medicine, in failing to acknowledge men's emotional distress and the support for stoical masculinities (Ridge 2010).



Vignette

L visits his GP. He is feeling depressed, but doesn't say this is the reason for his consultation. Instead he focuses on the physical aspects of his health, such as not sleeping properly and feeling tired. His GP recognises that his symptoms might suggest depression and asks L about factors that may be causing him to experience stress. L resists any attempt to discuss his personal life. His GP is reluctant to probe and, instead, discusses ways to help improve his sleep. L leaves the surgery feel very frustrated and reluctant to return.

Aggressive and unsafe sexual behaviour

In a culture where sexual behaviour is highly prized as a signifier of masculinity, men may find themselves expected to be highly interested in heterosexual sex. Social approval is given to men who have multiple female partners, demonstrating their sexual prowess and therefore asserting their masculinity. Any behaviour that suggests a man is anything other than heterosexual will be stigmatised and consequently avoided by those wishing to emphasise their heterosexual masculinity. For men who have sex with other men, this stigmatisation may lead to social isolation and unsafe sexual practices, possibly due to a reluctance to seek advice or information.

There may also be a dominant belief that men have uncontrollable sexual urges, validating the coercion of, or aggressive behaviour towards, potential or actual sexual partners. Indeed, the language commonly used to describe sexual activity is generally aggressive in tone and asserts male dominance. If coercion and sexual violence are perceived as 'normal' male behaviours, this may reduce men's ability to make their own choices about sexual relationships and the avoidance of

unwanted or unsafe sexual behaviour (Lee and Owens 2002).

In terms of physically aggressive behaviour, some may view this as a normal part of being male. Men's expressions of aggression tend to be more direct and physical than women's. This means health issues may arise, particularly in terms of physical injury but also related to mental health, both in the perpetrator and the victim.

Theories may seek to explain violence in men but, because it is such a complex social phenomenon, violence can perhaps best be understood as the final outcome of an intricate web of interacting factors. These factors may include the use of drugs and alcohol, the social situation, the personality of the aggressor and the behaviour of the victim. However, male physical aggression can also be seen as part of the construct of masculinity, with violent, masculine practices exalted in some communities (O'Brien, Hunt and Hart 2009).

Vignette

F is 18 years old. He lives in inner city Bristol but wants to move to somewhere quieter. F has been beaten up several times by some of the lads in his area and one incident resulted in a broken nose. F thinks he is lucky his injury was not more serious and is now worried about going out.

Risky behaviour

In traditional societies, boys make the transition to being a man through various rites of passage. Typically, these will involve strength and physical skill, perhaps through hunting prey or demonstrating stamina and resilience to physical adversity. In modern cultures, these traditional rites of passage are no longer a relevant part of men's development and so alternatives are



sought to signify that the man is no longer a boy. In some religions, such as Judaism, a particular ceremony may signify the transition but, for those without a strong faith background, another way must be found. This could mean adopting unhealthy behaviours: from smoking cigarettes and drinking excessive amounts of alcohol to driving dangerously and undertaking hazardous sporting activities. What is central to all these activities is that they encompass an element of risk.

As a result of their roles as 'risk takers', it appears that men are more likely than women to experience adverse health and social consequences. Men are more likely than women to smoke, drink heavily and use illicit drugs. They are, therefore, more at risk than women from the associated harm to their health (Thom 2003).

Vignette

R is 15 years old. He lives with his mum and grandmother but spends most of his time outside the home with his friends. Recently, they have started to use cannabis and R has joined in. One of his mates knows where to get crack cocaine and suggests they should give it a try. R is a bit worried about this but feels he has to go along with it.

Changing behaviour

It is important to have an appreciation of other aspects of health psychology and how these may impact on men's health and wellbeing. The key to promoting a healthy lifestyle lies in the ability of the individual to change their behaviour or substitute unhealthy behaviours for healthy ones. An important part of this is self efficacy. Self efficacy is a person's belief or personal judgment of his or her own ability to succeed in reaching a specific goal. If self efficacy is low, then the individual may struggle to achieve their goal.

Motivation also plays a part in behaviour change, activating the goal-orientated behaviour. Motivation may be intrinsic, whereby it comes from within the individual, rather than from any external forces; or extrinsic, whereby the individual is motivated by external factors, such as rewards or the avoidance of punishment. These issues are complex and several theoretical models exist to support behavioural change. A review of the evidence by the National Institute for Health and Clinical Excellence (2007) proposes several key points to enhance behaviour change by motivating and supporting people to:

- understand the short, medium and longer term consequences of their health-related behaviours, for themselves and others
- feel positive about the benefits of health-enhancing behaviours and changing their behaviour
- plan their changes in terms of easy steps over time
- recognise how their social contexts and relationships may affect their behaviour
- identify and plan for situations that might undermine the changes they are trying to make
- plan explicit 'if-then' coping strategies to prevent relapse
- make a personal commitment to adopt health-enhancing behaviours by setting (and recording) goals to undertake clearly defined behaviours, in particular contexts, over a specified time
- share their behaviour-change goals with others.

When examined under the lens of masculinities and the impact on men's health behaviour, it could be suggested that some of these practices would be difficult for men to engage with. For example, given the need for men to avoid



expressing emotion, deny any weakness or vulnerability and dismiss the need for help in order to maintain their own and others' perceptions of their masculinity, sharing behaviour-change goals with others may be problematic.

Key Points

- Every culture or society will have its own, predetermined expectations of what it means to be a man and, consequently, of how men should behave.
- Within most western cultures, the hegemonic or dominant concept of masculinity is associated with whiteness, heterosexuality, marriage, authority and physical toughness.
- Masculinity is a dynamic and contextual construct: it can be better understood as one of a number of cultural reference points around which each man organises and adopts behaviour.
- Men may adopt health-related beliefs and behaviours to demonstrate that they fit the hegemonic masculinity of their culture, including: a reluctance to seek help; avoidance of the expression of emotion; aggressive and unsafe sexual behaviours and attitudes; and a high level of involvement in risky behaviours.
- Caution should be exercised in planning health services for men to ensure that they do not reinforce or perpetuate stereotypical images.
- Health psychology is a complex issue and several theoretical models exist to support behavioural change.



6. Improving men's health - what works?

Summary

It is clear that men, just like women, faced gendered inequalities in health. This means it is vital to ensure that health services and health interventions address these inequalities in an effective manner. It is critical to test the effectiveness of any healthcare programme or intervention before adopting it. We have to be clear about what we know works and what still needs to be tested. To date, many healthcare programmes and interventions have been adopted without appropriate evaluation. However, there is a small evidence base that demonstrates what works in relation to promoting men's health. This section reviews that evidence base.

Literature Review - Method

In order to inform strategies to improve the health of men in Bristol, a broad scoping review of the literature was undertaken specifically around the topics of:

- what works
- what initiatives and interventions are effective in engaging men with health services
- seeking help with health and improving men's health outcomes.

The review was undertaken in June and July 2010 by a skilled and experienced member of the Directorate of Public Health, NHS Bristol (Maslen 2010). Sources searched included:

- National Institute for Health and Clinical Excellence (NICE) guidance
- King's Fund
- Hand searches of Journal of Men's Health and Journal of Men's Health & Gender

- NHS Evidence – Health Information Resources
- PsychInfo
- Embase
- Medline
- HMIC (Health Management Information Consortium)

Search terms used and combined in different ways in the electronic bibliographic databases included exploring: *Men/*Male/*Masculinit*; *Health; *Health Care Service*; *Health Promotion; *Health Behaviour* *Health practice*; *Utilisation of health services; *Attitude*

This was augmented by: ancestry searches of key papers, citation searches and searches of key authors in the field.

Searching was predominantly limited to UK populations only, with the rationale that different healthcare systems are organised differently, making meaningful comparisons about access and use difficult. Additionally, searching tended to focus on literature published in the last five years, unless it appeared to be a key resource.

Findings of the literature review

It is critical to test the effectiveness of any healthcare programme or intervention before adopting it. We have to be clear about what we know works and what still needs to be tested. To date, many healthcare programmes and interventions have been adopted without appropriate evaluation. However, there is a small evidence base that demonstrates what works in relation to promoting men's health.

This evidence base on what works is complex and often contradictory. However, one systematic review has been found that examined health promoting interventions with men (Robertson et al 2008). This review found 749 citations, of which 338 articles were assessed and 27 met the inclusion criteria. Most studies were male



sex specific, i.e. prostate cancer screening and testicular self examination, as opposed to general health concerns, relevant to both men and women. Other topics included alcohol, cardiovascular disease, diet and physical activity, skin cancer and smoking cessation. Twenty three interventions were effective or partially effective and 18 studies satisfied all quality criteria. The review found that there was little published evidence on how to improve men's uptake of services. Robertson et al (2008) conclude that it is not possible to confirm that targeting men works better than providing services for all people. Large scale studies are required to help produce evidence that is sufficiently robust to add to the small evidence base that currently exists in this field.

Several other studies have been found that evaluate specific interventions or are related to specific aspects of men's health. Analyses of these studies are presented below. However, in terms of the specific interventions, these were all based in the north of England and, although evaluated with varying degrees of robustness, the findings may not necessarily translate into the context of men's health in Bristol.

A key finding is that men want services to be easily accessible. This means flexible opening times. Opening hours of health services should reflect the needs of all potential participants, particularly those who have difficulties in accessing the service. Male service users pointed out that it was often difficult for those in full time work to attend on those occasions when the service did not extend into the evening (Kirkcaldy and Robinson 2005).

The venue of healthcare provision was also found to be important in several studies. Men appear to like convenient settings for healthy lifestyle programmes

and activities (Robinson et al 2010). Working with industry and community based services was found to be effective in opening new avenues for the delivery of primary care, although men will attend clinics if given a medical reason or a specific appointment is made for them (White et al 2008). The "Go" campaign at Halton and St Helens Primary Care Trust created a dedicated service built around the needs of local men, involving flexible times for health checks, non-clinical settings, and accessible venues, which was found to have contributed to the success of the project (Go Men's Health Programme). Linnell and James (2010) also found that issues around venue choice were a more significant factor than originally perceived. Although not a formal evaluation, Phipps (2008) found success in establishing a men's health promotion unit at a builder's merchant. The importance of venue is also confirmed by White, Conrad and Branney (2008) who found that going into the workplace helped recruit men onto a well received weight management programme. They suggest that this can be seen as an example of how mainstream health services can be integrated with the more traditional occupational health provision, particularly as the men in this study reported that they would not have attended had the sessions been outside the workplace.

The uptake of health information and health services can be improved by making them male friendly, anonymous, and more convenient (Banks 2001). For young men in particular, anonymity is as important as confidentiality (White et al 2008). New forms of social media (for example, online social networking sites, blogging, iPhone apps and podcasts) have the potential to enable young men to engage with health information in new and interesting ways (Robinson and



Robertson 2010a). Given concerns about young men's engagement with health services, innovative information technology formats, particularly using the Internet, have been tried in the past. However, concern persists around surfing 'addiction', quality control and equal access. In response to this concern, Robinson and Robertson (2010a) found that approaches to health promotion using new information and communication technologies offer distributed control over information content and quality, and a lay social context for accessing information. Online communities can potentially legitimise young men's participation in discourses around health and support sustained engagement.

Culturally sensitive interventions may also be important. However, there is a lack of evidence to determine for whom and what form this should take. Although not based in the UK, one study has been found that examines gay men's uptake of smoking cessation services (Schwappach 2009). This found that the participants stated strong preferences towards a culturally adapted cessation programme for gay men. Qualitative results indicate that men felt torn between their wish for support, bonding, and community alternatives to the 'smoking gay' environment and fears for failure and loss of reputation. Gay men reported their likely use of a gay-specific intervention, with such interventions offering support in abstaining from smoking, without abstaining from gay social life.

Motivating men to attend for health screening or 'health checks' has been perceived as a key challenge, particularly as men in the most deprived areas are often the most disengaged from services and, in some cases, socially isolated. Research by the University of Liverpool (as yet unpublished) has found that provision of what men in St Helens asked for - "a service just for us" - provided an excellent

motivational tool (Go Men's Health Programme). The initial results of the programme have surpassed all expectations, with the first sessions being oversubscribed. The programme has continued to meet its challenging targets. More than half (57%) of the men attending have since gone on to access other services, including diet and exercise interventions, smoking cessation programmes and health trainer services. This success reflects ongoing engagement that will result in genuine improvements in health. It is anticipated that this kind of approach, which takes practical steps to target those in need, will help to convert positive policy aims into improved health outcomes. However, judgement should be reserved until the final report is published.

Two studies have been identified that consider social marketing in relation to men's health. Social marketing is the systematic application of marketing, along with other concepts and techniques, to achieve specific behavioural goals for a social good. In essence, it comprises of large scale, broad based programmes to improve public health through a focus on behaviour change.

The PITSTOP programme offers a number of useful lessons to the UK's emerging social marketers in public health because of its quantifiable outcomes, strategic success and lessons learned through the development and delivery of a programme of health checks (O'Brien and Forrest 2008). The project was aimed at older men and market research with this group indicated that men wanted the campaign to be hard hitting, humorous and to avoid blaming men for being unhealthy. It was also found that motoring analogies were prominent; hence the name PITSTOP and the development of a 'Knowsley Man' Haynes maintenance manual in partnership with the UK Men's Health Forum. This health information book was written in the style of a vehicle



maintenance manual, suggesting that the project subscribed to the dominant perceptions of masculinity within the community. Over 3,000 men had health checks in the first two years of the project, many of whom had poor health-related lifestyles and did not access other local health services. An independent evaluation showed that awareness of the campaign was 57% and that 85% of men who had a health check indicated they had made simple lifestyle changes. Male life expectancy increased in Knowsley at a faster rate in 2006 than in 2003.

Robinson and Robertson (2010b) offer a critique of social marketing; in particular, the application of marketing approaches to men's health. They suggest that, from a men's health perspective, social marketing becomes problematic if it consistently uses homogenised images of hegemonic masculinity as a promotional tactic to influence individual men's behaviour. Instead, rigorous social marketing planning procedures, critically informed by current men's health research, should be adopted. They also acknowledge the need for further research on sophisticated social marketing strategies promoting alternative models of masculinity.

Little is known about the circumstances that might encourage men to rethink their engagement with healthy behaviours and to access health information and advice. However, there is some evidence that suggests that ageing, illness, and fatherhood were some of the experiences that prompted men to re-evaluate their health practices (O'Brien, Hunt and Hart 2009). Informal support systems may also have a role to play, providing a bridge to healthcare access for groups who traditionally fall outside the reach of orthodox service delivery (Kierans, Robertson and Mair 2007). The interdependence between men's and women's health has received scant

attention in the academic world, and it has not been possible to source any robust evidence. However, it is possible that the role women play in supporting the health of their family will have an impact on the health of the men and boys they live with. One study has been found, showing that women exert an important influence on the decisions of men to seek health care. Men were 2.7 times more likely than women to be influenced to seek health care by a member of the opposite sex. Married patients were 2.4 times more likely than unmarried patients to be influenced to seek health care by a member of the opposite sex (Norcross et al 1996). The limitation of this study is that it is set in California, USA and it is almost 15 years old.

Further, qualitative research also supports the idea that women can influence men's use of health services. Madjar et al (2007) studied women's role in the detection of prostate cancer. They found that women are interested and careful observers of their male partner's health, noting even minor changes that men tend to ignore or deny. This study highlights that, more than anything, women want to grow old with their partners; they don't want them to die from something that could have been detected and treated earlier. From these findings, it could be suggested that women may be able to exert a positive influence on men's decisions about seeking healthcare services. However, since no-one seems to have actually asked men about the role women have in influencing their healthcare-seeking behaviours, more research into this area is urgently needed.

One study has examined the personal attributes of health professionals working with men which contribute towards their ability to successfully engage service users (White et al 2008). This found that health workers needed to be:



- non-judgemental and non threatening
- creative, male focused and realistic
- able to see beyond the behaviour of the lads, and to use humour appropriately
- willing to wait for success
- able to use a public health model.

They also suggest that:

- male-orientated resources need to be developed and tested
- having a team with a range of expertise enables a broader range of activities to be supported.

Further literature is available, specifically related to promoting men's mental health and the skills of health workers (Conrad and White (2010)). Mental health and illness are associated with stigma; and managing emotions related to relationships and sexual health may be particularly difficult subjects for men and health workers alike to tackle. Skill is required in order to broach potentially difficult or embarrassing subjects and not all practitioners will have the necessary attributes. To succeed, those who already have these skills should be supported and encouraged to educate a new generation of practitioners. This will have lasting benefits for those working with men and the men themselves (Conrad and White 2010).

In terms of promoting men's mental health, the evidence base is mainly anecdotal, with practice examples given to support recommendations. One such example is given by Scambor (2010) and whilst the findings may not be generalisable, they do offer a useful perspective on what factors may impact on the uptake of mental health promotion services for men. Recommendations include:

- any team providing services for men should be multidisciplinary and not necessarily limited to health professionals. Often men will present with 'problems' that are seemingly unrelated to the actual issue that is of concern – they may, for example, seek advice for divorce or access to their children before revealing the extent of their emotional difficulties
- men's health services should network with other services and professionals. Men with specific health problems may have interrelated problems which require referral to other agencies
- men appreciate services that are clearly identified as being for men and often expect that these services will be provided by male workers
- the promotion of men's health and men's health services is likely to be met with resistance. Public relations will be crucial and there will be a need to maintain ongoing contact with the general public and professional networks to promote a clear, consistent image and message.

Only one study has been found that has directly asked men what they want from health promotion interventions (Coles et al 2010). This study highlights how most interventions tend to focus on hegemonic masculinities and take a 'one size fits all' approach. The researchers sought to overcome this limitation by undertaking a qualitative study with 82 middle aged and older men. They found that, despite gender stereotypes, men were keen to engage with healthcare services but felt there were barriers to them seeking help. What they really wanted was direct advertising and health information specifically for men. However, given that this research was undertaken within an established health project for men in the north of England it may not be transferable to Bristol. There may be some



value in undertaking a similar study with the men of Bristol to identify what is important to them and what they really want from healthcare and health promotion interventions.

Key points

- There is a small evidence base which demonstrates what works in relation to promoting men's health. This evidence base is complex and often contradictory.
- It is not possible to confirm that targeting men in health promotion interventions works better than providing services for all people.
- Specific interventions identified in the literature review were all based in the north of England and, although evaluated with varying degrees of robustness, the findings may not necessarily translate into the context of men's health in Bristol.
- Men want services to be easily accessible. This means flexible opening times in convenient, non-clinical locations.
- New forms of social media have the potential to enable young men to engage with health information in new and interesting ways.
- Culturally sensitive interventions may also be important. However, there is a lack of evidence to determine for whom and what form this should take.
- From a men's health perspective, social marketing becomes problematic if it uses homogenised images of hegemonic masculinity as a promotional tactic to influence individual men's behaviour.
- There is some evidence that suggests that ageing, illness, and fatherhood were some of the experiences that prompted men to re-evaluate their health practices.
- One study has been found that shows that women exert an important influence on the decisions of men to seek health care.
- Health workers need to have a well developed set of skills to work effectively with men. Having a healthcare team with a range of expertise enables a broader range of activities to be supported.
- What men probably want from health promotion interventions is direct advertising and health information specifically for men.



7. Improving health care services for men

Summary

As well as the evidence base, there are some powerful drivers that can influence the promotion of men's health and the provision of health services that address gender and other health inequalities. These include the statutory responsibilities placed on NHS Trusts by the Equality Act, 2010 and the standards for quality and safety enforced by the NHS regulator, the Care Quality Commission. NHS commissioners and public health departments may be able to improve health services and reduce gendered inequalities by leading on the development of appropriate strategies and care pathways that address the health needs of men.

The Equality Act

The Equality Act, 2010 came into effect on 1 October 2010. The Act aims to simplify the law by bringing together several pieces of anti-discrimination legislation. For the first time, the UK has a single Act of Parliament, requiring equal treatment in access to employment, as well as private and public services, regardless of age, disability, gender reassignment, marriage or civil partnership, maternity or pregnancy, race, religion or belief, sex or sexual orientation.

As discussed in the section on policy context, the Equality Act, 2010 may be seen as a very useful device for challenging inequalities in men's health. The statutory nature of the Act (and the need to ensure equal treatment in access to public services) means that the NHS must address the health needs of men and the key issues surrounding the health inequalities they experience. This will entail collecting evidence that services do ensure equal treatment for men; and

redesigning services where they are found to be lacking. New initiatives may also be required, to ensure inequalities are addressed in ways that are meaningful for men.

The Care Quality Commission (CQC) is an NHS regulator. This organisation was set up to ensure that people in England get better health and adult social care. To do this, the CQC:

- registers, and therefore licenses, care services, if they meet essential standards
- monitors care services to make sure they continue to meet essential standards
- acts to improve poor quality care.

The essential standards include an outcome related to respecting and involving people who use services. This clearly states that, in order to comply with Regulation 17 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2010, services must:

'take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they have.'

'encourage service users, or those acting on their behalf, to express their views as to what is important to them in relation to their care or treatment.'

CQC (2010) p 44

All NHS Trusts, including NHS Bristol, need to demonstrate that they meet the essential standards. As such, this would seem to reinforce the need for NHS Bristol to address the health needs of men and the key issues surrounding the health inequalities they experience.

There is evidence to suggest that most of the innovative developments in men's health (and men's mental health in



particular) have not been driven by mainstream healthcare providers setting up new services for men. Conrad and White (2010) have identified that, what usually happens is that individual practitioners recognise a need and set up services for men under their own volition. No evidence of commissioners of services actively planning and purchasing work in this area has been found.

NHS Bristol aims to be the most successful Primary Care Trust at improving health, including improving the health of the most disadvantaged (NHS Bristol 2010c). NHS Bristol has also publicly stated its commitment to eliminating discrimination on the basis of gender identity, sex, marital status, age, disability, race, religion, nationality, ethnicity, sexuality, pregnancy and maternity or social class (NHS Bristol 2010d). An equality policy has been developed that will turn this commitment into reality by developing and implementing action plans to identify and eliminate discrimination, reduce health inequalities and promote equality of opportunity. This is relevant to inequality in men's health, given the large body of evidence supporting the need for action. NHS Bristol has further demonstrated its commitment to tackling inequality in men's health by commissioning this present work and it is important to ensure that appropriate recommendations for strategic and operational actions are created in consultation with stakeholders and service users. If meaningful and achievable recommendations are developed and acted upon, NHS Bristol may achieve its goal of being the most successful Primary Care Trust at improving health, including improving the health of the men of Bristol.

Key Points

- Powerful drivers can influence the promotion of men's health and the provision of health services that address gender and other health inequalities, including Equality Act, 2010 and the Care Quality Commission's standards for quality and safety.
- No evidence has been found of commissioners of services actively planning and purchasing work in the area of men's health and health inequalities, particularly in relation to mental health.
- NHS Bristol has demonstrated its commitment to tackling inequalities in men's health by commissioning this work.
- It is important to ensure that appropriate recommendations for strategic and operational actions are created in consultation with stakeholders and service users.



Conclusion

Recent, national health policy has paid little attention to men's health issues, with gender inequalities being primarily focused on women's health. However, the tide is turning and the importance of men's health as an issue for gender inequality is significantly increasing. A variety of evidence demonstrates that men experience poorer health than women in many areas and are significantly more likely to die at an earlier age. The need for NHS Bristol to address the health needs of men and the key issues surrounding the health inequalities they experience has been identified.

Every culture or society will have its own, predetermined expectations of what it means to be a man and, consequently, of how men should behave. Within most Western cultures the hegemonic or dominant concept of masculinity is associated with whiteness, heterosexuality, marriage, authority and physical toughness. Combined with inequalities in health, this can cause considerable difficulties for men who do not fit this profile. Concepts of masculinities and psychological aspects of health behaviours can create challenges for health professionals in promoting men's health and for men who try to adopt healthy lifestyles.

It is vital to ensure that health services and health interventions address these inequalities in an effective manner. It is critical to test the effectiveness of any healthcare programme or intervention before adopting it. We have to be clear about what we know works and what still should be tested. To date, many healthcare programmes and interventions have been adopted without appropriate evaluation. However, there is a small evidence base that demonstrates what

works in relation to promoting men's health and wellbeing. It will be critical to supplement this evidence base by testing and fully evaluating the effectiveness of any future healthcare programmes or interventions introduced by NHS Bristol or its strategic partners.

As well as the existing evidence base, there are other powerful drivers which can influence the promotion of men's health and wellbeing, as well as the provision of health services addressing gender and other health inequalities. These include the statutory responsibilities placed on NHS trusts by the Equality Act, 2010 and the standards for quality and safety enforced by the NHS regulator, the Care Quality Commission. NHS commissioners and public health departments may be able to improve health services and reduce gendered inequalities by leading on the development of appropriate strategies and care pathways which specifically address the health and wellbeing of men.



Recommendations

This author considers that recommendations are best made in consultation with stakeholders who have a vested interest in men's health and have had the opportunity to read the report in its entirety. However, some key points leap out and these have been included below as a starting point for stakeholder discussions. This list is not exhaustive and other recommendations should be identified by the stakeholders who will be involved in acting on the implications of this report:

- there is a need for NHS Bristol to address the health needs of men and the key issues surrounding the health inequalities they experience
- it is critical to test and fully evaluate the effectiveness of any healthcare programme or intervention that is introduced by NHS Bristol
- more research is needed into healthcare services and interventions for promoting men's health
- given the lack of a quality evidence base, there may be some value in undertaking a research study with the men of Bristol to establish what is important to them and what they really want from healthcare and health promotion interventions.



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Useful resources

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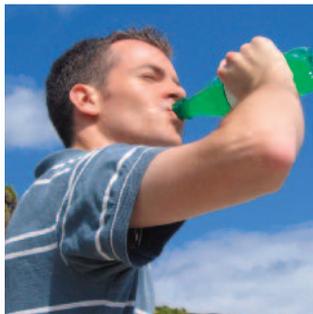
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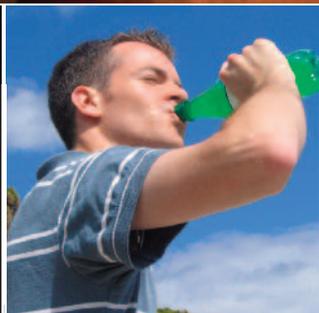






A close-up photograph of several ripe yellow bananas and bright orange oranges, filling the top half of the page.

A Picture of Health?



Men's Health and Wellbeing in Bristol

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