



GLOBAL ACTION ON
MEN'S HEALTH

WHO SELF-CARES WINS

a global
perspective on
men and
self-care



A report from Global Action on Men's Health

GLOBAL ACTION ON MEN'S HEALTH

Global Action on Men's Health (GAMH) was established in 2013 and launched during International Men's Health Week in June 2014. GAMH brings together men's health organisations, and others which share their objectives, in a new global advocacy network.

GAMH's mission is to create a world where all men and boys have the opportunity to achieve the best possible health and wellbeing wherever they live and whatever their backgrounds.

Far too many men and boys suffer from health and wellbeing problems that can be prevented. Globally, male life expectancy at birth is just 70 years but poor male health is not recognised or tackled by global health organisations or most national governments.

GAMH wants to see:

- Global health organisations and national governments address the health and wellbeing needs of men and boys in all relevant policies
- Men and boys encouraged and supported to take better care of their own health as well as the health of their partners and children
- Health practitioners take greater account of the specific needs of men and boys in service delivery, health promotion and clinical practice
- Other agencies and organisations, such as schools and workplaces, helped to be more aware of their significant impact on the health of men and boys
- Sustained multi-disciplinary research into the health of men and boys
- An approach to health that fully recognises the needs of both sexes in policy, practice and funding and which promotes greater gender equality.

GAMH uniquely represents a wide range of men's health and related organisations each of which has experience of policy development, advocacy, research and service delivery. It is concerned about a broad and cross-cutting range of men's health issues (e.g. health literacy, risk-taking behaviours, use of services, etc.) GAMH's has a strengths-based view of men and boys and its focus is primarily on public health and the social determinants of health

Global Action on Men's Health
c/o Men's Health Forum, 32-36 Loman St, London SE1 0EH, UK

www.gamh.org
[@globalmenhealth](https://twitter.com/globalmenhealth)



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NOTES

In this report, 'men's health' is used as shorthand for 'the health and wellbeing of men and boys'.

The term 'health practice' is preferred to the more commonly-used concept of 'health behaviour'. In many ways, the terms are synonymous but 'health practice' suggests that what people 'do' is not simply a matter of individual decision but is also influenced by a range of wider social, economic and cultural factors.¹

Comparisons between men's health and women's health should not be read as meaning that women's health is unproblematic or that bringing men's outcomes into line with women's would be sufficient. That is far from the case – women's health also needs significant attention. But because the differences in male and female health are only to a small degree inevitable (less than 1-2 years of the life expectancy 'gap' is believed to be genetically determined)², they are one useful indicator of where action is needed.

A limitation of this report is that it is based on evidence published in English and focused primarily on the Global North which covers about one-quarter of the world's population and includes the United States of America, Australia, New Zealand, Canada and Europe. Information relevant to the Global South (broadly including Africa, Latin America, and the developing countries in Asia), has been included wherever possible, however.

All figures cited have been rounded for the purposes of clarity.

ABBREVIATIONS

COPD	Chronic obstructive pulmonary disease
GAMH	Global Action on Men's Health
ISF	International Self-Care Foundation
NCD	Non-communicable disease
SCF	Self Care Forum
SDG	Sustainable Development Goal
STI	Sexually transmitted infection
UK	United Kingdom
UN	United Nations
USA	United States of America
WHO	World Health Organisation

Foreword

Self-care is a practical, person-centred set of activities that we should all be undertaking to maintain our health, wellness and wellbeing. Through self-care people can be healthier and remain so into old age, managing minor ailments themselves. They can also better manage, delay or even prevent the appearance of so-called 'lifestyle' diseases such as heart attacks, strokes, diabetes and many cancers.

The promise and prospects for self-care are clear, but there are in fact many personal, environmental and systemic barriers. This report, the first to look broadly and systematically at men and self-care, expands our understanding of the importance of gender. Men's self-care practices and risk factors, such as smoking, risky levels of alcohol consumption and unhealthy diets, are worse than women's. Men bear the burden of gender norms that encourage risky health behaviours and discourage help-seeking. The result is poorer health outcomes than women.

In the self-care field as elsewhere, men's health has been generally overlooked. This report is therefore a very welcome synthesis and summary of the key issues relating to men and self-care. Importantly, the report considers the opportunities for improving men's self-care. It is clear that there is now enough evidence from research and examples of good practice to make the changes that are needed. Measures to improve men's self-care should be an essential part of the effort to improve overall health outcomes.

Looking at men's health through the lens of self-care presents an important opportunity for men, their partners and families and their employers. It is also an opportunity for policymakers and health providers to reduce the costs of addressing male morbidity and mortality at a time of unprecedented and growing demands on health systems and budgets.

Some countries have incorporated aspects of self-care and gender into health policies and promoted some innovation and notable practices. However, all countries are a long way from implementing robust and meaningful policy prescriptions designed to promote individual and population self-care capabilities, shift professional practices, or reorient healthcare systems towards a preventative ethos. A focus on men's self-care and health should be an important and explicit consideration going forwards.

Dr David Webber, President
International Self-Care Foundation

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EXECUTIVE SUMMARY



A global perspective on men and self-care

Executive Summary

Globally, men's health has improved significantly over the past 40 years in terms of life expectancy and healthy life expectancy. Average male life expectancy stood at 70 years in 2016. Most men do enough physical activity to benefit their health, do not smoke or drink alcohol, and want to take charge of their own health.

Men's health remains far poorer than it need be, however. Global male life expectancy is four years lower than female and the 'sex gap' is widening. There are also significant variations in men's health outcomes between and within countries.

Improved men's self-care practices would result in better health for men as well as for women and children. They would also help achieve UN's SDGs and reduce costs for health systems.

While better self-care would undoubtedly benefit men's health, an analysis of men's practices in respect of the ISF's 'Seven Pillars' of self-care suggests that men's knowledge and health literacy, mental wellbeing, self-awareness and agency, diet, risk avoidance and personal hygiene standards are currently far from optimal. Men often do not make effective use of health services and products and, while they are generally more physically active than women, many are too sedentary.

The barriers to improving men's self-care include male gender norms, a lack of policy focus on men and health services that have been designed without men in mind. Moreover, neither men's health nor self-care are strategic health priorities globally or nationally.

Recent developments provide an opportunity to improve men's self-care. These include the SDGs, the adoption of a regional men's health strategy by WHO Europe, the national men's health policies in Australia, Brazil and Ireland, and an expanding evidence base about how to engage men effectively in health.

There are now many good examples of a range of successful interventions with men in the fields of health information, self-management, sports-based, workplace and community programmes, digital services and primary care.

Improving men's self-care effectively requires action on a multi-layered, systems-wide basis. The necessary steps include:

- Macro measures that make societies more equitable.
- Tobacco, alcohol and sugar control measures.
- Health policies, including national men's health policies, that recognise the needs of men.
- Establishing self-care as a strategic priority in public health policy and practice.
- Improving men's health literacy.

- Health services that are more accessible to men, including pharmacy and outreach services.
- Better training in men's health for health and related professionals.
- Recognition of the heterogeneity of men and a more intense focus on communities of men with the worst health outcomes.
- Taking full account of male gender norms, respecting men (while holding them accountable for actions that harm others) and building on the positive aspects of many men's experience, knowledge, skills and attitudes to health and wellbeing.
- Accelerated research into improving men's engagement in self-care and better practical guidance for policymakers and practitioners.
- Involving men as active agents in self-care initiatives.

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INTRODUCTION: THE GLOBAL STATE OF MEN'S HEALTH



Introduction: the global state of men's health

This is the first-ever report to look at men and self-care systematically at the international level. It is needed because men's health, despite some recent improvements, remains unnecessarily poor. In large part, this is the result of men's health practices, such as smoking, risky levels of alcohol consumption, an inadequate diet and not using health services effectively. These practices are primarily the result of male gender norms and a lack of engagement with men's health by health policymakers and practitioners at all levels from the local to the global. But the SDGs and other developments, including the adoption of a men's health strategy by WHO Europe and emerging evidence about how to work with men effectively, have created a new opportunity for men's health advocates to make the case for a fresh approach. Measures to improve men's knowledge and health literacy and their access to primary care as part of an overarching strategic framework would help to improve men's self-care and their health outcomes significantly.

The Good News

Male life expectancy at birth has improved significantly over the past 40 years with the global average increasing from 56 years in 1970³ to 70 years in 2016⁴. In 2016, life expectancy for men was 80 years or more in 15 countries.

Healthy life expectancy at birth – the number of years that someone can expect to live in good health – also increased for men, from 58 years to 62 years between 2005⁵ and 2016⁶.

Many men's health practices are beneficial to their health. A clear majority – three quarters – of men globally are not smokers, for example, and the global prevalence of smoking in men fell by an average of 2% a year in the period 2005-2015.⁷ Many men want to quit smoking – in the 21 countries covered by the Global Adult Tobacco Survey, the proportion of male smokers who say they intend to quit ranges from 42% in China and Egypt to 77% in Uruguay.⁸ The percentage of male smokers who actually attempted to quit smoking in the previous 12 months ranged from 12% in China to 56% in Vietnam.

Around 60% of men globally do not currently drink any alcohol⁹ and the proportion of male non-drinkers aged 16-24 in England specifically increased from 16% to 25% between 2005 and 2015, a trend also reported for some other countries.¹⁰ Around three-quarters of men globally do enough physical activity to benefit their health.¹¹

Many men monitor their health status and make conscious decisions about when and how to seek help.¹² The notion that men generally do not

use, or largely avoid, primary care health services is also a myth.¹³ They attend primary and secondary care services in large numbers. Men also use health checks and screening services. In the UK, for example, eight out of 10 men aged 65 take up the offer of screening for abdominal aortic aneurysms.¹⁴ There is evidence that differences in consultation rates in primary care between male and female patients in receipt of medication for cardiovascular disease and depression are relatively small.¹⁵

Men generally want to take charge of their health and four men in every five feel as confident as women when it comes to managing their own health, according to an international survey of men's health in which 16,000 adults across eight countries participated.¹⁶ In a separate survey, 90% of men in Ireland indicated that they like to be very involved in decisions about their own health and the medicines they take, a finding consistent with a desire for increased self-care.¹⁷ Men living in a socially deprived local community in the UK have been found to be keen to engage with healthcare services and to welcome the opportunity to discuss their healthcare needs.¹⁸

A GAMH survey of professionals who work with men in nine countries about the current state of men and self-care found that about one-fifth thought that men's and boys' engagement with self-care was 'good' or 'very good' and almost two-fifths thought it was 'fair'. (More information about the GAMH survey can be found in the Appendix on page 52.)

Many national and international health organisations are now showing a greater interest in addressing men's health issues. WHO Europe's new men's health strategy for its 53 member states is of particular significance.¹⁹ Ireland updated its national men's health policy in 2017²⁰ and Australia is developing a new policy for 2020-2030.²¹ UNAIDS has recommended a range of gender-sensitive policy and practice responses to tackle the burden of HIV and AIDS on men.²²

The problems

In 2016, average global male life expectancy lagged behind women's by four years.²³ There was not a single country where men lived longer than women. About 70 countries had a life expectancy 'sex gap' of five years or more and two countries, Lithuania and Russia, had a gap of over 10 years. In Russia, a baby boy born in 2016 is expected to live for 66 years and a baby girl for 77 years.

The sex gap is widening. In the 40 years between 1970 and 2010, adult mortality fell by 34% in women and 19% in men globally. The gap between adult male and female mortality widened by 27% in that period.²⁴ It has been projected that, by 2030, the difference in life expectancy between men and women will increase to seven years.²⁵ A separate, more recent study predicts a sex gap of six years by 2040.²⁶

Life expectancy varies greatly between men in different countries. In 2016, life expectancy for men was 81 years in Switzerland, the highest in the world, but 60 years or under in over 20 countries (the lowest was 51 years in Lesotho).

There are significant differences in male life expectancy within countries. Average male life expectancy in the UK was 80 years in 2016, 10 years above the global average, but men living in one deprived neighbourhood in the town of Blackpool had a life expectancy of 68 years.²⁷ In a much more affluent neighbourhood in the town of Bracknell, life expectancy was 90 years.

Life expectancy and healthy life expectancy by WHO region (2016)

WHO region	Life expectancy at birth (years)		Healthy life expectancy at birth (years)	
	Male	Female	Male	Female
Africa	60	63	53	55
Americas	74	80	66	70
South-east Asia	68	81	60	61
Europe	74	81	66	71
Eastern	68	71	59	60
Western Pacific	75	79	68	70
Global	70	74	62	65

World Health Organisation, Life expectancy and Healthy life expectancy, data by WHO region. 2018.⁶

Race is also very relevant. In the USA, for example, African American males have a life expectancy (71 years) that is approximately eight years shorter than that of Hispanic males (79 years) and about five years shorter than that of White males (76 years).²⁸ African American males living in poverty are at the greatest risk for overall mortality.²⁹ In Australia, the indigenous Aboriginal and Torres Strait Islander male populations have an estimated life expectancy of 69 years, 11 years lower than that of non-Indigenous men.³⁰ Roma men in the Czech Republic and Hungary live about 10 years fewer than non-Roma men.³¹

The most common causes of male deaths

The most common cause of male death globally in 2016 was ischaemic heart disease followed by stroke and COPD.³² In fact, seven out of the 10 top causes of death for men were NCDs. Health practices – such as smoking tobacco, risky levels of alcohol consumption, a poor diet and delays in seeking appropriate healthcare – are significantly implicated in NCDs. The male mortality and morbidity rates for NCDs, and other conditions, could be significantly reduced by a range of medical and public health actions, including better self-care.

Although some men's health practices are beneficial, health-damaging practices are widespread. While many men say they want to take responsibility for their health this does not necessarily translate into action.³³ The GAMH survey of professionals working with men found that a significant proportion (39%) thought that men's and boys' engagement with self-care was 'poor' or 'very poor'. It is clear that many men's lack of effective self-care is having a significant detrimental impact on their health outcomes.

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MEN AND SELF-CARE



Men and self-care

Defining self-care

The SCF in the UK defines self-care as: ‘The actions that individuals take for themselves, on behalf of and with others in order to develop, protect, maintain and improve their health, wellbeing or wellness.’¹³⁴ The SCF sees self-care as a continuum or sliding scale. The scale starts with the individual responsibility people take in making daily choices about their lifestyle, such as brushing their teeth, eating healthily or choosing to do exercise. Moving along the scale, people can often take care of themselves when they have common symptoms such as sore throats or coughs, including by using over-the-counter medicines. The same is true for long-term conditions where people often self-manage without intervention from a health professional. At the far end of the scale is major trauma where responsibility for care is entirely in the hands of the healthcare professionals until the start of recovery when self-care can begin again.

The WHO defines self-care as ‘the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health-care provider.’¹³⁵ The scope of self-care includes health promotion; disease prevention and control; self-medication, providing care to dependent persons; seeking hospital/specialist care if necessary; and rehabilitation including palliative care.

The ISF has developed a framework for self-care that is organised around seven ‘pillars’ or ‘domains’.¹³⁶ The ISF definition aims to build on the SCF, WHO and other definitions with the aim of providing a practical description of the all the elements positioned from the individual’s point of view. This report utilises the ISF definition from a men’s health perspective.

Self-care is the most dominant form of primary care in all countries and virtually all individuals and communities engage in some type of self-care.¹³⁷ Improving self-care is increasingly seen by public health advocates as an essential and sustainable intervention that should be facilitated by governments and healthcare providers.



Gender and self-care

Gender has been largely absent from discussions about self-care. The WHO's handbook on self-care for community workers and volunteers includes the word 'gender' only once.³⁸ A major report on the state of self-care in Australia by the Australian Health Policy Collaboration does not mention gender or men even once.³⁹ A King's Fund report on people's involvement in their own health and healthcare in the UK omits any consideration of gender issues.⁴⁰

Few studies of self-care practices by people with specific health problems have looked at the impact of gender norms.⁴¹ The American Heart Association's scientific statement on self-care for the prevention and management of cardiovascular disease takes no account of gender⁴² nor does the Diabetes Canada Expert Committee's clinical practice guidelines on self-management education and support.⁴³

How gender norms act as barrier to effective self-care and why they must be addressed at the policy and practice levels is very clearly set out in a White Ribbon Alliance report on women, children and self-care in the global context.⁴⁴ The impact of gender norms on men's health practices specifically is well-known and relatively well-researched.⁴⁵ The direct connections between male gender norms and risky health practices are highlighted in a new report from Promundo which states that: 'Men's health is shaped by a specific set of masculine norms that encourage certain attitudes and behaviors, particularly risk-taking, aggression and limited self-care, among others.'⁴⁶

A recent paper in the WHO Bulletin stated:

Sociocultural norms and related patterns of behaviours differ according to gender. These can affect health behaviours in different ways for a variety of conditions. There is growing recognition of the roles in risk-taking played by sociocultural norms and related qualities and patterns of behaviours traditionally associated with being a man (referred to as masculinity). The behaviours include avoiding condom use, greater use of harmful substances and lower rates of seeking testing and treatment for HIV. ... Gender is also associated with responses to symptoms and signs of illness. Studies have shown that women are more likely to seek health care than men do, even after adjusting for reproductive health consultations.⁴⁷

Self-care for men cannot be improved effectively without taking account of gender norms.

The benefits of improved men's self-care

Better health and wellbeing for men

The impact of male health practices is very clear. About one third of the excess male mortality at ages 50–70 in developed countries since 1880 is attributable to smoking alone.⁴⁸ Around half of the sex difference in all-

cause mortality in Europe is due to smoking and around one fifth is due to alcohol consumption.⁴⁹ About a fifth of male deaths in Austria from circulatory diseases and cancer are thought to be potentially preventable by changes to health practices.⁵⁰ Globally, about 45% of male deaths are due to health practices, according to Institute for Health Metrics and Evaluation data.⁵¹ Better self-care by men would therefore lead to directly to improved mortality and morbidity outcomes.

Achieving the United Nations' Sustainable Development Goals

The UN's SDG 3 on health and well-being contains important commitments to reducing by one third premature mortality from NCDs, promoting mental health and well-being and strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and the harmful use of alcohol.

WHO data shows that, globally in 2016, 52% of all deaths from NCDs were male.⁵² Of the major NCD killers, the biggest sex differences in deaths were in digestive disorders (59% of male deaths, 41% of female), cancer (57% male, 43% female) and respiratory disorders (54% male, 46% female). The difference in cardiovascular disease deaths was smaller (51% male, 49% female). Men are also more likely to die prematurely from NCDs: men accounted for 58% of all the years of life lost in people who died before they reached the age of 70.⁵³

Men are also much more likely to die as a result of suicide and to misuse alcohol and narcotic drugs (data on these issues can be found below.)

Improved health and wellbeing for women and children

Better men's health has the potential to improve that of their female partners and children. This is most obvious in the area of sexual and reproductive health where safer sex practices by men would clearly prevent the transmission, in both directions, of a wide range of infections and their consequences. Greater male involvement in contraception would also help to reduce the number of unplanned pregnancies.

High morbidity and mortality rates in men impact on women in another way, especially in lower-income households and countries: the loss or incapacity of the primary breadwinner, frequently a man, can have a hugely detrimental effect on partners and children.⁵⁴ They may have to take on caring responsibilities, limiting employment and educational opportunities and reducing current and future income. The cost of medicines can also have a huge impact on family resources.

In many families, especially in the Global South, men are the main decision-makers about issues affecting health,⁵⁵ such as the purchase of food and medicines, opportunities to attend health services, educational and employment opportunities, or contraceptive use. Men who are better informed about health issues are more likely to make choices for themselves and their families that lead to improved health outcomes.

Addressing men's mental health issues, including alcohol and drug misuse, could contribute to a reduction in male violence against women, children and other men. A WHO report suggested that, in the USA and in

England and Wales, victims of domestic violence believed their partners to have been drinking prior to a physical assault in 55% and 32% of cases respectively.⁵⁶ In Australia, 36% of intimate partner homicide offenders were under the influence of alcohol at the time of the incident while in South Africa, 65% of women experiencing spousal abuse within the last 12 months reported that their partner always or sometimes used alcohol before the assault.

Reduced costs for health systems

Globally, the vast majority of tobacco smokers are male by a ratio of about 4:1.⁵⁷ WHO projections suggest this ratio could increase to 5:1 by 2025. The economic burden of tobacco use is therefore overwhelmingly due to men's smoking practices. The amount of healthcare expenditure due to smoking-attributable diseases alone totalled USD 422 billion in 2012, equivalent to 6% of global health expenditure.⁵⁸ The total economic cost of smoking (from health expenditure and productivity losses together) totalled USD 1,436 billion, equivalent in magnitude to 2% of the world's annual gross domestic product. Almost 40% of this cost occurred in developing countries. It is therefore clear that reductions in male smoking rates would be economically beneficial. Because the health burden of alcohol falls disproportionately on men,⁵⁹ there would be further significant savings if their alcohol consumption was also reduced.

Middle-aged Canadian males are more likely to smoke tobacco (26% v. 20%), consume hazardous or harmful levels of alcohol (15% v. 8%), and have excess weight (66% v. 47%) than middle-aged Canadian females, resulting in an annual economic burden that is 27% higher in males than females.⁶⁰ If the prevalence of these risk factors was reduced modestly in males - a 1% reduction in the difference between men and women each year between 2013 and 2036 - there would be a cumulative cost saving of CAD 51 billion. A separate analysis suggests that men's premature mortality and morbidity costs the US economy approximately USD 479 billion annually.⁶¹

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THE SEVEN PILLARS OF SELF-CARE AND MEN



The Seven Pillars of self-care and men

This section examines men's problematic health practices in relation to each of the ISF's Seven Pillars of Self-care. Wherever possible global statistics have been used with specific examples from individual countries. Because this section aims to provide an overview of the key issues rather than a detailed analysis, the data has mostly not been broken down by age, socio-economic status, sexuality, ethnicity and other specific demographic groups.

1. Knowledge and health literacy

Health literacy is a complex and evolving concept but, broadly, it means more than simply being able to read pamphlets, make medical appointments, understand food labels or follow a doctor's advice.⁶² Rather, it refers to the ability of individuals to gain access to, understand and use information in ways which promote and maintain good health for themselves, their families and their communities.

Men's health literacy is an under-researched field.⁶³ Some of the research that has looked at gender and health literacy has not found any significant differences between the sexes. But there are also studies which very clearly suggest that men have lower levels of health literacy than women.

Men generally have lower health literacy levels than women. A study of British adults found that men were twice as likely as women to have limited health literacy.⁶⁴ A separate analysis of the characteristics of people in London (UK) with coronary heart disease found that those with low health literacy levels were more likely to be male.⁶⁵

In the USA, women have been found to have higher average health literacy than men: 16% of men had 'below basic' health literacy compared with 12% of women.⁶⁶ Another American study concluded that almost half (48%) of men had poor health literacy compared to 39% of women.⁶⁷ Lower levels of health literacy in men have also been reported for mental health issues specifically⁶⁸ and there is evidence that women have higher health literacy levels than men in regard to male depression.⁶⁹ When asked to identify whether a series of symptoms of depression in men were true or false, women were more likely than men to select the correct answer.

Research into gender and health literacy in South Korea found that women had a significantly higher level of health literacy than men in three specific areas: (a) understanding and filling out medical forms (39% of females v 30% of males), (b) understanding directions on medication bottles (47% of females v 41% of males), and (c) understanding written information provided by health care professionals (53% of females v

40% of males).⁷⁰ The authors conclude that 'the importance of gender differences in health literacy ... suggests gender-specific intervention may be warranted to reduce the existing gap in health literacy in both Korean men and women.'

Low health literacy levels are a barrier to active information-seeking by men⁷¹ who are less likely to seek out health information than women. Studies usually find that women are more likely to look for health information by a margin of 10-20%.⁷² Women are 50% more likely than men to look for health information on the Internet in Germany.⁷³ Young French women (aged 15-30) were 80% more likely to use the internet for health purposes compared to men with similar patterns evident in Saudi Arabia, Brazil and Japan.⁷⁴ Men are also more likely to engage in 'passive' information-gathering (i.e. relying on chance encounters and other individuals to provide unsolicited information) whereas women are more likely to be 'active' information gatherers (i.e. actively and with purpose seeking out information regarding a specific issue).⁷⁵

Men also tend to have lower levels of knowledge of specific health issues. For example, they have lower levels of awareness of hypertension⁷⁶ and are less able to provide an accurate estimate of the alcohol drinking guideline for their own sex.⁷⁷ A study of weight, diet, physical activity and nutritional knowledge among university students in the USA found that men were less likely to be knowledgeable about nutrition as well as more likely to be overweight or obese, more likely to consume red meat, fast food, sugar-sweetened beverages, wine and beer.⁷⁸ Gender differences in knowledge about dietary recommendations and the health benefits of fruit and vegetables explain the largest part of the difference in consumption frequency between men and women.⁷⁹ Men in Greenland are much less likely to be able to name one symptom of diabetes than women (43% v 58%) or one complication (38% v 56%).⁸⁰

A low level of cancer awareness or knowledge has been linked to delayed help-seeking for cancer symptoms by men.⁸¹ Women were more likely than men to recognise a range of common cancer symptoms, according to a study in England.⁸² The largest gender difference was found to be for recognition of 'change in the appearance of a mole': the odds of recognising this symptom were 60% higher in women than men. In Uganda, research found that under half (46%) of men had heard of prostate cancer and only 10% had a good knowledge of the symptoms.⁸³ Awareness appears to be even lower in rural Zimbabwe: here, according to one study, only 21% of men had heard of prostate cancer and just 1% were aware that frequent urination was a symptom.⁸⁴

Men are less likely to 'know their numbers' in relation to blood pressure, cholesterol and body mass index and are also less likely to take up opportunities for health screening. In the USA, for example, men have been found to be much less likely than women to have a blood pressure, cholesterol or dental check.⁸⁵ Whereas 32% of hypertensive young women in the USA are aware of their hypertension, just 25% of hypertensive young men are aware.⁸⁶ There are similar findings for elderly men and women in Iran.⁸⁷ Overweight and obese men (with a BMI of 35 or less) in the USA have been found to have higher levels of weight misperception than equivalent women.⁸⁸ Men with diabetes in Bangladesh are less likely than

women to know they have the condition and less likely to be receiving treatment.⁸⁹

Men in many countries are less aware of their HIV status, according to UNAIDS. In Malawi, for example, men living with HIV are 12% less likely to be aware of their status and 20% less likely to be virally suppressed than women living with HIV. In Kazakhstan and Niger, knowledge of HIV status among men living with HIV is a third lower than it is among women living with HIV, and viral suppression among men is half that of women. Across sub-Saharan Africa, men and boys living with HIV are 20% less likely than women and girls living with HIV to know their HIV status, and 27% less likely to be accessing treatment.⁹⁰

2. Mental wellbeing, self-awareness and agency

ISF defines self-awareness as ‘the personal, practical application of an individual’s health knowledge to their own health situation; in other words, health literacy combined with the internalization of knowledge.’⁹¹ Agency is described ‘as the capacity and the intention of an individual to take action based on their knowledge and awareness of their particular situation and condition – physical and mental.’

This section of the report focuses on mental wellbeing; evidence relating to self-awareness and agency is presented elsewhere.

Sex and gender differences in mental health are under-researched.⁹² However, it does seem clear that common mental health problems such as depression and anxiety exist at a higher level in men than can be assumed from the diagnostic data. The Royal College of Psychiatrists in the UK has suggested that the incidence of depression in men is probably the same as for women⁹³ but because men are less likely to contact health services for mental health problems and, because many men present their mental and emotional distress differently from women, the diagnosis is often missed.⁹⁴ A large survey of 16-64 year olds in an English county found that men with symptoms of a common mental disorder were 34% less likely than women to have sought some form of help.⁹⁵

Men are more likely to kill themselves than women. Globally, the suicide rate for men in 2016 was 14 per 100,000 compared to 8 per 100,000 for women.⁹⁶ The highest rate for men was in Europe at 25 per 100,000 compared to 7 per 100,000 for women.

Men are more likely than women to drink alcohol at risky levels or use illegal drugs and this, at least in part, may be an attempt to cope with mental health problems.⁹⁷ (Alcohol and drug use in men is covered in more detail below.) Men are also more likely to be at-risk or problem gamblers⁹⁸ or to report an addiction to pornography.⁹⁹ There is evidence that men are more likely to be affected by so-called ‘workaholism’.¹⁰⁰

Body image disorders are increasing in men. A British study found that most men were dissatisfied with their muscularity: about two-thirds considered that their arms and chests were not muscular enough. 17% of men had a definite fear that they might gain weight and 32% reported

that they had 'exercised in a driven or compulsive way' as a means of controlling weight.¹⁰¹ Up to 25% of those showing signs of an eating disorder are male¹⁰² and there is evidence that increasing numbers of men are misusing anabolic steroids in order to increase their muscularity.¹⁰³ Gay men are more likely to experience body image disorders than heterosexual men.¹⁰⁴

The prevalence of fathers' depression and anxiety in the perinatal period (i.e. from conception to one year after birth) is approximately 5-10% and 5-15% respectively.¹⁰⁵ This can impact on children's emotional and behavioural outcomes and also on maternal mental health. However, many fathers feel reluctant or unable to express their support needs or to seek help. They often prioritise their partner's needs, question the legitimacy of their experiences and feel excluded by services.

3. Physical activity

Too many men are physically inactive. Although men are generally more likely to be physically active than women, a significant proportion, about a quarter (23%), are deemed to be insufficiently active.¹⁰⁶ Inactivity levels in men are highest in the high-income countries (32%) and lowest in the low-income countries (13%). Men in Kuwait are the most inactive (67%) and men in Uganda are the least inactive (6%).

4. Healthy eating

Men generally have less healthy diets than women. Fruits, vegetables, nuts/seeds and whole grains were, on average, less heavily consumed by men than women globally in 2010.¹⁰⁷ Men consumed 73g of fruit a day, for example, while women consumed 90g. The comparable figures for vegetables were 200g and 218g. Men also ate more meat: 44g of unprocessed red meat (40g for women) and 15g of processed meat (13g for women). Men are also more likely than women to have a diet that is high in salt.¹⁰⁸

Men in Brazil are significantly more likely than women to eat fruit or vegetables on fewer than four days a week and to consume soft drinks and artificial juices on four or more days a week.¹⁰⁹ In Turkey, 81% of men have been assessed as having a 'poor' diet compared to 64% of women.¹¹⁰ In the USA, men are more likely to eat fast food - 38% of men compared to 35% of women ate it on a given day.¹¹¹ Amongst men, the most frequent consumers were non-Hispanic black men (42%).

5. Risk avoidance or mitigation

Men are generally less likely to have practices that avoid risks to their health. Adult men are still more than five times more likely to smoke than adult women.¹¹² Over 15 countries have an age-standardised male prevalence rate of 50% or more for tobacco smoking with the highest rate (78%) in Timor Leste. Gay and bisexual men are more likely to smoke than heterosexual men.¹¹³

Globally in 2016, around 39% of adult men drank alcohol compared to a quarter of women (25%).¹¹⁴ On average, men consumed just under two 'standard drinks' a day, well over twice the amount consumed by women. (One standard drink is equivalent to 10g of pure alcohol.)

Men are three times more likely than women to use cannabis, cocaine or amphetamines.¹¹⁵ 80% of those who inject non-prescribed drugs are male.¹¹⁶

Safe sun measures – such as using sunscreen, wearing sunglasses, and seeking shade – are more commonly taken by women than men. Men in Austria, for example, are 60% more likely to take risks with sun exposure.¹¹⁷

Many men take significant risks with their sexual health and, consequently, put their sexual partners at risk too. Men generally have more sexual partners than women, are more likely to acquire a STI, and are more reluctant to practice safer sex, especially condom use. Less than 60% of adult men in 13 low- and middle-income countries said they used a condom at last sex with a non-regular partner.¹¹⁸ The proportion of sexually active men aged 15–59 years who have had more than one sexual partner or who have paid for sex in the past year ranges from 2% in Niger to 39% in Gabon, and averages 19% across 37 countries in sub-Saharan Africa, Asia, Latin America and the Caribbean. Although most heterosexual men using an online dating service in Australia used some sort of contraception when they last had intercourse, only 35% used a condom.¹¹⁹

Men often combine several unhealthy practices. A study of men in London (UK) found that about three quarters (72%) of men presented with combinations of risk factors.¹²⁰ Physical inactivity combined with a lack of fruit and vegetables was the most common combination. Co-occurrence was more prominent for unemployed, widowed, divorced/separated and white British men. There have been similar findings for men in Brazil who are over twice as likely as women to have multiple risk factors.¹²¹ In Turkey, about half of men aged 18-69 have three or more concurrent NCD risk factors.¹²²

There is no significant difference in overall immunisation coverage for boys and girls.¹²³ In some countries and communities, boys are privileged over girls; in others, the opposite is true and girls have greater access to vaccines than boys. The low status of women in many societies can reduce the chances of both boys and girls being vaccinated by preventing access to immunisation services. In most countries that provide the human papillomavirus (HPV) vaccine, however, boys have been excluded from vaccination programmes even though this can prevent cancers (anal, head, neck and penile) as well as anogenital warts in men.¹²⁴

6. Good hygiene

Men are more likely to take less care of lower their personal hygiene in part because there are fewer cultural pressures on men than women to adhere to high standards.¹²⁵

Men are less likely than women to wash their hands after using the toilet.¹²⁶ A study of the handwashing practices of college students using restrooms in the USA found that 76% of women washed their hands compared to 57% of men and that 56% of women used soap compared to 29% of men.¹²⁷ Male students in Ghana are less likely to wash their hands after defaecation; of those who did wash their hands, men were less likely to use soap or to wash both hands.¹²⁸ 22% of British men do not always wash their hands after defaecating at home compared to 17% of women.¹²⁹

Men are also more likely to consume food at risk of contamination with live pathogens, such as undercooked hamburgers, raw oysters and runny eggs¹³⁰, and to have poorer oral health practices (e.g. regular toothbrushing).¹³¹ A study of the toothbrushing habits of 11-15 year olds across 20 countries found that girls were twice as likely as boys to brush more than once a day.¹³²

7. Rational and responsible use of products, services, diagnostics and medicines

Men generally under-use health services, particularly primary care services. Studies from around the world – including Australia¹³³, Malaysia¹³⁴, Malawi¹³⁵, Suriname¹³⁶, UK¹³⁷, North America¹³⁸ and the European Union¹³⁹ – show that men are less likely to seek help from primary healthcare services than women. Men are particularly reluctant to seek help for mental health problems.¹⁴⁰ Men are more likely to miss general practice appointments they have already made.¹⁴¹

Men who smoke are less likely than non-smokers to consult a GP and men who drink alcohol at harmful levels are less likely to have a regular health check.¹⁴² Men in Brazil generally avoid healthcare because help-seeking is seen as 'weak'; when services are used, it is primarily to deal with pain.¹⁴³

Men in Ireland are much less likely than women to visit a community pharmacy (75% of women do so each month compared to 45% of men) but, more significantly, fewer men (51% v 60%) state that they would be happy to talk to a pharmacist about a personal matter even in a private consultation area.¹⁴⁴ A similar study in the UK found that three quarters (76%) of women compared to two thirds (63%) of men had visited a pharmacy to obtain medicine or ask for advice in the previous month.¹⁴⁵

Men in the UK are less likely to participate in free health checks designed to detect undiagnosed cardiovascular disease and diabetes or the risk factors for these conditions.¹⁴⁶ Men are also less likely to have an eye health check.¹⁴⁷ Despite being at greater risk of bowel cancer, men are less likely to take part in screening programmes. One international

review of 15 programmes in 12 countries found that women had higher participation rates in 14 programmes.¹⁴⁸ The sex difference was greatest in Finland, with a 75% participation rate among women compared to 60% among men.

There is evidence that the factors associated with delays in help-seeking by men include uncertainties about which service is most suitable or their particular symptoms.¹⁴⁹ Men can also be deterred by the unavailability of primary care services at convenient times.¹⁵⁰

When men do access primary care services, there is evidence that consultation times are shorter than for women.¹⁵¹ Infrequent use of and late presentation to health services have been associated with men experiencing higher levels of potentially preventable health problems and having reduced treatment options possibly resulting in higher hospitalisation rates.¹⁵² It seems that men are not less likely than women to follow medical advice, however.¹⁵³

Men's use of self-management support interventions for long-term conditions is sub-optimal and they are believed to be poorer self-managers than women despite having an increased incidence of many of the most serious and disabling long-term conditions.¹⁵⁴

The extent to which men are missing from services is highlighted by an analysis of men with raised blood pressure in several eastern European countries. Only between 8% and 35% of men with raised blood pressure, including those previously diagnosed, receive antihypertensive treatment. The proportion of men with controlled blood pressure is even lower, however, ranging between 2% and 19%.¹⁵⁵

Almost one in five adults in Europe is estimated to have purchased medicines online¹⁵⁶ and much of this trade is illicit with no guarantee that the products are either genuine or safe. Men are more likely to search online for drugs that will tackle sexual dysfunctions or increase sexual pleasure and that accelerate body-building while women are more likely to seek weight loss drugs.

A survey of 1,000 men in the USA with erectile dysfunction found that more than 4 in 5 men (82 percent) believe it is difficult to determine if an online pharmacy is legitimate, yet more than 1 in 3 (36 percent) would consider purchasing drug treatments based on an online search.¹⁵⁷

As well as concerns about the safety of the products, for some conditions self-medication of this kind can lead to a delayed diagnosis by a health professional with potentially serious consequences. It is well-established, for example, that erectile dysfunction is a symptom of underlying cardiovascular disease or diabetes and can predict the onset of a cardiac event.¹⁵⁸

WHO SELF-CARES WINS

THE BARRIERS TO IMPROVING MEN'S SELF-CARE



The barriers to improving men's self care

Gender norms

The influence of gender norms on lifestyle practices cannot be underestimated. A comprehensive review of the social determinants of health across Europe stated:

Differences in health outcomes between men and women are connected with issues related to sex (the biological and physiological characteristics that differentiate men and women) and gender (socially constructed roles and behaviours of men and women based on norms and values of a particular society).

Men's poorer survival rates ... reflect several factors – greater levels of occupational exposure to physical and chemical hazards, risk behaviours associated with male lifestyles, health behaviour paradigms related to masculinity and the fact that men are less likely to visit a doctor when they are ill and are less likely to report on the symptoms of disease or illness.¹⁵⁹

Although gender norms vary between societies and cultures, most have some common denominators when it comes to specific norms for men and women.¹⁶⁰ The 'Man Box' is a useful concept that refers to a set of beliefs, communicated by parents, families, the media, peers, and other members of society, that put pressure on men to behave in a certain way.¹⁶¹ Men are expected to be self-sufficient, to act tough, to be physically attractive, to stick to rigid gender roles, to be heterosexual, to have sexual prowess, and to use aggression to resolve conflicts. These socially-reinforced rules about what 'real men' should do remain largely in place despite many of the changes in men's and women's lives over the past 50 years.

The Global Early Adolescent Study, which covers 15 countries of widely varying levels of development, found that the gender norms boys learn in early adolescence – particularly the emphasis on physical strength and independence – make them more likely to be the victims of physical violence and more prone to tobacco and other substance abuse, as well as homicide.¹⁶² Social stigmatisation and ridicule by their peers is a significant barrier faced by boys who attempt to challenge gender norms.¹⁶³

Men express a widespread reluctance to seek help for health problems because it is seen as challenging to conventional notions of masculinity.¹⁶⁴ This is the case even for older men with serious health problems.¹⁶⁵ The psychological barriers linked to gender norms that inhibit men include their need for independence and control, embarrassment and 'restricted emotional expression'.¹⁶⁶ Many men endure pain and downplay

symptoms in order to adhere to masculine norms. One study, looking at psychological help-seeking, found that the gender gap in help-seeking attitudes is entirely due to masculinity beliefs.¹⁶⁷ In Uganda, men's view that reproductive health is 'women's business' has been identified as a barrier to their involvement in contraceptive uptake and using family planning services.¹⁶⁸

Men are often mocked for displaying signs of weakness; for example, men with a viral respiratory illness may be described as suffering from 'Man Flu', a term that implies they are essentially attention-seeking malingerers even though there is evidence that men have higher rates of influenza-associated deaths compared with women in the same age groups, regardless of underlying disease.¹⁶⁹ In fact, men may not be exaggerating symptoms at all but have weaker immune responses to respiratory viruses, leading to greater morbidity and mortality than seen in women.

Health-promoting masculinity

Masculinity tends to be viewed one-dimensionally as a monolithic and almost entirely negative (or even 'toxic') social construct. But not all the traits of traditional masculinity are implicated in risky health practices. The specific masculine norms of self-reliance, power over women, and being a 'playboy' are linked to poor mental health-related outcomes, for example, but conformity with the masculine norm of primacy of work is not significantly related to any mental health-related outcome.¹⁷⁰

There are aspects of masculinity that can be considered socially valuable – such as the courage of firefighters or military personnel – and some that are actually health-promoting. Many men's interest in fitness and physical activity can be beneficial to their health, for example, and there is evidence that once men decide to change a lifestyle practice – such as smoking or losing weight – they are more likely to succeed than women.^{171, 172} Men's sense of responsibility as fathers can also impact positively on their health practices.¹⁷³

There are also some risky men's health practices that may also have beneficial aspects. A study of men in Scotland found that meeting together in pubs to drink beer provided men with friendship and social support that was important for mental wellbeing.¹⁷⁴

In some cultures, male gender norms do not appear to prevent men seeking healthcare. Igbo men in south eastern Nigeria, for example, are expected to be strong, tough, independent, firm and decisive but they are nevertheless willing seek healthcare when they are ill.¹⁷⁵ Young men in Senegal with 'traditional' masculine attitudes look after their health in part because their religious beliefs take precedence and because they consider a healthy man to be better-placed to meet his family responsibilities.¹⁷⁶

Not all men follow gender norms rigidly, of course. An increasing number do not follow some, many or all of them. There is also evidence that masculinity may be changing in ways that will ultimately be beneficial to men's health. It is well-established, for

example, that many more men are now active and involved parents,¹⁷⁷ a trend that defies traditional male norms. There is evidence that, in many western countries, young men are less homophobic¹⁷⁸ and increasingly open to sexual contact with other men even if they continue to define themselves as heterosexual.¹⁷⁹

Male gender norms tend to make it harder for men to practice better self-care even if they want to and those men who most closely identify with 'traditional' masculinity are more likely to exhibit damaging lifestyle practices.¹⁸⁰ Men who conform strongly to masculine norms also tend to have poorer mental health and less favourable attitudes towards seeking psychological help.¹⁸¹ A study across 51 countries around the world has suggested that the more patriarchal a society is, the worse the health outcomes for men.¹⁸² It has also been shown that, in the USA specifically, gender inequities at state level are significantly associated with male mortality.¹⁸³

A study of men in Russia suggested that heavy drinking of strong spirits 'elevates or maintains a man's status in working-class social groups by facilitating access to power associated with the hegemonic ideal of the real working man'.¹⁸⁴ In rural India, men's use of tobacco is closely linked to their perception that a 'real man' should be daring, courageous and confident and able to demonstrate his manliness by smoking.¹⁸⁵

Heterosexual men in the Dominican Republic who were most concerned to demonstrate masculine characteristics were significantly more likely to have had two or more sex partners in the past 30 days and to have never or inconsistently used condoms with non-steady partners.¹⁸⁶

Young men in Australia who conform most closely with the norms of the Man Box are significantly more likely to engage in regular binge drinking and to have been involved in traffic accidents than young men who do not conform with those norms.¹⁸⁷ Nearly 40% of young men 'inside' the Man Box reported being involved in a traffic accident in the past year compared to just over one in 10 young men who were 'outside' the Man Box. Almost one in three young men 'inside' report getting drunk at least once a month compared to about one in five 'outside'.

Gender norms impact on food choices. Energy dense, spicy and strong foods are perceived as 'masculine' while soft and sweet foods such as dairy products and fruits are perceived as 'female'.¹⁸⁸ Meat, especially red meat, has been described as 'an archetypical masculine food'.¹⁸⁹ A study of attitudes about beef in four countries (Argentina, Brazil, France, and the USA) where it is a 'central food' found that men generally liked and desired beef more than women and held more positive attitudes towards its consumption.¹⁹⁰ Men in the USA who more strongly identify with hegemonic masculine norms have been found to be more strongly attached to eating meat and less willing to give it up.¹⁹¹

The negative impact of male gender role norms is reinforced by the impact of socio-economic disadvantage: in the UK, for example, health inequalities are greater between groups of men ranked by deprivation than between similarly ranked groups of women.¹⁹²

Ethnic minority men can also be deterred from help-seeking by racism

and distrust of the medical establishment as well as gender norms.¹⁹³ Gay men can be deterred by experiences of homophobia from healthcare services.¹⁹⁴ Discrimination can also be a barrier to ex-prisoners, most of whom are male, seeking to access primary care services.¹⁹⁵

Escaping the Man Box

Individual men who live within the 'Man Box' cannot easily break out by an act of will. The social and cultural norms of masculinity with which men have grown up impact on health in similar ways to other social determinants of health such as social class and ethnicity. It has been suggested that gender socialisation actually places heavier constraints on males than females.¹⁹⁶

This means that while it is clearly the responsibility of individual men to take care of their own health, strategies to improve men's health cannot simply be based on attempts to exhort them to change their lifestyle practices.¹⁹⁷ Those with least access to the financial and social resources that could enable them to play a more active role in their own health will find it hardest to make changes. A multi-dimensional and structural approach – which takes account of male gender norms, professional practice, the way health services are delivered and wider issues such as employment, education, housing and transport – is much more likely to be effective.

Lack of a policy focus on men

There has been a marked lack of interest in men's health by the world's most influential global health institutions. An analysis of the policies and programmes of 11 such organisations, including WHO, found that they did not address the health needs of men.¹⁹⁸ A complementary study of 18 Global Public Private Partnerships for Health (e.g. GAVI, Global Road Safety Partnership and TB Alliance) came to similar conclusions.¹⁹⁹ An assessment of the World Bank's gender policies and its financing for gender programmes in the context of global health found that it had given little emphasis to the needs of males.²⁰⁰

A study by the Global Health 50/50 initiative, based at the University College London Centre for Gender and Global Health, looked at the gender-related policies of 140 major organisations working in and/or influencing the field of global health.²⁰¹ Its analysis showed that:

- Only 40% of organisations mention gender in their programme and strategy documents
- Most organisations (66%) do not define gender in their institutional policies
- Just 31% define gender in a manner that 'is consistent with global norms' (i.e. a focus on men as well as women and also on the structures and systems that determine gender roles and relationships)

- Only 55% of organisations state a commitment to gender equality in their strategies or policies
- 34% state a commitment to gender equality to benefit all people (women and men)
- 21% state a commitment to gender equality to benefit women and girls exclusively
- 65% of organisations do not disaggregate their programme data by sex

The report argued that ‘many global health organisations still operate with a narrow view of gender and its relationship to health It is important to again emphasise that the concept of gender is not interchangeable with women A focus on the health of women forms part of and is complementary to, but not synonymous with, the promotion of gender equality in health.’

The UN’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) overlooks boys²⁰² and world leaders at the 2016 G7 Ise-Shima Summit in Japan made important commitments to improving women’s health but did not mention men, or how they could be engaged to support improvements in women’s health.²⁰³ The WHO’s Global Action Plan, published in 2018, has also been criticised for equating gender equality with a women’s empowerment agenda, and paying scant, if any, attention to what gender means to health outcomes across the whole of society.²⁰⁴

The European Commission published a major report on the state of men’s health in 2011²⁰⁵ but it did not include any recommendations for action and has not yet led to any observable changes in policy. The European Commission’s Strategic Plan 2016-2020 for Health and Food Safety²⁰⁶ does not mention gender inequalities nor does the section on cross-cutting policy in the EC’s State of Health in the EU Companion Report 2017.²⁰⁷

A report by the European Parliament’s Committee on Women’s Rights and Gender on promoting gender equality in mental health and clinical research, published in 2016, largely overlooks men and boys and adopts a definition of gender that effectively includes only women and girls.²⁰⁸ The recent WHO Independent High-Level Commission report on non-communicable diseases makes only the briefest mention of gender and does not address the burden of NCDs on men.²⁰⁹

The omission of men from the agendas of international health organisations is mirrored at the national level. Only three countries – Australia, Brazil and Ireland – are known to have published national men’s health policies. While all three policies have had a positive impact, they have also been criticised for a range of problems pertaining to governance, implementation and monitoring as well as a lack of resources.²¹⁰ Governments in some other countries – including Canada, Denmark and the UK – have funded men’s health organisations and projects but not adopted a systematic approach.

Few health services are designed with men in mind

The policy vacuum around men's health has meant that relatively few services are actually targeted at men or delivered in a way that meets men's needs. During an outbreak of yellow fever in Angola in 2016, 70% of confirmed cases were in men but low numbers were being vaccinated.²¹¹ An analysis found that the vaccination campaign was not well adapted to their needs: men were unable to access the clinics during working hours, many believed the vaccine itself to be dangerous, they were deterred by long waits when they did attend clinics and they did not know where to get vaccinated. Vaccination uptake in men only increased once male-targeted marketing was introduced, including commercials with famous football players, and vaccination was made available after working hours and at weekends.

Men often find conventional primary care services difficult to access.²¹² Booking systems can be hard to use and appointments may not be available at convenient times, often because of work commitments.²¹³ The increasing number of men working in the insecure 'precariat' sector of the economy may well find it even harder to take time off work for medical appointments. In some countries, healthcare has to be paid for and there may also be a loss of income for the time taken off work. In these circumstances, many men subordinate health care because of the pressure of their role as a provider for their families.

About 70% of men in Australia say they delay or avoid visiting a doctor or other health professional to address their health concerns at least some of the time but that they would be more likely to attend a dedicated men's health service.²¹⁴ Of those men aged under 65 years who report delay or avoidance, the most common reasons for doing so were that they assumed the problem will fix itself, they waited until symptoms affected their capacity to work or function, they were too busy with other priorities and they considered it more important to look after their loved ones.

A study of Aboriginal and Torres Strait Islanders specifically found that feelings of invincibility, shame, being uncomfortable, fearful, along with long waiting times, having a lack of knowledge, and culturally inappropriate staff/services were barriers to service utilization.²¹⁵ Enabling factors included convenience, the perceived quality of the service, feeling culturally safe and/or a sense of belonging, and having a rapport with staff. Many men in the study supported the idea of gender-specific services and/or times when a clinic is opened for men only and is staffed by men.

There has been a marked lack of professional training on men's health. Sex and gender in general are not adequately included in pre- or post-qualification programmes in the health field. Medical education generally confines itself to specific sex-based reproductive function disorders, such as pregnancy, infertility, birth control, menstrual disorders, and prostate problems when it deals with differences between men and women.²¹⁶ No or only very limited attention is paid to the similarities and differences between the sexes and genders in the etiology, risk factors, prevention, presentation, and response to treatment for all health conditions.²¹⁷

Where gender is discussed, it is often assumed to be relevant to women's health alone.²¹⁸

A review of Brazil's national men's health policy emphasised the importance of professional training.²¹⁹ It called for the implementation of 'trainings, trainings and more trainings' to help challenge institutional cultures and health workers' own gender norms and stereotypes, such as categorising men as either 'uncooperative' or 'victims' of their own masculinities, or as 'instruments' to improve the health and wellbeing of women and children.

The general absence of professional training is reinforced by the lack of attention to sex and gender, and men's health specifically, in high-ranking medical and health journals.²²⁰ The Lancet has acknowledged that it does not require the research it publishes to include sex-disaggregated data.²²¹

Over half (58%) of respondents to GAMH's survey of professionals working in men's health believed that, in the fields with which they were familiar, health organisations' engagement with men and boys was 'poor' or 'very poor'. 14% of respondents thought the engagement was 'good' or 'very good' and just over a quarter (27%) considered it to be 'fair'.

Self-care is not a strategic priority

ISF considers that countries need to institutionalize self-care by incorporating it into the building blocks of public policy.²²² But while some promising self-care policy programmes have been implemented, they have been too few and too isolated. One-off initiatives are not enough to create the fundamental shifts in practice that are required. Self-care is still far from being a health policy priority involving health ministers and policymakers at the national and international levels.

The UK government published a new public health strategy in 2018. Entitled *Prevention is better than cure: Our vision to help you live well for longer*, the 41-page document mentions 'self-care' just once.

It is also still widely-believed that self-care is solely the responsibility of individuals who have a more-or-less equal capacity to do so. This has meant that the people who most need support with self-care are generally not being targeted by existing programmes.²²³ Health practitioners may also lack the time, knowledge and communication skills to inform patients effectively about self-care or paternalistically believe that healthcare is primarily the responsibility of the medical profession.

WHO SELF-CARES WINS

OPPORTUNITIES FOR IMPROVING MEN'S SELF-CARE



Opportunities for improving men's self-care

There have been several recent developments that suggest that there is now a new opportunity to make progress with improvements to men's self-care. It is being increasingly recognised that public health can be more effectively improved if gender differences are taken into account, that gender is not just a women's issue and that there is good evidence about how to address men's health.

The Lancet: Gender and health are also about men and boys

'Attention to the gendered dimensions of health has tended to focus on improving the disadvantages and vulnerability of girls and women. But to fully understand the ways that gender shapes how people live, work, and optimise health, more awareness is needed about the circumstances of men's lives that adversely affect their health. Men consistently experience shorter lifespans, greater threats to health and safety, and less access to health care than women Being gender blind benefits neither men nor women.'²²⁴

Editorial

The Sustainable Development Goals

The SDGs adopted by the UN in 2015, address, among other global concerns, health and well-being for all (Goal 3); gender equality (Goal 5); and the reduction of inequality within and among countries (Goal 10). Goal 3 contains commitments to reducing by one third premature mortality from NCDs, promoting mental health and well-being, strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol, and halving the number of global deaths and injuries from road traffic accidents. The Goal also aims to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and to improve the implementation of the WHO Framework Convention on Tobacco Control. All these commitments, if successfully implemented, would be particularly beneficial to the health of men and boys across the world; equally, they cannot be optimally realized without an approach that takes account of the specific health needs, social contexts and the related health practices of men and boys.²²⁵

The Declaration of Astana on primary care, agreed by world leaders in 2018 in response to the health-related SDGs as well as the goal of Universal Health Coverage (UHC),²²⁶ does not mention 'self-care' by name but does include a commitment to:

promote health literacy and work to satisfy the expectations of individuals and communities for reliable information about health. We will support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care, guided by health professionals. We will protect and promote solidarity, ethics and human rights. We will increase community ownership and contribute to the accountability of the public and private sectors for more people to live healthier lives in enabling and health-conducive environments.²²⁷

WHO Europe

WHO Europe adopted a strategy for men's health for the 53 countries in its region in September 2018.²²⁸ This is the first WHO region to develop a specific strategy for men's health and it was partly inspired by the SDGs. The strategy seeks to transform patterns of care (including self-care, parenting, care of family and unpaid care) and urges member states to prioritize interventions to reduce the disproportionate exposure of boys and men to alcohol and tobacco use, substance abuse and road traffic injuries and to promote healthy eating choices at home, in schools and at work. The strategy is not binding on member states but there is a clear expectation that each will take some steps and it also provides a platform on which civil society organisations can make the case for action. PAHO, the WHO region covering 52 countries in North, Central and South America as well as the Caribbean, is currently also developing a men's health strategy and other WHO regions may now feel encouraged to do so too.

A high-level WHO-Europe meeting in 2017 on non-communicable diseases agreed an Outcomes Statement which contained a commitment to a gender-based response which would take account of both men and women.²²⁹ Member states agreed to 'address the impact of gender norms and roles and the social determinants of health on the differential exposure to risk factors between men and women, on their health-seeking behaviours and on the responses from health-care providers.'

European Commission

The European Commission in 2015 launched a three-year project, GenCAD, which aims to improve the prevention of chronic diseases and patient outcomes through a better understanding of sex and gender differences. Coronary artery disease has been selected as an example.²³⁰ There has also been significant EC investment in two transnational projects on men's health: EuroFIT²³¹ and Step By Step²³².

EuroFIT aims to harness the loyalty that many football fans feel to their club to attract them to a lifestyle change programme delivered by community coaches in the club's stadium. 20 leading football clubs in the UK, Netherlands, Norway and Portugal are involved. Step by Step plans to create a new model of community health service delivery for men who are in poor health or socially isolated. The goal is to improve their physical and mental health as well as their employability. The project is being developed in the UK, France, Belgium and the Netherlands.

UNAIDS

Blind Spot, a report published by UNAIDS for World AIDS Day 2017, showed that men are less likely than women to know their HIV status, less likely to access and adhere to HIV treatment and, as a consequence, more men are likely to die of AIDS-related illnesses.²³³ The report recommended a range of gender-sensitive policy and practice responses, including making health and HIV services more easily accessible and appealing for men and boys, opening clinics outside standard working hours, making HIV services available outside of traditional clinical settings, including at workplaces and places of leisure (including sports activities), and using social media nudges and reminders, including via mobile phone apps and SMS messages, to provide health information and linkages to services. Blind Spot could serve as a blueprint for analyses of a range of global men's health issues.

National men's health policies

National men's health policies have been developed in Australia, Brazil and Ireland. A men's health policy has also been under development in Iran but it is not known whether this has been formally adopted and implemented.²³⁴ In 2017, after a largely positive independent review,²³⁵ the Irish policy was extended for a further five years and explicitly linked to the government's over-arching public health policy, Healthy Ireland.²³⁶ There is also evidence that the Australian and Brazilian policies have had a positive impact^{237, 238} and there is a consensus among men's health organisations that national policies have an important role.²³⁹

An expanding evidence base

A gender-sensitive approach is needed to take account of the gendered nature of human behaviour; gender-neutral interventions will generally be less successful. There is now far more evidence on best practice approaches to tailoring self-care interventions so they more effectively engage men. Much of the evidence has been independently evaluated or published in peer-reviewed journals and is therefore likely to be robust.

Health information for men

Health information aimed at men should ideally be targeted at 'fine-grained' segments of men within different age groups.²⁴⁰ This approach enables greater account to be taken of specific needs and identities. Information should reflect men's existing skills and knowledge, be easy to access, contain clear messages, have engaging content and not use stereotypical images of masculinity that undermine or constrain men's individuality. Information should also be produced by a trusted brand.

The language used in health promotion to engage men is also important. Coca Cola and Pepsi Cola launched Coke Zero and Pepsi Max when they realised that men were reluctant to buy 'Diet'-branded drinks. The same applies to the language used in health promotion. Many men prefer to talk about 'healthy eating' or 'fitness' rather than 'dieting',²⁴¹ for example, or 'stress' rather than 'mental health'.²⁴²

The more knowledge a man has about cancer symptoms, the more likely he is to seek help.²⁴³ Men are more likely to act on information on cancer provided by doctors.²⁴⁴ Cancer risk reduction information that is easy-to-read, uses visual aids and is entertainment-based can also be effective, particularly for men with lower literacy levels.

Men with rheumatoid arthritis prefer practical support with a focus on expanding their knowledge through question-and-answer sessions with medical staff, online information, talks by researchers and symptom management sessions.²⁴⁵

The Men's Health Forum (Great Britain) has pioneered the production of health information for men in the form of [Man Manual](#) booklets which are non-didactic and contain easy-to-read non-medical text and humorous cartoons. They are published and co-branded by Haynes, a publisher of car maintenance manuals which is well-known and trusted by many men.

Written by health experts, the Man Manuals cover a wide range of topics, including specific health problems (eg. diabetes, cancer, stress) as well as general health. Some are aimed at specific groups of men, such as farmers, gay men and transgender men. The booklets can be purchased by men via Amazon or in bulk by organisations. Some companies have commissioned booklets specifically for their male employees. Well over one million Man Manuals have been distributed to date.

The Men's Health Foundation (Stiftung Männergesundheit) in Germany also publishes a range of health information aimed specifically at men. Designed to be compact, comprehensive, easy-to-understand, factual and visually appealing, 25 different leaflets have already been published covering different diseases as well as general health issues such as exercise, nutrition and work-life balance. The leaflets are free and available from the Foundation, doctors' practices and the Ministry of Health's men's health web portal.

Self management programmes

Self-management interventions for men with long-term conditions are less likely to be acceptable to men if they are viewed as incongruous with valued aspects of their identity, particularly when activities are perceived to challenge masculine ideals associated with independence, stoicism and control.²⁴⁶ Men are more likely to find self-management support more attractive when it is seen as being action-oriented, having a clear purpose, and offering personally meaningful information and practical strategies that can be integrated into daily life. Activities that are facilitated by men with a shared illness experience can also be helpful.

[HeadsUpGuys](#) ([headsupguys.org](#)) is a Canadian website which provides free information, practical tips and guidance aimed specifically at men about managing and recovering from depression.²⁴⁷ Developed by a credible provider (the University

of British Columbia) with start-up funding from the Movember Foundation, the site is designed to capitalise on men's desire for independence, autonomy and preference for self-sufficiency while also normalising help-seeking. HeadsUpGuys seeks to position effective self-management as a manly strength.

The site contains a self-check screening tool for depression, practical self-management tips and videos of men telling their stories of recovery. There is also guidance for supporters of men living with depression. Since its launch in 2015, there have been over 600,000 visits to the site and more than 80,000 self-checks have been completed.

TrueNTH is a new global initiative, led by the Movember Foundation, to improve the prostate cancer survivorship experience. Its aim is to support men and their families through all stages of the disease – from diagnosis through to end of life. This novel programme was launched in 2014 in the UK, Australia, New Zealand, the USA and Canada.²⁴⁸ In the UK, the TrueNTH Supported Self-Management initiative, aims to create a new post-treatment care pathway for men able to manage their own care. Men eligible for this new model of care will be given the tools to self-manage and will not receive traditional outpatient follow-up. Patients can decide for themselves if there is a need for a follow-up appointment in clinic.

Once recruited, patients take part in a one-off, four-hour supported self-management introductory course, run by a cancer nurse specialist and a support worker. This aims to provide them with the skills and confidence to self-monitor for symptoms and signs of recurrence, and to manage lifestyle changes. They are also given access to the TrueNTH online portal. The results of their PSA tests are forwarded to the portal so that men can view them at home. Men no longer need to attend face-to-face clinic appointments to discuss normal PSA test results. Patients are asked to complete regular assessments in the form of a 'health MOT checklist', which can be accessed either via the portal or in paper format. The checklist provides a way of identifying any concerns or problems the patient might have in living with prostate cancer.

Sports-based interventions

Sport can provide a hook that engages men by capitalizing on their existing values and interests and making them feel safer around a 'feminised' topic like health.²⁴⁹ There have been many interventions based on soccer, rugby, hockey and other sports that have successfully worked with men on different health issues.

Premier League Health was a national men's health programme delivered by 15 Premier League soccer clubs in England. The independent evaluation showed that it reached men with multiple health practices contributing to chronic conditions who were typically regarded as 'hard to contact or engage' (over one-third of

the participating men reported that they did not consult their GP and over half never engaged with a health advice service).²⁵⁰ Despite having substantial health needs, these participants were unlikely to be exposed to conventional health promotion opportunities made available through these channels. Men taking part in the programme demonstrated significant increases in weekly physical activity and daily consumption of fruit and vegetables and significant decreases in daily sitting time, weekly alcohol consumption and body mass index. The evaluation confirmed that health interventions delivered in professional football clubs have a powerful reach with male supporters, but also with men not engaging with primary care and health information services.

Football Fans in Training (FFIT) in Scotland is another good example of a lifestyle programme – in this case, weight management – which uses soccer to target men specifically. Based at professional football clubs, it has achieved significant participation and resulted in positive outcomes: men who took part in the programme lost almost 5 kg more weight than men in the comparison group.²⁵¹ They also had lower waist size, lower percentage body fat and blood pressure, reported higher levels of physical activity, better diets and felt better about themselves. The FFIT approach is now being used more widely in Europe, branded as EuroFIT²⁵², and also for hockey fans in Canada.²⁵³

Grassroot Soccer uses football to educate and mobilize at-risk young people (male and female) in several sub-Saharan African countries to overcome health challenges and live healthy lives.²⁵⁴ Its SKILLZ curriculum uses football-based activities to encourage healthy habits and equitable gender norms among teenage boys and it assists with referrals to various health services, including sexual and reproductive health services. The programme's outcomes include significant improvements in knowledge of risky practices and in awareness of local resources for support.

Among Grassroot Soccer's activities is a brief, low-cost intervention, Make-The-Cut-Plus, which aims to boost demand for voluntary medical male circumcision among males (aged 14–20 years) in secondary schools in Botswana, Kenya, South Africa, Swaziland, Zambia and Zimbabwe. The project employs a trained, recently circumcised young male coach who leads one-hour football-themed sessions at schools. Afterwards, the coach follows up with participants who expressed an interest in voluntary medical male circumcision and arranges transport to a clinic. A study conducted at 26 schools in Bulawayo, Zimbabwe, found that the intervention more than doubled the likelihood of service uptake.

Workplace interventions

The evidence suggests that men are more likely to participate in health promotion programmes in settings they are familiar with, such as workplaces. Workplace initiatives are also more likely than conventional health services to be easy-to-access for men.

POWERPLAY is a Canadian health promotion initiative aimed at men in blue-collar occupations that aims to be both fun and acceptable. It has healthy eating, physical activity and well-being components and is designed with a competitive theme, so co-workers can form teams and compete against each other. It provides motivational and creative messages, as well as positive incentives, online resources and flexible programme and policy suggestions for employers.

One part of the POWERPLAY programme is known as the 'Northern Circle Route Challenge'.²⁵⁵ Participants are required to accumulate enough steps to walk 'virtually' around Northern British Columbia, a distance of about four million steps or 2,775 km. To assist with this challenge, participants are given a personal pedometer and asked to record their daily step counts. Participants are encouraged to accumulate 10,000 steps per day, a goal which has been associated with indicators of good health. Educational materials are also included and focus on providing participants with tips for being active at work, healthy eating on the go, stress management, making healthy drink choices, and physical activity maintenance.

An evaluation found that POWERPLAY is particularly effective at increasing physical activity levels: on average, participation in weekly vigorous physical activity almost 60 minutes per week and moderate physical activity increased by over 50 minutes per week.²⁵⁶

In Ireland, the **Farmers Have Hearts** programme provides male farmers with health checks at farmers' markets across the country. The aim is to identify men at risk and encourage them to see their GP. An evaluation found that most (82%) of the farmers checked were aware of a family history of heart disease, stroke or diabetes, almost half (46%) had high blood pressure, almost half (46%) had raised total cholesterol levels and almost nine out of 10 (86%) were overweight or obese.²⁵⁷ Three quarters (78%) of farmers had three or more cardiovascular risk factors. The majority of farmers (79%) were advised to visit their GP and, within 12 weeks, a third (32%) had done so.

Community programmes

Community-based health promotion for men can be challenging for service providers because men have traditionally not responded to this sort of approach and because providers themselves may be unsure of how to engage men.²⁵⁸ But there is now good evidence, that appropriately delivered, community-based initiatives can deliver positive outcomes.

The **Men on the Move** programme in Ireland is a free, 12-week community-based 'beginners' physical activity programme for inactive adult men that aims to improve the overall health and well-being of participants. It consists of structured group exercise twice a week, two facilitated experiential workshops, a 24-page health information booklet, a pedometer for independent activity sessions, weekly phone contact, a customised wallet card to record measures taken and a 5km celebration event at the end.

An evaluation showed that the programme was successful in recruiting men with a high level of risk factors such as high blood pressure, overweight/obesity and being sedentary.²⁵⁹ The majority of men participating in Men on the Move reported increased levels of physical activity, fitness and energy. But importantly other positive spin-offs of the programme included improved dietary habits, nutritional knowledge, and weight loss. It also contributed to improvements the quality of life of the men; for example, nearly double the men (68%) reported satisfaction with their energy level at the end of the programme compared to the start (35%).

Barbers' shops in Los Angeles (USA) have been used to reach African American men with high blood pressure.²⁶⁰ 52 shops took part in a study in which barbers encouraged customers who were identified as having uncontrolled high blood pressure to meet with pharmacists in the shop. Men with high blood pressure were either prescribed drug therapy by the pharmacists (under a collaborative practice agreement with the participants' doctors) or to an active control approach in which the barbers encouraged lifestyle modification and doctor appointments.

At the start of the programme, the men's average systolic blood pressure was 153 mm Hg in the drug therapy group and 155 mm Hg in the active control group. After six months, the mean systolic blood pressure fell by 27 mm Hg (to 126 mm Hg) in the drug therapy group and by 9 mm Hg (to 145 mm Hg) in the active control group. A blood-pressure level of under 130/80 mm Hg was achieved among 64% of the participants in the drug therapy group compared to 12% of the participants in the active control group.

An outreach **Prostate Health Clinic** in a socially-deprived and ethnically diverse part of London (UK) was established in an African and Caribbean Community Centre.²⁶¹ An evaluation found that about 330 men attended over an approximately 100-day period. About half were black African or black Caribbean and most came because of urinary problems or for a check-up. They knew of the clinic through advertising or word-of-mouth. Of those with symptoms, 50% had not attended a GP to discuss them. Almost 60 men were referred to secondary care and nine men were diagnosed with prostate cancer. The clinic's users felt that the service was accessible and professionals involved with the project considered that the clinic was beneficial especially for those reluctant to visit their GP.

The **Men's Pie Club** in Newcastle (UK) aims to tackle loneliness in men. Funded by the Movember Foundation and delivered through a partnership of the social enterprise Food Nation and the Men's Health Forum (Great Britain), this pilot project is built around many men's enjoyment of pies - creating them, cooking them, eating them, sharing them and selling them. Its broader aim to improve men's social connectedness, diet and physical and mental health.²⁶²

Digital services

Because many men experience barriers that inhibit their use of primary care services, including general practice, men's health researchers and advocates have suggested that greater digital access could be particularly beneficial for men.²⁶³ The internet has become an important tool for men seeking health information.²⁶⁴ Men are particularly likely to use it because it is easily and continuously accessible, low-cost, and enables men to feel in control, independent and autonomous and appears not to compromise traditional male behavioural norms (e.g. that men 'should' be strong, resilient and self-reliant).²⁶⁵

Don't Change Much (dontchangemuch.ca) is an online health information service provided by the Canadian Men's Health Foundation. It covers nutrition, physical activity, sleep, mental health, smoking and drinking. It aims to inspire men to make changes but in realistic small steps. Backed by a large number of sports stars, Don't Change Much contains a health self-assessment tool, a 'Manopedia' (a guide to common men's health problems) and entertaining videos with key health tips.

The **GeM app** has been developed by The Men's Health Foundation (Stiftung Männergesundheit) in Germany to support men to lead a healthy lifestyle. The app uses a scientifically-validated questionnaire to create for each user an individualised daily coaching programme covering a range of issues, including physical activity, nutrition, sleep, drinking, and stress. It aims to enable change with minimal effort on the part of the user. The app enables users to collate personal health information and to create a medical record. It also helps men prepare for consultations with the doctor.

Man MOT was developed by the Men's Health Forum (Great Britain) to help improve men's use of primary care services. It provided a suite of online health information and advice services aimed at men. Its centrepiece was an anonymous and confidential online live text chat-to-a-GP service. This was available from 19.00 - 22.00 on Mondays and Thursdays. There were also occasional additional issue-specific chat sessions, for example on stress, as well as an open-all-hours email enquiry service which provided additional direct access to GPs (and provided answers within 72 hours). Additionally, Man MOT offered web-based male-targeted health information in a more traditional magazine-style format and a 'Find local services' search facility.

An independent evaluation of Man MOT concluded that, if the service is properly marketed, men – especially young men – will use online health information and advice services.²⁶⁶ Men generally prefer to access online services via mobile platforms and living in an area of deprivation does not appear to create a barrier to access. Online health information and advice services are likely to receive a disproportionate demand from men about sexual health, urological and mental health issues.

Man MOT users described feeling empowered by the service. It made it easier for them to justify taking time away from work and enabled

them to interact more effectively when visiting their GP. Men said they used Man MOT as a first port of call for non-emergency health concerns. They thought that Man MOT filled a gap in service provision by providing the opportunity to ask a medically trained professional a question without having to arrange a GP consultation involving taking time off work. They also believed that the service enabled them to be more proactive in accessing conventional services; they would probably have delayed visiting the GP for longer if they had not used Man MOT. Most of the men surveyed said they followed the advice provided by Man MOT and all of them said they would use the service again.

QuitNow Men (men.quitnow.ca) is a tailored, evidence-based smoking cessation website optimized for use on desktop and mobile devices by men in Canada. It offers a range of tactics and tools and an opportunity for users to interact in a discussion forum or share their stories. The pilot study findings revealed that the site appeals to men who want to quit and demonstrates potential as a self-guided smoking cessation resource.²⁶⁷ At a six-month follow-up, a quarter (24%) of users reported having quit smoking.

E-MAT is a virtual reality tool which aims to enhance men's awareness of a range of testicular disorders.²⁶⁸ E-MAT comprises three levels. The first involves a 3D space with two walnuts that represent the testes. The user moves around the walnuts using the controller, while the voiceover provides information about the normal size and shape of the testes. A lump, swelling and pain appear consecutively and are accompanied by light-hearted responses from the voiceover such as: 'That doesn't look good! That wasn't supposed to be there! That escalated quickly!' Participants walk toward the walnuts while using the controller and to 'touch' each abnormality with the hand avatar, which triggers a humorous response from the voiceover and haptic (touch) feedback from the controller.

The second level involves a 3D model of a real testis with structures such as the spermatic cord and epididymis. The voiceover links some of the abnormalities experienced in the first level to testicular structures, eg. a purple lump appears on the surface of the testis to indicate a cancerous growth. In the third level, the key messages from the intervention are reiterated, namely the importance of knowing one's own testes, performing self-examination, and seeking timely medical attention for testicular symptoms.

E-MAT has evaluated well in a pilot study and, with virtual reality rapidly gaining popularity among young men, its developers believe it is ready for testing via public platforms.

Primary care services

Primary care services in traditional settings can be made more accessible to men. Solutions include: addressing the practical barriers such as limited opening hours and difficult-to-use appointment systems; greater use of digital technologies for making appointments and for information,

advice and even some consultations; training for health professionals on men's health issues is important; and better outreach services that take services to where men are such as workplaces, faith and leisure venues.²⁶⁹ Creating a more male-friendly ambience within traditional settings – by providing male-interest magazines and male-targeted health information posters and leaflets, for example – might also make a difference. Pharmacy services could have a particularly important role in improving men's self-care.²⁷⁰

Pregnancy could provide a good entry point for men since in some countries they are already encouraged to attend antenatal services with their female partners to provide support for women and children's health. While they are there, men could be offered preventative health and screening services.²⁷¹

The Men's Health Initiative Risk Assessment Study in the USA looked at whether community pharmacists could encourage men who were overdue for a physical examination to visit a doctor.²⁷² Over a 12-week period, pharmacists identified over 380 men aged 25-74 with potential health risks that were untreated or uncontrolled or who had not had a physical examination within the past year. One man had not been examined for 23 years. Two thirds (64%) of the men who were advised to see a doctor went on to do so, demonstrating that pharmacists can identify men at risk and motivate them to seek follow-up care.

The nurse-led AHEAD project in the UK aimed to improve the uptake by men aged 40-65 of free health checks and respiratory, cardiovascular and diabetes chronic disease reviews in general practice.²⁷³ Male patients who had already declined three previous invitations to attend either a health check or a chronic disease review were identified and targeted. They were invited for a blood test and posters, promotion banners and the practice reinforced the message that men should attend.

The number of men who attended for health checks increased by over 250% year-on-year (to over 400 men a year) and over 50 new cases of chronic disease (hypertension, diabetes, asthma, COPD, mental health, coronary heart disease or stroke) were detected. The number of men on the pre-diabetic register more than doubled to 112.

Men's use of two family planning clinics in the USA was increased significantly by a range of methods including encouraging female clients to inform their male partners, friends and relatives about reproductive health services, outreach work (eg. presentations to community-based organisations working with men), reducing clinic wait times, staff training on the 'culture of men' and providing services to male clients, and changing the clinic environment by displaying male-appropriate leaflets and posters.²⁷⁴

As a result, the number of male clients more than doubled (from about 4,000 in a two-year period to over 8,380). The number of chlamydia tests on men increased even more sharply (by 150%), especially among adolescents.

WHO SELF-CARES WINS

NEXT STEPS



Next steps

Improving men's self-care effectively requires a multi-layered, systems-wide approach. It is not enough simply to try to persuade men to change and then to blame them if they fail. An approach based on information alone, even if male-targeted, will also be inadequate, especially for those men at greatest risk of poor health outcomes.

1. Governments and health systems should use the 'big levers' at their disposal to make structural changes that create the conditions that enable and encourage men (and women) to self-care more effectively. Policies that create more equal societies with better education and employment opportunities, a healthy standard of living for all citizens and sustainable communities will have a major impact on health and wellbeing and on the capacity of men and women to self-care. Put simply, a man living in poverty in a low-income country is less likely to have enough control over his life and feel sufficiently empowered to self-care effectively than an affluent man in a high-income country. Societies that are more gender-equal are also likely to have better health outcomes for both sexes.

2. Tobacco and alcohol control measures – such as higher taxes, minimum pricing, restrictions on advertising, limits placed on where and when people can smoke and drink – are proven to have an impact on usage. Smoking bans have been effective in reducing male consumption and cardiac events, for example.²⁷⁵ It has been estimated that a tax imposing a 20% increase in the price of sugar-sweetened beverages in the UK would result in a fall in the volume consumed by 35% in boys aged 4-10, a fall of 25% in boys aged 11-18, 13% in men aged 19-64 and 4% in men aged 65 or over with an impact on obesity, diabetes and dental health problems.²⁷⁶ A similar study in Germany estimated that a tax on sugar-sweetened beverages would in fact disproportionately benefit men because they have higher consumption rates of these beverages and drink less juice and milk.²⁷⁷ It is also possible that a tax on red and processed meat, recently mooted in response to health and environmental concerns, would help to reduce consumption in men, the biggest consumers of meat products.²⁷⁸

3. Developing and implementing effective self-care policy and practice must become an international, national and local priority. This policy and practice must also be gender-sensitive. In the GAMH survey of health professionals, 90% of respondents believed that health organisations should develop gender-sensitive approaches to self-care that take account of men and boys.

4. Governments and local authorities should introduce health policies that recognise the needs of men. National men's health policies can make a significant impact but it is also important that specific policies – on cancer, cardiovascular disease, smoking or obesity, for example – take account of men. Other areas of public policy – such as education, parenting, employment, leisure and recreation, housing and transport – also have the potential to impact on men's health and wellbeing and men's ability to self-care. Restrictions on long working hours insecure

employment, affordable public transport and safe walking and cycling routes, lifelong educational opportunities, shared parental leave and better access to parks and other open spaces are among the measures that could make a difference.

National men's health policies – introduced to date in Australia, Brazil and Ireland – can have a potentially significant impact. A dedicated policy can help to:

- **Push men's health further up the health and wellbeing agenda by identifying men's health as a priority area for action.**
- **Provide an identity for what might otherwise seem a somewhat amorphous and intangible issue.**
- **Help to provide the leverage for resource allocation and activity by practitioners and policymakers across a range of sectors and disciplines.**
- **Establish clear targets and outcomes.²⁷⁹**

5. Action is needed to improve men's health literacy. Schools have an important role in communicating information about health risks and help-seeking to boys but this needs to be reinforced by longer-term exposure to health information. Health communications need to take full account of gender in a similar way to advertising by commercial organisations, such as for colas, cigarettes and razors. Health services need to adopt similar social marketing approaches although without reinforcing stereotypes or using sexist imagery.²⁸⁰

6. Health services must become more accessible to men. This requires a mix of marketing, outreach, streamlining appointment systems, introducing more flexible opening hours and making the environment more male-friendly (eg. by displaying men's health information and male-interest magazines in waiting areas). Digital services – for information, advice and even routine medical consultations – should be further developed with men in mind.

7. Better use of community pharmacy services by men should be encouraged. Pharmacy has significant advantages for men because it is often easier-to-access than GP clinics with convenient opening hours and no need to make an appointment. It is also more anonymous.²⁸¹ To improve male uptake, pharmacies will need to introduce male-targeted marketing, offer health checks, provide private consultation areas, and display male-targeted health information. Male grooming products and the increasing over-the-counter availability of previously prescription-only drugs (such as sildenafil, better-known as Viagra), as well as online pharmacy services, may also help to attract more men.

8. More services should be offered 'where men are', in local communities, sports venues, workplaces and faith and leisure settings. Workplaces can have a particularly important role in health promotion – for example, by providing healthier foods and encouraging physical activity – and can contribute to higher levels of self-esteem and empowerment by offering training and education opportunities as well as fulfilling and secure work at a wage that respects employees' knowledge, skills and experience.

9. Health policymakers and practitioners need to be better informed about men's health. Pre-qualification courses for clinical staff should cover sex and gender issues and not just from a medical perspective. Post-qualification training should also be made available. The ENGAGE training programme in Ireland, which is aimed at health, education, social service and other staff from a wide variety of disciplines, provides a good model.

ENGAGE is a one-day training programme implemented in Ireland. It aims to increase participants' understanding of best practice in engaging men with health programmes. Health practitioners receive evidence-based tools to engage men, connect with a network of supportive peers, and learn about harmful gender roles and norms that contribute to practices such as the under-utilization of health services. The training helps raise awareness about gender-sensitive health care in order to improve the quality of care given to men, and to generate positive and sensitive clinical engagements.

An evaluation found that, between 2012 and 2015, ENGAGE trainers delivered over 60 one-day training programmes to 810 participants. Overall, participants were highly satisfied with the training immediately post training and at a five-month follow-up. Participants' self-reported level of knowledge, skill and capacity in identifying priorities, engaging men and influencing practice beyond their own organisation increased immediately following training and, with the exception of improving capacity to engage men and influencing practice beyond their organisation, these improvements were sustained at five-months post training. The vast majority of service providers (93%) reported that ENGAGE had impacted their work practice up to five-months post training. The evaluation suggested that ENGAGE has succeeded in improving service providers' capacity to engage and work with men and that this could improve their health outcomes.²⁸²

10. Men should not be treated as a single homogenous group with the same needs, attitudes and practices. Men are differentiated by nationality, culture, faith, socio-economic status, race, age, sexuality and disability. An 'intersectional' rather than a 'one-size-fits-all' approach is much more likely to work.

11. Men's self-care initiatives should be introduced using the concept of 'proportionate universalism' in order to flatten the social gradient in health outcomes. This means that interventions should be universal, not targeted at particular groups of men, but with a scale and intensity that is proportionate to the level of disadvantage. This would mean, for example, that all men are encouraged to participate in bowel cancer screening but that a particular effort is made to engage men in the groups with the lowest levels of uptake.

12. Self-care initiatives aimed at men must take account of male gender norms but be selective about when to attempt explicitly to change those norms. Challenging male gender norms can be appropriate in programmes that deal with issues that impact on women's health – such as sexual and reproductive health or gender-based violence – but

may not be needed or helpful in interventions on weight management or cancer symptom awareness. Indeed, there is evidence that supports the notion of working with prevalent social constructs of masculinity, including strength, resilience, and independence, as distinct from being focused on changing these masculinities.²⁸³ What is most important is that health providers deliver interventions that make a difference to men's health outcomes; it is not their role to 'remodel' masculinity. In any event, it is possible that successful interventions implicitly impact on male gender norms: a man who was previously taking risks and who becomes engaged with his health may have adopted a different way of being a man, even if by default.

13. Masculinity should not be pathologised or regarded as inherently problematic. Rather than simply blaming men for their risk-taking or reluctance to seek help, it is important to understand the causes and consequences of men's health practices and to develop practical and non-judgemental responses.²⁸⁴ This does not mean, of course, that individual men should not be held accountable when they put others at risk or cause them actual harm.

14. Self-care interventions should adopt an 'assets-based' approach that builds on the positive aspects of many men's experience, knowledge, skills and attitudes to health and well-being.

15. Although the research and evidence about how to improve men's health is far more robust and extensive now than 10 or 20 years ago, there are still significant gaps, including in how men can be better engaged in self-care. A more sustained effort is now needed in this field. There is a need, too, for better practical guidance for policymakers and practitioners; they would benefit, for example, from a range of 'how to do it' guides along the lines of those already produced by the Men's Health Forum (Great Britain) on engaging men in self-management support,²⁸⁵ weight management²⁸⁶ and mental health.²⁸⁷

16. Self-care initiatives aimed at men should fully involve men and the organisations that represent them. Policymakers and practitioners, whether male or female, are not best-placed to judge what men want in terms of information, services and support. Researching men's views and needs is important but they should also be active agents in the design and delivery process.

WHO SELF-CARES WINS

APPENDIX: THE GAMH SELF-CARE SURVEY



Appendix: the GAMH self-care survey

Objective

The aim of this survey was to ascertain the views of professionals engaged in working with men about the current state of men and self-care.

Methodology

Survey Monkey was used to design and host a survey designed by GAMH. Information about the survey was shared with GAMH's members and via the GAMH Twitter feed. GAMH members were asked to share information about the survey with relevant people. The survey was open for about seven weeks in March/April 2018. The survey was available only in English.

Who responded

A total of 66 responses were received. 63 respondents identified the countries in which they are based. Almost half of these 63 respondents were based in the UK (N=31) and about one quarter (15) were from Australia. The remainder were from Ireland (5), Canada (4), New Zealand (2), USA (2), Denmark (1), Germany (1) and Gibraltar (1). One respondent stated that they were based in both Australia and the UK.

64 respondents identified their role. 28% (N=18) were health professionals, 17% (11) were academics/researchers and 14% (9) were advocates (e.g. working for a NGO). One respondent was a policymaker. The remaining 39% (25) identified as 'other' and came from a wide variety of backgrounds, including youth work, education and community work.

Findings

Respondents were asked to assess broadly men's and boys' engagement in self-care in the fields they were familiar with. About one-fifth (21%) thought that men's and boys' engagement was 'good' or 'very good', almost two-fifths (38%) thought it was 'fair' while a further two-fifths (39%) thought it was 'poor' or 'very poor'.

A wide range of additional comments was received in response to this question. Some highlighted the difficulty of generalizing and pointed to variations in engagement between different groups of men (with older men more likely to self-care). One service reported that they were now seeing increasing numbers of boys accessing services while another respondent, working in the mental health field, believed that young male clients took no responsibility for self-care.

14% of respondents believed that, in the fields with which they were familiar, health organisations' engagement with men and boys on self-care was 'good' or 'very good'. Just over a quarter (27%) thought it was

'fair' and over half (58%) thought it was 'poor' or 'very poor'.

The additional comments highlighted what was seen as a general lack of service provision appropriate for men. One respondent said: 'Most health organizations do not understand health promotion and interventions from a gendered perspective. They expect people to come to them. They expect tools to be effective across genders. When they do get gender sensitive, they rely on stereotypes and assume all men are alike and will respond in the same way to the single male-centred approach.'

The survey asked which health and related issues respondents thought should be covered in the GAMH report on men and self-care. Options were provided based on the International Self Care Foundation's 'Seven Pillars' framework. Over four-fifths (89%) mentioned mental well-being, self-awareness and agency and knowledge and health literacy (83%). Over two-thirds (70%) mentioned physical activity and almost as many (65%) cited the use of health and medical products, services, diagnostics and treatments. Over half (58%) mentioned risk avoidance or mitigation and over two-fifths (44%) highlighted hygiene practices.

One third (33%) of respondents mentioned other issues that they thought the report should cover. These included diet, sexual health, suicide prevention and health and safety in the workplace.

Respondents were asked to identify up to five of biggest structural/social barriers to better self-care for men and boys at three levels: international, national and local.

For the international level, respondents made 178 suggestions. These were grouped into 10 broad categories. Excluding 'other', clearly non-structural/social barriers and unclear statements, the most commonly mentioned were a lack of interest by governments, policymakers and practitioners (N=28), social norms and stereotypes (24), service provision (22), lack of gender equality in healthcare (22), and education, information and knowledge (16).

Respondents made 128 suggestions about the most important steps international health organisations could take to improve the self-care of men and boys. Excluding 'other' and unclear statements, the most commonly mentioned were awareness raising, information dissemination and educational activities (N=30), service development (14) providing more funding and resources (11), policy development (10) and research (8).

For the national level, respondents made 187 suggestions. These were grouped into the same 10 broad categories. Excluding 'other', clearly non-structural/social barriers and unclear statements, the most commonly mentioned were a lack of interest by governments, policymakers and practitioners (N=39), education, information and knowledge (24), lack of gender equality in healthcare (21), service provision (20), and social norms and stereotypes (16).

Respondents made 140 suggestions about the most important steps national health organisations could take to improve the self-care of men and boys. Excluding 'other' and unclear statements, the most commonly mentioned were awareness raising, information dissemination and educational activities (N=32), service development (19), policy

development (13), providing more funding and resources (12) and greater gender-sensitivity by organisations (10).

For the local level, respondents made 155 suggestions. These were grouped into the same 10 broad categories. Excluding 'other', clearly non-structural/social barriers and unclear statements, the most commonly mentioned were service provision (N=30), a lack of interest by governments, policymakers and practitioners (22), education, information and knowledge (18), social norms and stereotypes (9) and lack of gender equality in healthcare (9).

Respondents made 125 suggestions about the most important steps local health organisations could take to improve the self-care of men and boys. Excluding 'other' and unclear statements, the most commonly mentioned were awareness raising, information dissemination and educational activities (N=21), service development (26), providing more funding and resources (10) and greater gender-sensitivity by organisations (8).

90% (N=57) of respondents thought that health organisations should develop gender-sensitive approaches to self-care that take account of men and boys. Three respondents (5%) said that gender-sensitive approaches were not needed. One respondent added: 'The gender differential has to be acknowledged [as] a one size fits all approach is unacceptable.' Another said: 'Especially at [the] point of contact, services [e.g.] doctors' surgeries and chemists could be more men friendly.'

Almost as many respondents (N=55, 87%) thought that it would be useful for GAMH to develop guidance for health organisations on developing gender-specific approaches to self-care that take account of men and boys. Three respondents (5%) said such guidance from GAMH was not needed. One respondent added: 'This would be very important. Keep it simple. The problem with a lot of information on this subject is that it is in research journals and papers and not easily available to those working with men. It needs to be simple with simple messages with supporting documents for those who want to understand more.' Another stressed that it would be important for any guidance to take account of disciplines such as psychology, economics and the behavioural sciences and a third respondent wondered whether the production of such guidance might be better left to local and national organisations rather than a global one.

The survey asked respondents if they were aware of any good case studies of self-care for men and boys. Just under a third (30%, N=18) said they were while over two thirds (70%, 43) said they were not. 14 respondents mentioned specific case studies.

16 respondents took the opportunity to add a comment of their own to the survey. The comments were very diverse but included: 'When engaged appropriately, men and boys are interested and engaged in their health', 'Health professionals need to have core modules in their courses [and] boys need the opportunity and access to user-friendly hard copy and electronic information on all aspects of health and well-being', and 'Men and boys need gender inclusive services and campaigns that make them feel that they are not excluded i.e. no pink/purple/flowery advertising. Make it actually say 'This is for you' rather than 'This is for anyone'.'

Discussion

The professionals engaged in working with men and boys who responded to the survey had mixed views about the engagement of men and boys in self-care in the fields they were familiar with. Although 39% through the level of engagement was 'poor' or 'very poor', a majority considered it to be 'fair' or better. This appears to confound the stereotypical and bleak view that men are largely disengaged from self-care specifically and health generally.

However, most respondents felt that health organisations were not engaged with men and boys in self-care. 58% considered the level of engagement to be 'poor' or 'very poor'. Consistent with this view, 90% of respondents believed that health organisations should develop gender-sensitive approaches to self-care that take account of men and boys and almost as many thought it would be useful for GAMH to develop guidance for organisations on this issue.

The two issues respondents most wanted GAMH to cover in its report were mental health and health literacy. Out of the ISF's Seven Pillars, only hygiene practices were highlighted by fewer than half of respondents. This suggests that the Seven Pillars were seen as a relevant framework for considering the issue of men and self-care.

The biggest structural/social barriers to better self-care for men that were identified by respondents were broadly similar for the international, national and local levels. The five most commonly mentioned barriers at all levels combined were a lack of interest by governments, policymakers and practitioners, service provision, education, knowledge and information, lack of gender equality in healthcare and social norms and stereotypes.

The five steps health organisations could take to improve the health of men and boys were identified by respondents as being awareness-raising, information and educational campaigns, service development, more funding and resources, policy development and greater gender-sensitivity by organisations. The steps identified were, like the barriers, broadly similar for the international, national and local levels.

Strengths and limitations

The survey was completed by a relatively large number of respondents given the small numbers of professionals working with men. The respondents were spread across nine countries and a wide range of professional roles. Most respondents answered most of the questions.

However, two countries, the UK and Australia, were disproportionately represented among the respondents and almost all the respondents were from English-speaking countries. All were from high-income countries. Six of the questions – on the structural/social barriers to better self-care for men and boys at international, national and local levels and the steps that could be taken by organisations at each of those levels to improve the self-care of men and boys – could perhaps have been more clearly-worded as they generated a significant number of non-relevant or unclear answers.

Conclusion

While professionals working with men have a range of views about the extent to which men and boys are engaged in self-care, it is clear that most believed there is considerable room for improvement. Health organisations at all levels are perceived not to be effectively engaging men and boys on this issue and it is believed that more should develop gender-sensitive approaches. The health issues of most concern were identified, broadly, as mental health and health literacy.

The potential solutions identified by respondents included awareness raising, information and awareness campaigns, service development and more funding and resources.

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