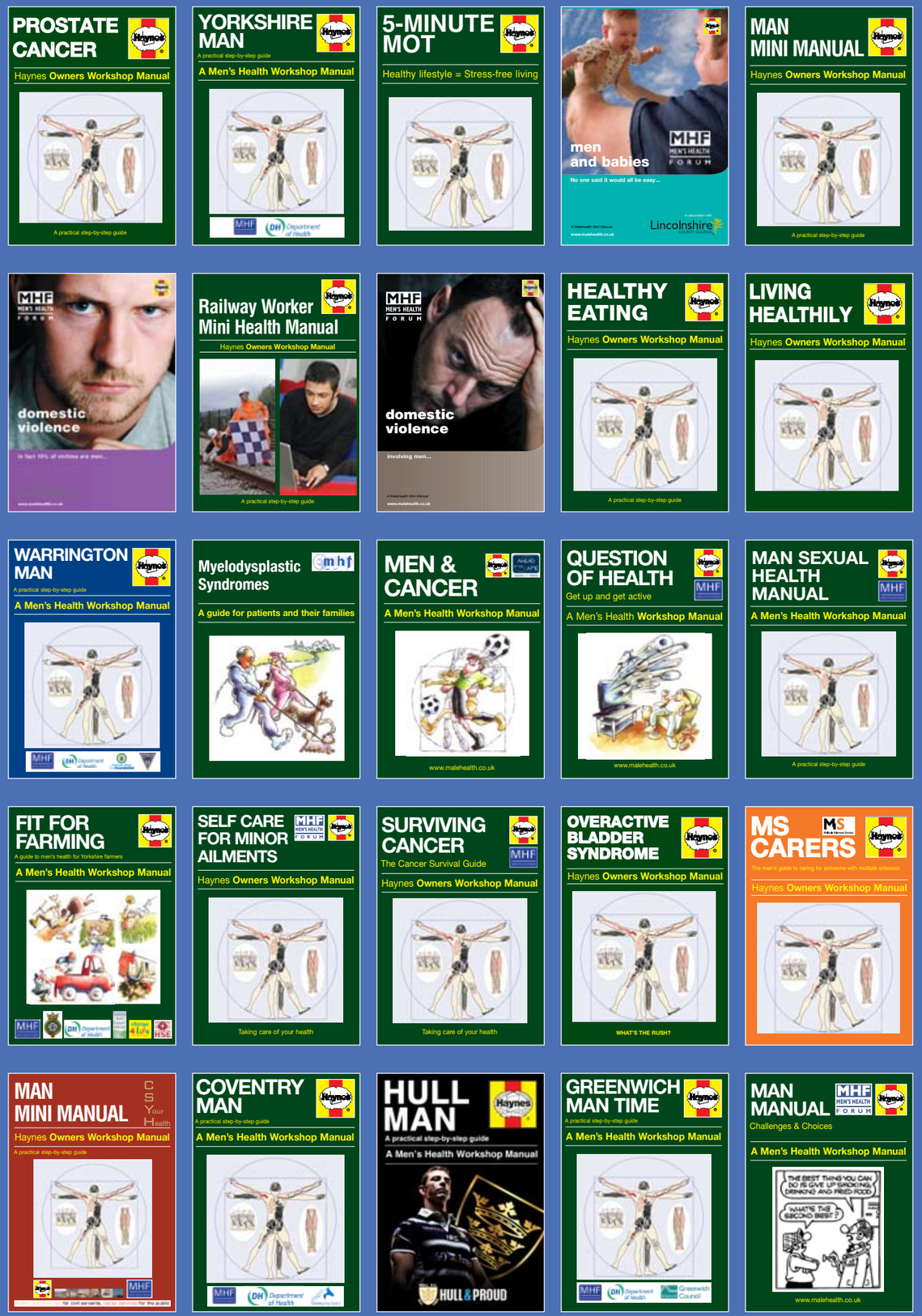
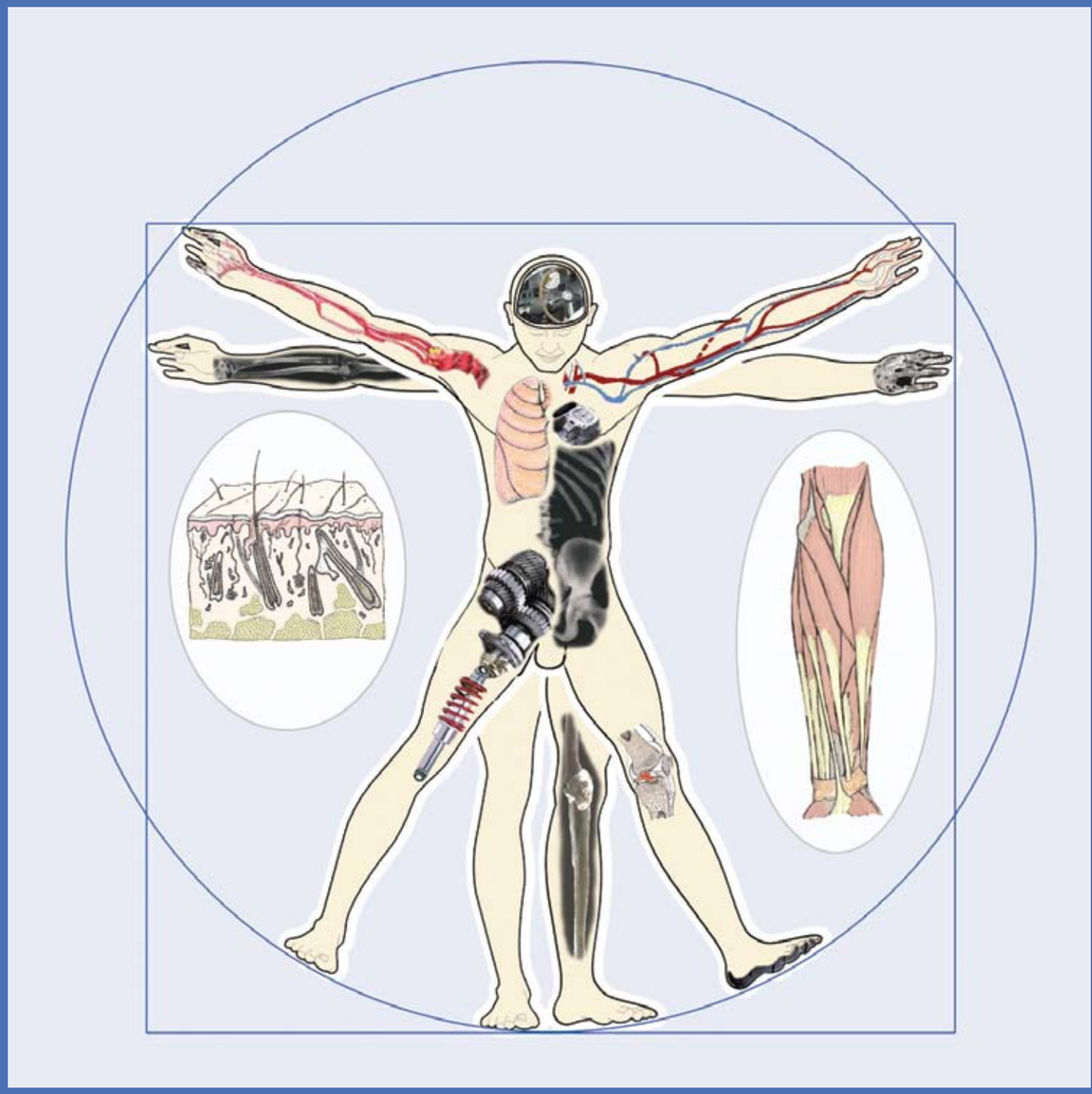



# EUROPEAN MEN'S HEALTH FORUM

## RESPONSE TO THE EC REPORT ON THE STATE OF MEN'S HEALTH IN EUROPE



## About The European Men's Health Forum

**EMHF is the only European organisation dedicated to the improvement of men's health in all its aspects, and a platform for the collaboration of a wide range of stakeholder groups in Europe.**

The European Men's Health Forum (EMHF) presents a new and major opportunity for a wide range of organisations and individuals to work together to raise the profile of men's health at a Europe-wide level and within individual countries. EMHF has been initiated by the Men's Health Forum, the leading advocate of men's health in England and Wales, with the support and collaboration of partners who share its aim of tackling the poor state of male health across all the countries of Europe.

EMHF is an independent, non-governmental, non-profit-making organisation. It is a membership association headed by an elected Board of Directors which represents the diverse range of Europe-wide and national organisations with an interest in men's health issues. The day-to-day work of the organisation is carried out a Secretariat headed by a Director.

## Acknowledgements

This document was put together using responses from a wide range of medical professionals with thanks from the emhf.

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All cartoons courtesy of Jim Campbell; the one on page 111 courtesy of the Irish Cancer Society

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# Response to the EC report 'The State of Men's Health in Europe'

EC, 2011 The State of Men's Health in Europe. Luxembourg, The European Commission

EC, 2011 The State of Men's Health in Europe (extended version). Luxembourg, The European Commission

# Country codes

| | | | | | |
|---|---|---|---|---|---|
| Austria | AT | Hungary | HU | Poland | PL |
| Belgium | BE | Iceland | IS | Portugal | PT |
| Bulgaria | BG | Ireland | IE | Romania | RO |
| Croatia | HR | Italy | IT | Slovakia | SK |
| Cyprus | CY | Latvia | LV | Slovenia | SI |
| Czech Republic | CZ | Liechtenstein | LI | Spain | ES |
| Denmark | DK | Lithuania | LT | Sweden | SE |
| Estonia | EE | Luxembourg | LU | Switzerland | CH |
| Finland | FI | Macedonia | MK | Turkey | TR |
| France | FR | Malta | MT | United Kingdom | UK |
| Germany | DE | Netherlands | NL | | |
| Greece | EL | Norway | NO | | |

# Foreword

The European Union recently discovered a new European country. Called Elam, it has roughly half the number of people of all Europe. Formerly shrouded in mystery, it's entire population has a life expectancy significantly less than the rest of Europe. Not surprising really as they suffer and die more often from just about every disease, especially cancer. Perhaps this could be the reason for the staggering rate at which they take their own lives, murder each other and die from accidents. Despite this, the populace uses its excellent health services less often and much later than do the rest of Europe. Until very recently all blame rested on their own shoulders, simply being an Elam was reason enough to explain away this huge anomaly.

Then along came the EC commissioned report into Elam health. Suddenly other, hitherto unknown explanations came to light. Although for instance, Elam health services were generally excellent they did not actually cater well for Elam needs. Worse still education appeared to reinforce the idea that Elam people should take risks with just about everything including their health. So shocking was these discoveries the EC could offer no suggestions or recommendations as to how to address this dreadful state of affairs.

Enter the European Mens Health Forum (EMHF) and welcome to the EMHF response and recommendation report put together by experts. It starts from the simple position that Elam people should not necessarily die early and that there are things, many now evidence based, that can be done to change their lives for the better. This book is not just a report, it is a challenge. It seeks to provoke politicians, health professionals, employers, educators, social engineers and yes, men themselves into pausing in their headlong fatalism to not only ask why, but also what we going to do about it and how.

If there really were such a place as Elam (Male) you would expect a cry of outrage, this response gives a voice to that outrage. Make your voice heard using the EMHF web site, we need your comments and suggestions. This is male health in 2011, it need not be the same in 2012 but it is up to you, the reader, to use your influence, knowledge, expertise and passion to give Elam people a passport to better health.

**Ian Banks**
President EMHF

# Contents

## 5



## 6



## 7



## 8



## 9



## 10



## 11



## 12



## 13



## 14



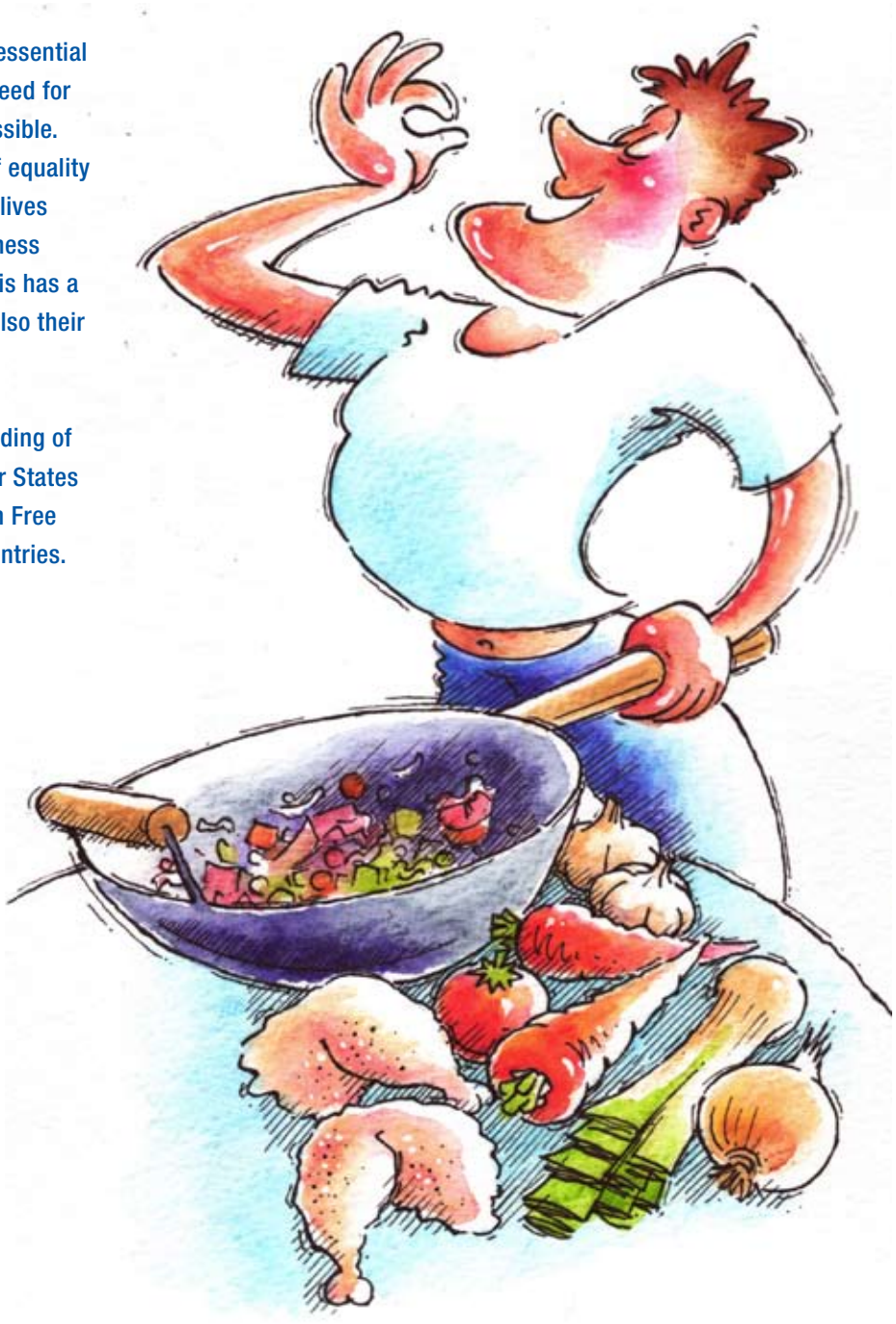
## 15

# Introduction

1

A better understanding of the health of men is essential for two main reasons. The first relates to the need for our male population to be as fit and able as possible. The second is tied to the fundamental values of equality and equity, as we are seeing many men whose lives are blighted through a collective lack of awareness and action on the problems they are facing. This has a huge impact not only on men themselves, but also their families and the wider society.

This report helps create the baseline understanding of the state of men's health across the 27 Member States of European Union, the 4 states of the European Free Federation Association and the 3 candidate countries.



# Putting the spotlight on men and men's health

Throughout European history, men have maintained a central and prominent place in society and have traditionally been the major holders of political and religious office and of economic resources. Nevertheless, the categories of 'men' and 'masculinity' have remained largely taken for granted, as the gender spotlight focused on women. It was not until the latter part of the last century that we began to witness an increased gender focus on men, including men's health. This included two important landmark events within the EU: the Men and Gender Equality Conference through the Finnish Presidency in 2006 and the Men's Health Conference as part of the Portuguese Presidency in 2007.

The commissioning of this report bears testimony to this continued interest and reflects increasing concern generally with the burden of ill-health experienced by European men. The report is particularly timely against a backdrop of unprecedented political, economic and social change that has occurred across Europe over the past 30 years. There have been significant economic changes with an overall decline of primary industry and, more recently, increased labour market vulnerability associated with economic recession. This is coupled with a changing demographic picture within Europe: with a declining younger population and an expanding older population, the workforce implications and pressure on resources are becoming more intense.

We need to acknowledge that currently we are losing a significant proportion of our working age men through premature mortality. This affects not only our industry and commerce, but also can alter the social and financial positions of families. The marked effect of poor socio-economic conditions on the health of men means not just an issue of gender equality, but a more fundamental equity concern, which relates to the right of all men to be able to live a long and fulfilling life.

# Social determinants of health

Men are not a homogenous group - as demonstrated in this report, there is much variation in health and life expectancy between men living in different contexts (e.g. different countries within Europe) and between men living in the same context (e.g. age-related or socioeconomic differences within the same country). Men's health status is therefore more than simply a consequence of biological, physiological or genetic factors; it is affected by much broader economic, social, cultural and environmental elements.

For the purpose of this report, therefore, we have taken the holistic bio- psychosocial definition suggested by the Men's Health Forum (England):

*"A male health issue is one arising from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level"*[1].

## Policy concepts and principles - One size does not fit all

Concerns over the state of men's health have seen the development of some strong NGOs including the European Men's Health Forum (EMHF), the Men's Health Forum in the UK, Ireland and Scotland[2], the Nordic Men's Health Society and other groups supporting the health of men (e.g., the European Patients Forum). Furthermore, numerous local initiatives across Europe have recognised that activity has to be focused on the individual needs of men and women for success to happen, many of which are captured in the Engender Database[3].

Despite this local recognition of its importance, the category 'men' is mostly conspicuous by its absence at both an EU and individual member state health policy level.

The state of men's health in Europe is a serious public health concern. Despite the principles of the Lisbon Strategy and pressure from the World Health Organization that all health policy should consider the specific needs of both men and women through their push for 'gender mainstreaming', and increased interest in men's health, there have been relatively few gendered policy responses in the EU member states relating to men's health. Indeed Ireland[4] is the only member state to have a full national men's health policy[5]. The near absence of men's health at the policy level has severely limited the capacity to develop well-coordinated national programmes in the EU member states that meet the health needs of men and their families.

The process of policy development men's health should not be defined in a narrow biomedical framework, but should embrace a broader, social determinants view. In this respect, effective men's health policy needs to draw on multiple strategies that target individual behaviours and that also focus on issues at the macro- economic, social, and environmental levels.

## Men's health as an investment

Many of the solutions of addressing the social determinants of men's health rely on the ability of professionals to recognize that men have significant potential to be a health resource rather than just a consumer of health services. Such a policy calls for a departure from the traditional focus on the 'deficiencies' of men with respect to their health. Public debate on men's health tends to be dominated by negative portrayals of men and masculinity, whereby men are blamed for failing the health services by not attending, for being violent and for taking risks. This Report supports a positive and holistic approach to men's health, one that addresses the underlying causal factors that can be attributed to men's poorer health outcomes and that create health-enhancing environments for boys and men.

Improving the health of men can also have both direct and indirect benefits for women and children. In the case of single-income, lower socio-economic group families, absenteeism from work due to a father's ill-health is likely to have significant material repercussions for the family as a whole. In the case of sexual or mental health, interventions that are successful with men are also likely to have positive spin-offs for men's families. This report adopts a broad, social determinants approach to defining men's health. It makes the case that men's health is more than simply a consequence of biological, physiological or genetic factors, but that it is also affected by much broader economic, social, cultural and environmental factors, which influence how men in different countries and different cultures experience health. It seeks to move beyond an approach that focuses only on differences between men and women to examine the many and varied differences between men and the many and varied ways of being a man in Europe. It recognizes, in particular, that social and economic factors, including poverty, are key determinants of the health status of men across the EU. By recognizing diversity within men, this report provides an important blueprint on men's health in the years ahead, and signposts the direction in which resources can best be directed.

# Recommendations for actions

- POLICY: Every country should have a men's health policy which is implemented. It should include a male premature death rate target for, say, 2020 which could be the rate of best performing EU country

- PRACTICE: Good practice in men's health should be highlighted and shared

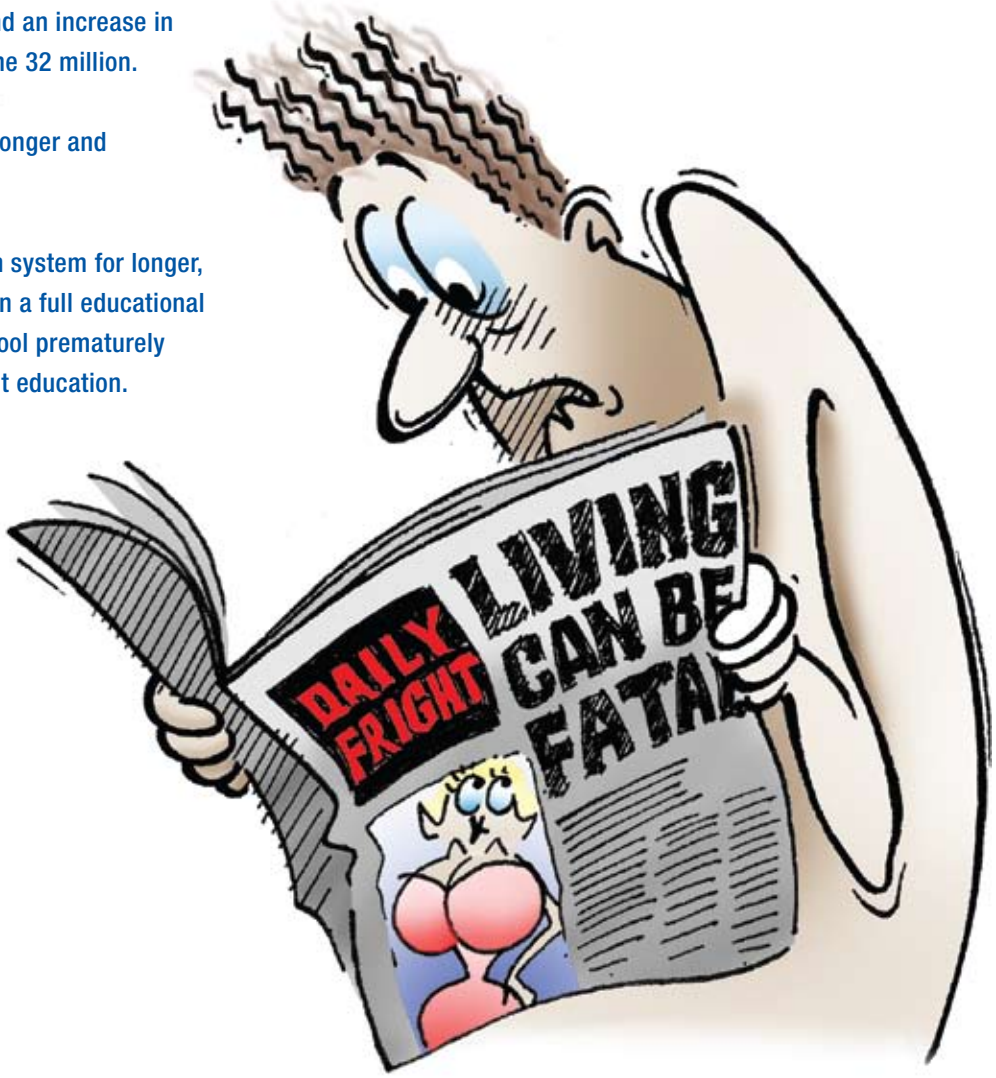
- RESEARCH: identify all the factors in post-industrial society both within and without the individual implicated in premature male death

- **The main recommendation in each section of this report is in bold**.

# The male population

# 2

- There is an increasing longevity of much of the male population, but this is coupled with a decline in the birth rate. If the current projections for the changing male population are correct, there will be a reduction of nearly 24 million working age men (aged 15-64 years) across the EU27 by 2060 and an increase in the number of men over 65 by some 32 million.
- Young men are living at home for longer and deferring the age of marriage.
- Boys and girls are in the education system for longer, but boys seem to be missing out on a full educational experience, with more leaving school prematurely and fewer entering tertiary or adult education.
- Patterns of work are changing, with men having higher unemployment levels than women, and men being less likely to have a job for life.



To be healthy is not just about the absence of disease; it is also dependent on being part of society, having an education, a job, a family and to be able to live a reasonably safe and secure life. Examination of these broader determinants of men's health and wellbeing and an exploration of the way men live their lives creates a useful backdrop to understand the context for the health challenges men are facing.

There has been a steady and continual change in the male population structure across Europe. A falling birth rate and longer life expectancy are creating a growing mismatch between the young and the old. There have also been major changes in the social roles of the population and in many cases these have been extremely beneficial and have improved the lives of both men and women.

There are emerging issues, however, that are seeing men in more vulnerable positions, such as the shrinking economy putting a strain on jobs leaving many men in transient part-time work or unemployed, or through the increasing likelihood of divorce resulting in men losing contact with children and having to face a future alone.

It is also recognised that men are not a homogenous group, with marked differences existing as a result of their social position within society. Examples include men who are facing the challenges of moving to life in a new country through migration or the seeking of asylum or are incarcerated in prison or are homeless or are living with disabilities.

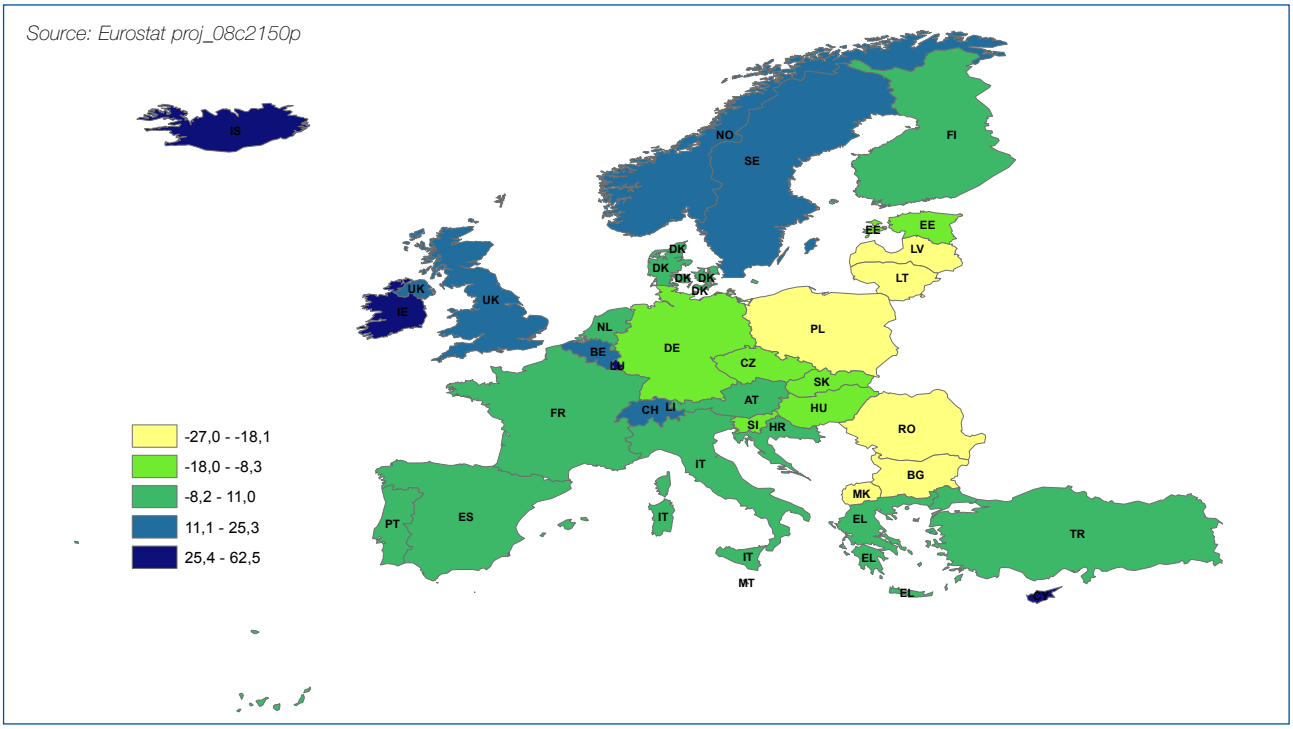
# Total male population

Over the past couple of decades there have been marked changes for many countries in the structure of their male population; for most this has seen an increasingly aged population, with a quite rapid reduction in the number of young as compared to the old. Few countries have seen an increase in their 0-14 age group, with the Eastern European countries showing the biggest decreases.

By 2060 EU 27 is expected to see 23.8m fewer men in the 15-64 working age bracket and an increase of 32m in those men aged over 65 years.

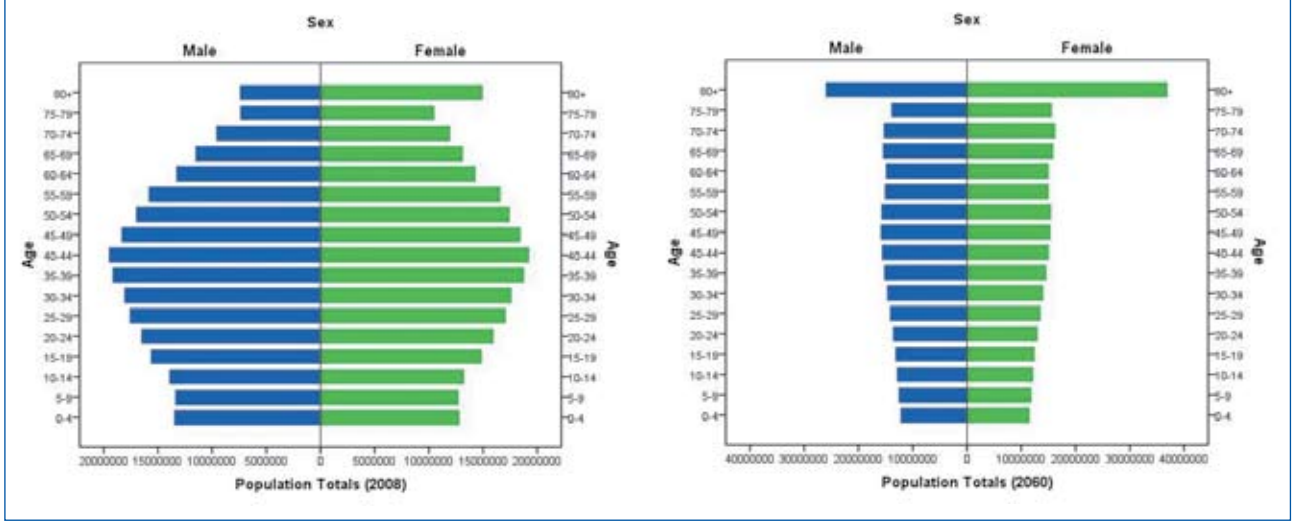
**Percentage change in male population from 2010 to projected numbers in 2060**

*Source: Eurostat proj_08c2150p*




**Population trends from 2010 to projected numbers in 2060**

*Source: Eurostat proj_08c2150p*



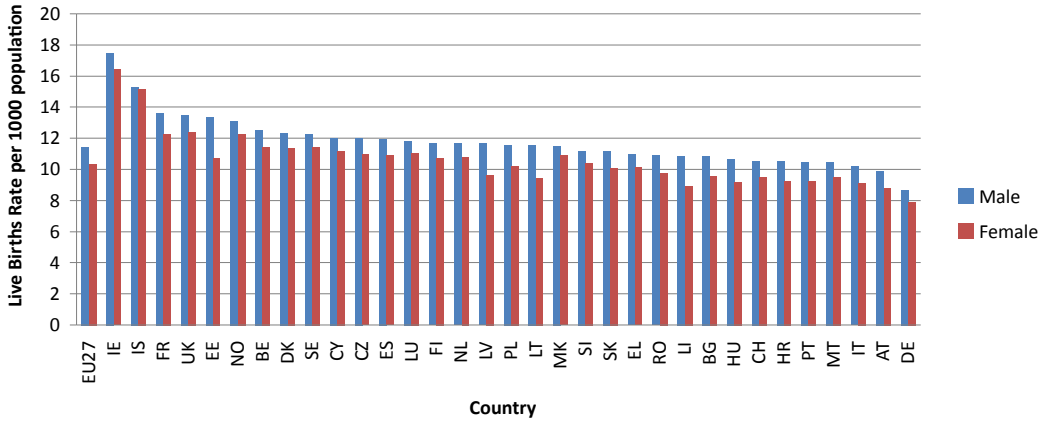
# Birth rate

There is a ratio of 105 boys for every 100 girls born, with the rate of live births varying between countries.

Ireland and Iceland have male live birth rates above 15 per 1,000 population as compared to Germany with 8 per 1000 population and the EU27 average of 10 per 1000 population. A falling birth rate has been noted (EC 2007) and highlights changing trends in the age of having children, and the numbers of children being born, rather than the survival of children at birth.

**Live births per 1,000 population, by country, 2008**

*Source: merged data from Eurostat demo_magec and WHO Health for all database.*




# Living arrangements

In 2008 half of the male population of the EU27 were still living at home at the age of 26 years[6]. A study by the Office of National Statistics[7] in Britain has found that 25% of men aged 25-29 years are still living with their parents (almost double that of women, 13%), with 10% of men still in the family home past the age of 30 years. The majority of these men tend to have lower educational attainment and to be economically inactive. However another group is men who left home to go to university and have had to return home through inability to find work.

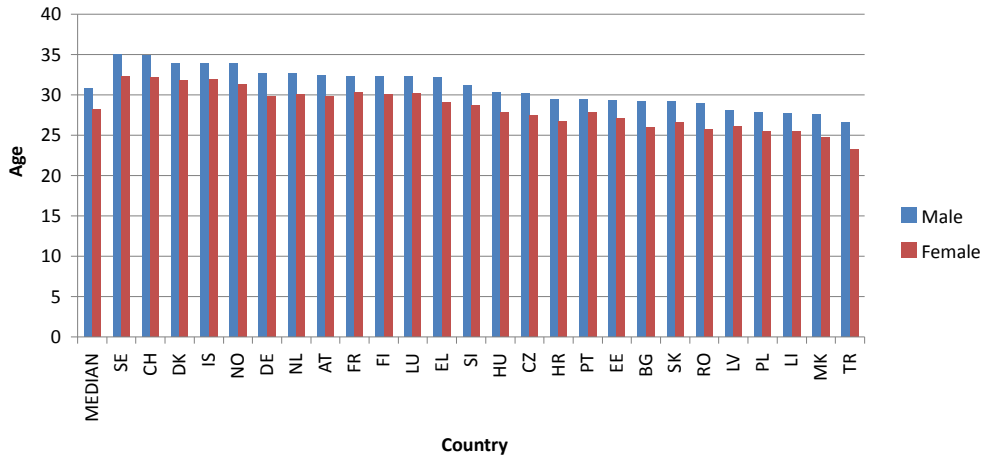
A Flash Eurobarometer[8] report found that the most common reason for young people staying at home was due to an inability to afford to move out and a lack of affordable housing. In contrast, a further study found that the dynamics within the family home and the educational level and social status of the parents had a greater influence[9]. Decreasing levels of parental support and being more romantically active have also been found to be strong indicators of when a child may leave the home[10].

# Marriage & Divorce

There is an overall trend across Europe that men are getting married later as compared to 1995, with Denmark and Poland having the lowest increase (just over 2 years), and Hungary now seeing a 5 year delay as compared to 1995 (for most countries it is just over 3 years). There are country by country variation in mean age of marriage for men and women.

**Mean age of 1st marriage by sex and country, 2008**

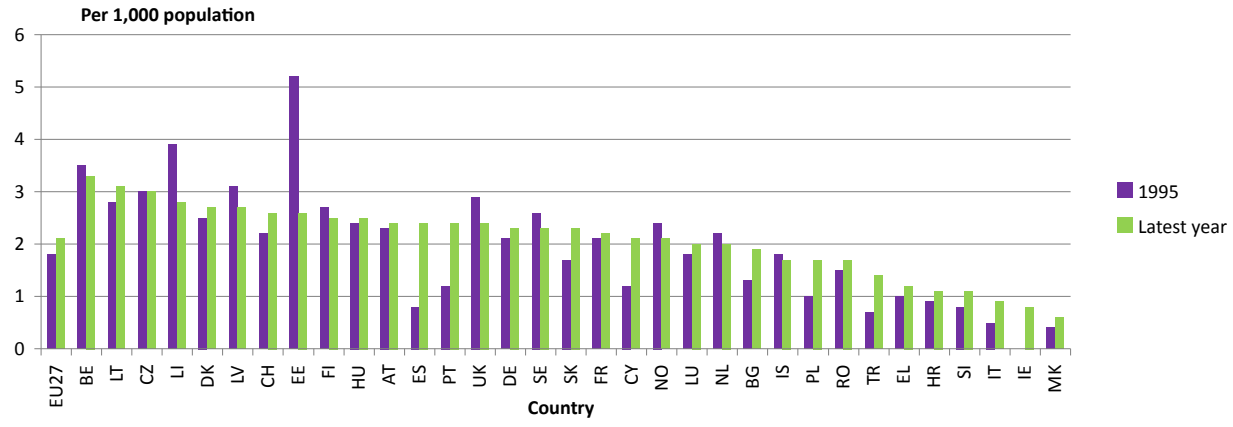
*Source: Eurostat Demo_nsinager*




The rate of divorce over the last ten years has continued on an upward trend in the majority of countries across Europe, with Spain seeing the biggest increase, but there are countries where there is either a very small increase or a decrease with Estonia seeing the biggest decrease in those getting divorced. The importance of being in a stable relationship is particularly important for men as it has been found that men who were never-married, divorced or separated are more likely to report poorer health, and also more likely to die prematurely than men who are married[11].

**Trends in divorce rate per 1000 population, by country, 1995-2008**

*Source: Eurostat demo_ndivind*



# Men as fathers

It is a new phenomenon for men to be present at the birth of their own children, to be involved to any great extent in caring for their small children, and taking parental leave, not to mention being primary caregivers for newborn babies and infants.

Among the European countries, the number of fathers who take parental leave is still low. However, considering the fact that cultural norms and stereotypical gender roles have existed for hundreds of years, the number of men taking an active parental role can also be seen as relatively high[12].

Studies on the ability of fathers to take care of newborns and infants show that fathers are fully capable of doing so and that the care they provided for their infants is similar to the mothers'[13].

Men's engagement in family life and upbringing seem to also have positive effects on men's health and men's lives in general. Men who avail of parental leave are less likely to get divorced, and men living with partners generally have better health. Furthermore it has been established that men engaging in parenthood have better physical and mental health[14].

# Education

Educational attainment influences overall health and wellbeing: men with professional qualifications have a much higher life expectancy and lower levels of long term health problems. Having limited education also increases the degree of social exclusion experienced.

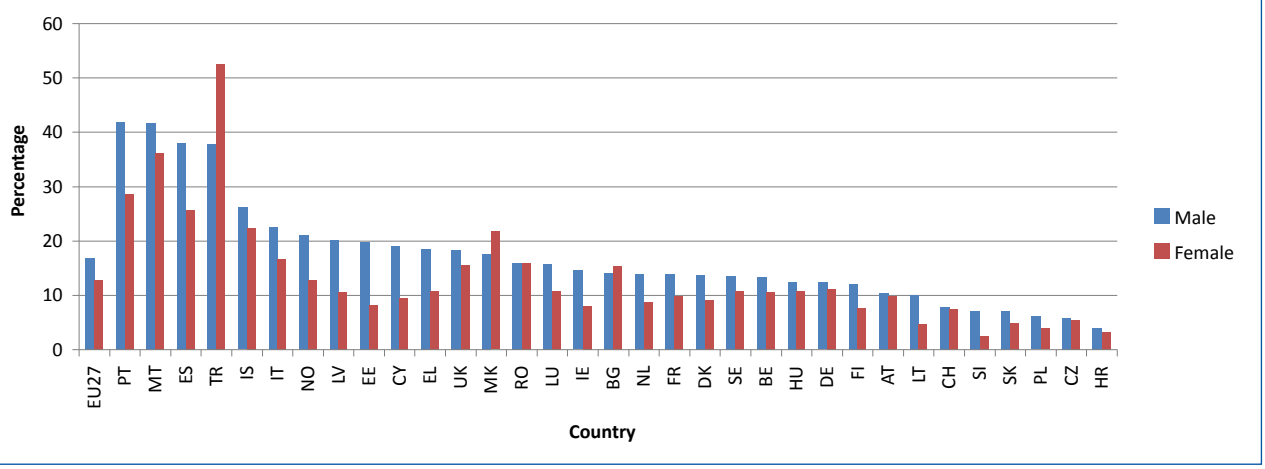
Boys are much more likely to be early school leavers. Boys' secondary education is more likely to prepare them to move directly into the labour market, compared to girls who are mainly being prepared for tertiary education, where they outnumber boys by a ratio of 1.23:1[15].

There has, however, been an increase of some 22% across the EU27 in the number of younger men (25-39 years) having had a tertiary level education as compared to older men (40-59 years).

The data relating to those who are not participating in adult education shows that there are similar numbers of men and women. However, marked differences exist between the countries; most noticeably between the extremes of Sweden and Hungary where nearly all of the population in Sweden are engaged in Adult Education compared to less than 10% in Hungary.

**Early school leavers, percentage of males and females aged 18-24 with at most lower secondary education and not in further education or training, by country, 2008**

*Source: Eurostat educ_jatt*



# Working Life

The employment status of men and women has changed considerably over time and it is now much more common for men and women living as couples to both be employed. When children are present then there is a shift to either more work for both partners or towards either the woman or man giving up their job. It should be noted however that, across the EU 27, employment rates for women drops 11.3% and for men increases by 7.7% when children are present[16].

Analysis of the use of time for men and women highlights that work forms the major part of most men's active lives[17]. In most capitalist societies men are still defined as the 'breadwinner', and being at gainful work is a very important factor in a man's life.[18]

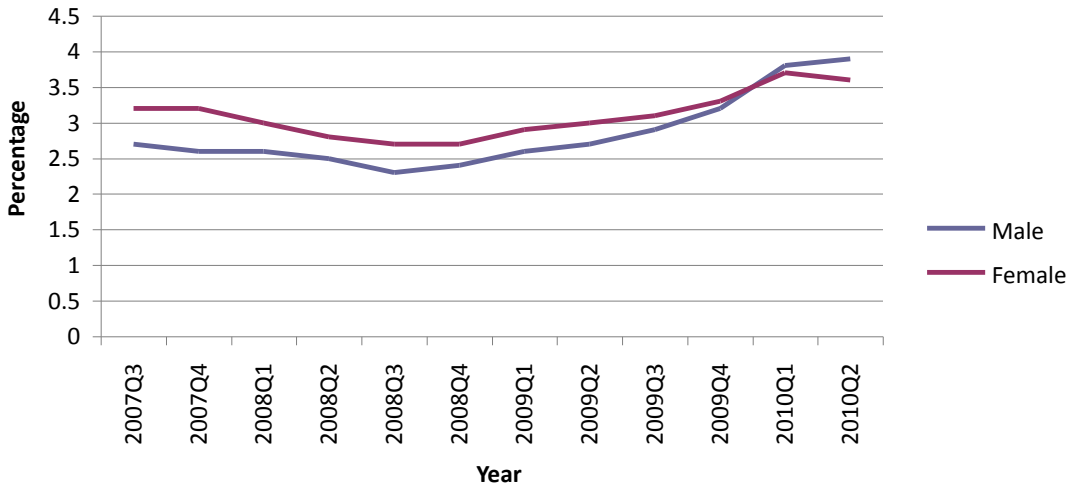
Across Europe the tendency is for there to be more men in full-time employment and more women in part-time employment, though this isn't always the case. In Estonia, Latvia and Lithuania there is a higher proportion of women in full time employment and in the majority of the Eastern European countries there are more men in part-time work than women. For some men the move into part time work has been a result of a lack of full time employment, especially in Bulgaria, where over 55% of part-time work is seen as involuntary[19].

Among those who are employed full time, longer hours are worked by men, with an EU27 average of 41.1 hours for men and 39.3 hours for women. Men who are self employed have the longest hours with the EU average of 47.8 hours for men and 44.6 hours for women.

The Europe 2020 strategy for jobs and growth was adopted in June 2010[20] with the aim of raising to 75% the employment rate for women and men aged 20-64, through the greater participation of young people, older workers and low-skilled workers and the better integration of legal migrants. By 2007 good progress was being made with more women entering the workforce and a period of relative stability and for the first time saw an increase in employment rates for men. Since then the global recession has created increasing unemployment in men. For the first time, the male long term unemployment rate is greater than female unemployment. This is due to manufacturing being much more affected by recession than services, especially engineering and the construction industries, which employ many more men[21].

**Long-term unemployment - quarterly average, by sex**

*Source: Eurostat une_ltu_q*



# Migrants & Asylum seekers

A wide range of health issues are connected to the migration of men, including communicable and non-communicable diseases, maternal and child health, work accidents, and psychological problems.

The migration process is usually a stressful event. It places migrant men at increased risk of morbidity. Social, economic, cultural and linguistic barriers may pose obstacles using health services and to the capacity of services to meet the needs of migrant workers. Many migrant men also find themselves working and living in hazardous conditions.

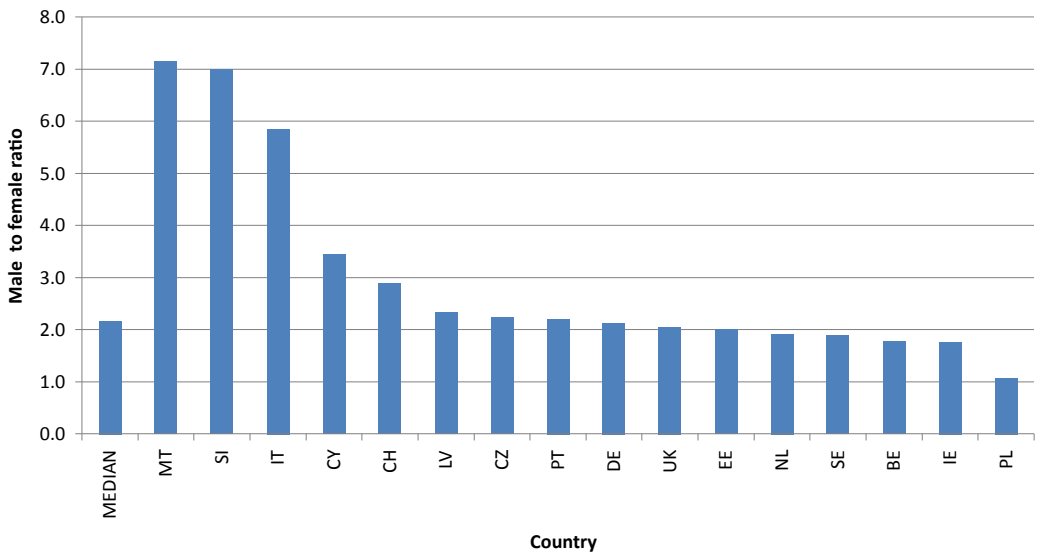
Migrant men are not necessarily disadvantaged in all aspects of health. Many studies have shown that chronic diseases are less prevalent in some migrant groups compared to host European populations. Many European countries have selection processes which deny admission to individuals with existing illness or support self-selection of healthier individuals. Another reason relates to a difference in timing between the health benefits and the health risks of migration. For several conditions, many migrants may display better health indicators than the host population.[22] However, over time these advantages decrease and migrants begin to assume the characteristics of the host populations.

Across Europe, about a third more men than women emigrate, with Slovenia having over twice as many men than women leave the country. There are nine countries where more women leave: these tend to be in Eastern Europe.

The number of asylum seekers across Europe varies considerably, with just 20 men seeking asylum in Latvia compared to 22670 in Italy and 12015 in the UK. In all countries there are higher numbers of male asylum seekers compared to female. Predominately it is in the younger age group that we see higher levels of men seeking asylum. Men also feature more highly in the failed asylum data: the majority of those who are rejected are male.

**Male to female ratio of new asylum applicants, by country, 2008**

*Source: Eurostat migr_asyappctza*



## Prisoner and Offenders

Men constitute the majority of the world's prison population.[23] Across Europe, approximately 2 million people are imprisoned, many of whom have multiple health and social problems[24].

Those entering the criminal justice system have often experienced a lifetime of social exclusion, including poor educational backgrounds, low incomes, meagre employment opportunities, lack of engagement with normal societal structures, low self-esteem, impermanence in terms of accommodation (including bouts of homelessness) and relationships with family members[25].

Research has also consistently demonstrated that the prevalence of ill health in the prison population is higher than what is reported in the wider community[26]. Factors within prison systems can demote aspects of prisoners' health. Examples include long periods of time locked in a cell; overcrowded conditions; a lack of privacy; limited autonomy, choice or control; bullying and violence and limited amounts of exercise[27].

Prisons can offer the opportunity for rehabilitation, both in terms of tackling the high proportion that go on to re-offend. They can also give opportunities for working with men to help to improve their health and well-being. Prisons can represent an escape from the toxic environments from which many prisoners have come, whilst drug rehabilitation and the teaching of life skills such as anger management and work skills can provide a basis for the successful re-integration within society[28].

## The homeless

Being homeless is one of the most extreme examples of poverty and social exclusion in European society[29].

Homelessness is usually associated with people's parents, other relatives or friends no longer being able or willing to accommodate them.[30] Alcohol and drug abuse are often strongly implicated. Though many women are affected by homelessness (often as a result of domestic violence), more men find themselves having to sleep rough. A study in the Netherlands found that 88% of the homeless were men[31], whilst a UK study found that young men were twice as likely to be homeless than young women.[32]

There is a particular problem with men who have found it difficult making the transition from an institution back into civilian life. A high number of ex-servicemen are affected by this through a combination of alcohol abuse and reactions to psychological trauma.[33]. Prison leavers are also a group who feature high in the data on the homeless, with 34% of London's rough sleepers having been in prison[34]. In some countries, illegal immigrants constitute the greatest proportion of those sleeping rough or using overnight shelters, the majority of whom are male.

The health implications of sleeping rough are profound, with increased risk of premature death and serious illness including increased risk of pneumonia, TB, sexually transmitted infections, new and compounded effects of existing mental health problems.

## Men who are disabled

Disability has a marked affect on the heath of men, their masculine identities, and the interaction between masculinity and health[35,36].

Disability comes in many forms and men are much more likely than women to have high levels of accident and work related disability. For instance, around 7% of European workers have some form of work-related hearing problem. The WHO considers adult onset hearing loss as the 15th most serious health problem[37]. The sectors identified as having the biggest problems being those mainly employing men: agriculture, forestry, fishing, mining and quarrying, extraction, energy and water supply, manufacturing, and construction[38]. With the changes in modern warfare and improvements in battlefield health care, there are also now a significant number of young men returning from conflict with severe disabilities.

Improvements in the care of the young disabled has resulted in a growing number of men entering adulthood with profound physical and learning disabilities. In addition to these men with very special physical and emotional health needs there are a much larger cohort of men with mild to moderate learning difficulties trying to negotiate an increasingly complex society[39,40].

## Summary

The emerging demographic picture will have a marked impact on men over the coming decades, with implications for how men live, are educated, and work. An expanding older population will put an increased strain on resources at a time when the younger population are diminished in number. Changing patterns of work and fewer jobs for men is occurring at a time when European policy is striving to retain more men at work for a greater proportion of their lives. The message that we need a highly qualified workforce still seems to be missing a large proportion of men, with relatively few entering into tertiary education or taking up adult education opportunities.

More men are living at home for longer before getting married and family size is reducing with children being born later in married life. For many men there is the prospect of divorce and the health challenges that brings.

The movement of men across borders through emigration, or asylum seeking may be plugging some of the demographic gaps in the younger population for some countries, but internal migration within Europe has a negative effect on the workforce in the home countries. It also brings with it challenges in how these young men will be enabled to manage their health and wellbeing in their host country as they tend to be working and living in poor conditions.

There are other groups of men who also face particular health challenges, which include those who are in prison, the homeless and men with disabilities.

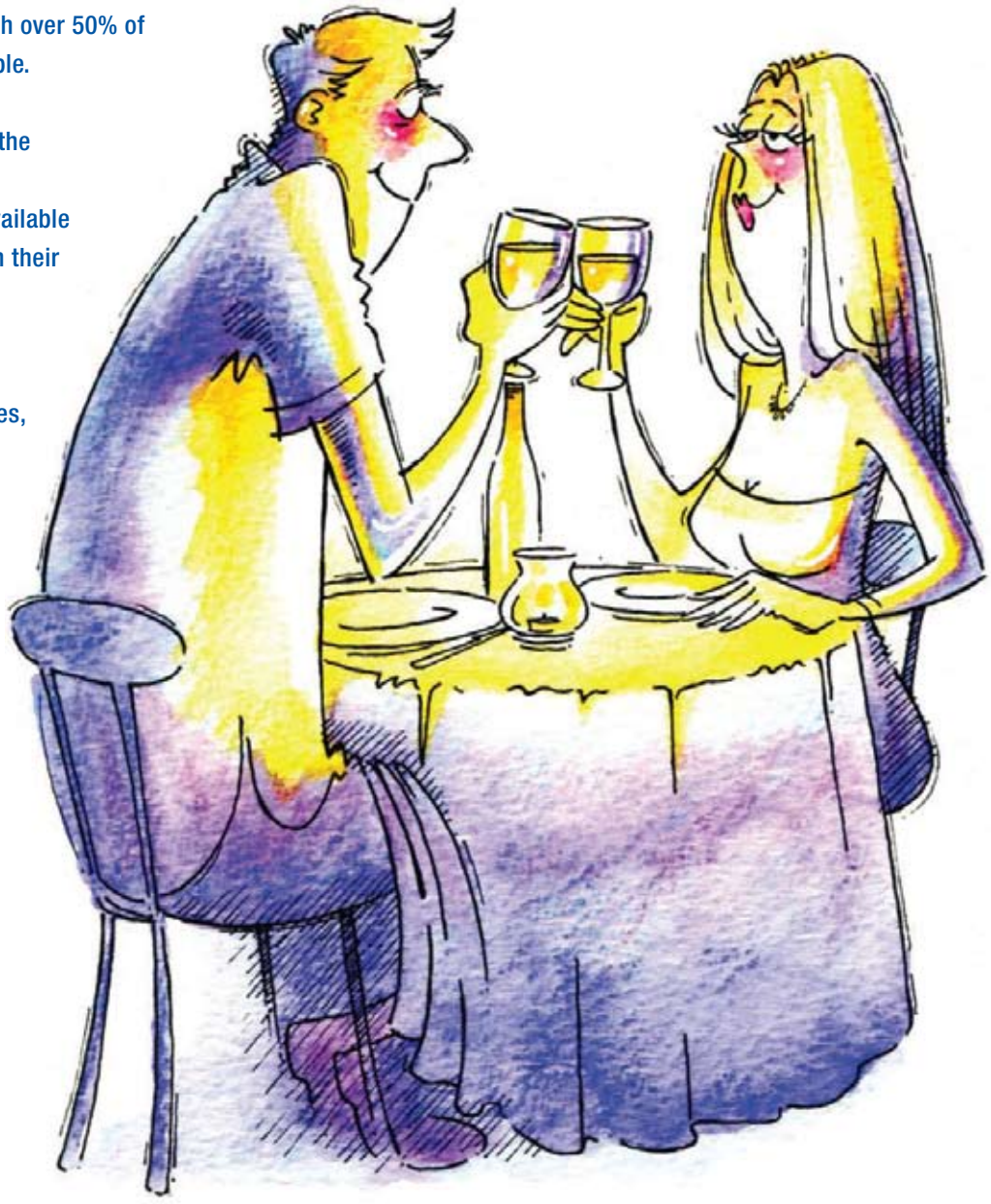
## Headline recommendations for actions:

- **Develop services and programmes that go where all men are (at all ages of their lives including schooling, education and the workplace) and which particularly reach out to excluded groups of men including those who are unemployed, homeless, migrants, prisoners or ex-prisoners, disabled, divorced etc.**

# Lifestyle & Preventable risk factors

# 3

- Poor lifestyles and preventable risk factors are still some of the principle causes of premature death and morbidity in men, with over 50% of premature deaths being avoidable.
- There are strong links between the socioeconomic and educational background of men and their available health choices, which impact on their wellbeing.
- A gender element exists with regards to men's lifestyle choices, with social pressure increasing the likelihood of adopting risky behaviour.



Lifestyle and health behaviours play a critical role in influencing health, illness, and mortality. Epidemiological studies implicate particular lifestyle patterns as a major factor in premature death rates[41], particularly among men[42].

This has been confirmed by a growing shift in health care policy towards the importance of health behaviours, disease prevention and lifestyle[43]. At both EU and individual member state level, policy statements clearly implicate cigarette smoking, excess alcohol consumption, physical inactivity and poor diet in the aetiology of many of the principal causes of mortality and morbidity, including cardiovascular and respiratory diseases, and some cancers. It is, however, crucially important to understand that lifestyles are not simply the product of individual choice. They are influenced by much broader economic, social, environmental and cultural factors[44,45]. Across and within Member States those who are in poorer material and social conditions eat less healthily, exercise less, consume more alcohol, and are more likely to smoke or misuse drugs. In the context of addressing premature mortality among men, there is a growing awareness of the need for lifestyle modification early in life among men engaged in damaging health behaviours.

# Tobacco Smoking

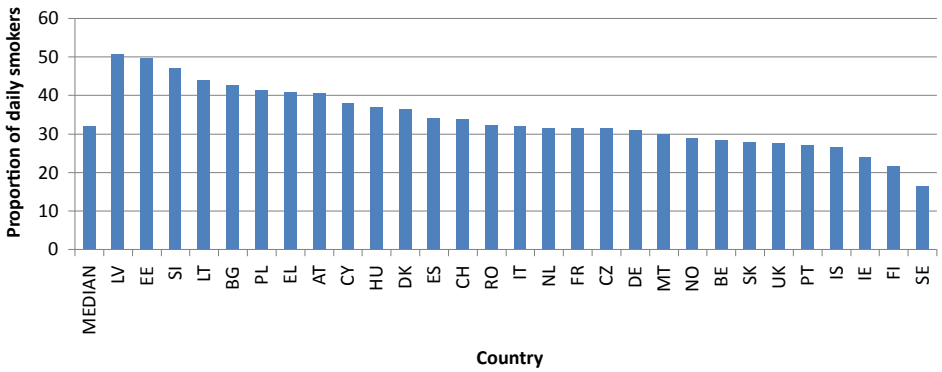
Tobacco use is the major causes of preventable death in Europe. It has been estimated that 15% of all deaths in the European Union - including 25% of all cancer deaths - could be attributed to smoking[46]. Every year, over half a million Europeans die prematurely because of tobacco use or exposure to tobacco smoke. In addition to the loss of life, smoking-related deaths and illnesses impose enormous economic burdens - over €100 billion per year. Across Europe, men are more likely than women to have ever smoked tobacco: 63% of men have smoked tobacco at some point in their lives, compared to 45% of women. Men are also more likely to be current smokers (32% vs 21%)[47]. However, some countries have seen a reduction in the sex gap in smoking over recent years due to decreases in the number of male smokers and increases in the number of female smokers[48]. Although men are more likely than women to smoke, there is variability in smoking prevalence between men in different countries and among men within the same country. The proportion of male daily smokers ranges from a low of 17% in Sweden to a high of 51% in Latvia. In some countries half of the population smoke; in others only 1 in 6 men do so.

Smoking prevalence varies with education level. In nearly all countries, men with post-secondary education and men in higher socioeconomic groups are least likely to smoke.[49].

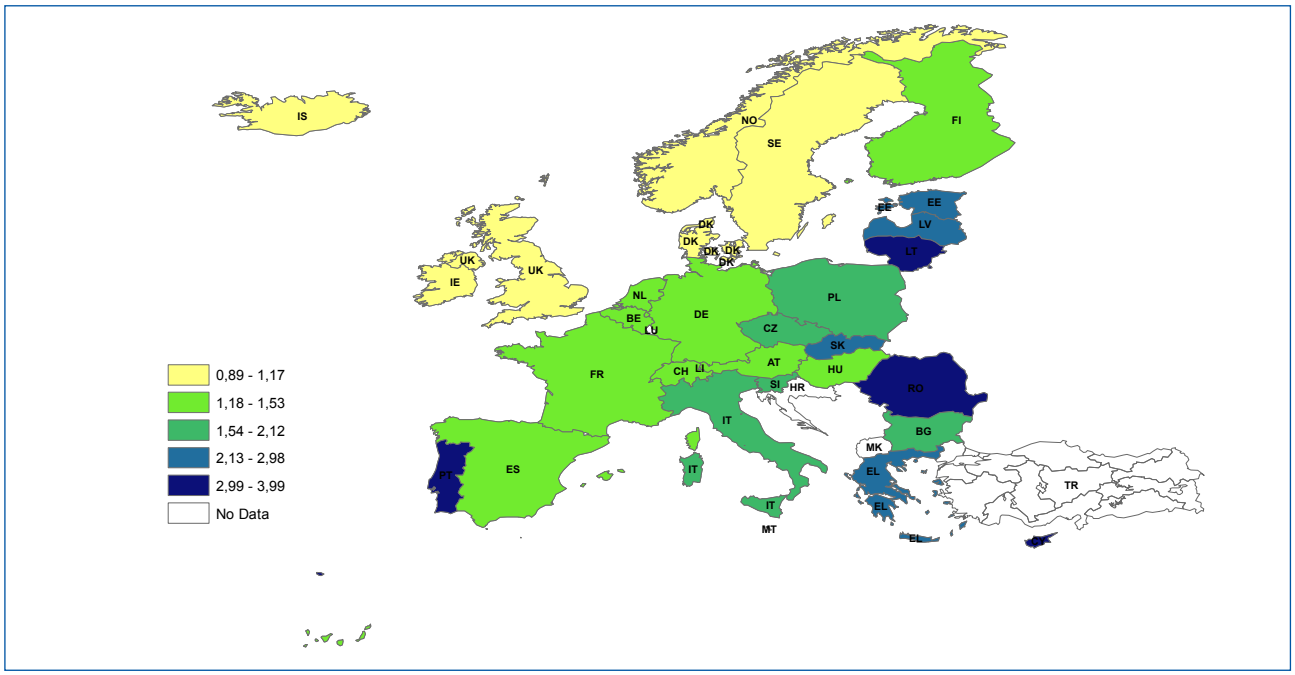
Among young people there is less clear

**Proportion of daily smokers, by country, 2004**

*Source: Eurostat hlth_ls_smke*



**Male to Female ratio of proportion of daily smokers**




evidence of sex differences. In the majority of countries, girls are more likely to be smokers, but the sex differences are moderate in most. As observed among adults, there is wide variation in the prevalence of smoking among boys across Europe: the proportion of 16 year old male smokers ranges from 15% in Iceland to 44% in Latvia. Although there are no definitive patterns, rates of smoking among young men tend to be higher in Central and Eastern Europe, and lower in northern Europe. Other European surveys reveal that boys and young men perceive significantly less risk associated with smoking tobacco[50]. In addition to being more likely to smoke, men - particularly manual workers - are more likely than women to be exposed to tobacco smoke at their place of work (ibid). Furthermore, there is wide variation between countries within Europe in terms of the presence and comprehensiveness of restrictions on smoking in workplaces. Among people who work in enclosed workplaces, men are less likely than women to be employed in smoke-free workplaces (ibid).

# Alcohol consumption

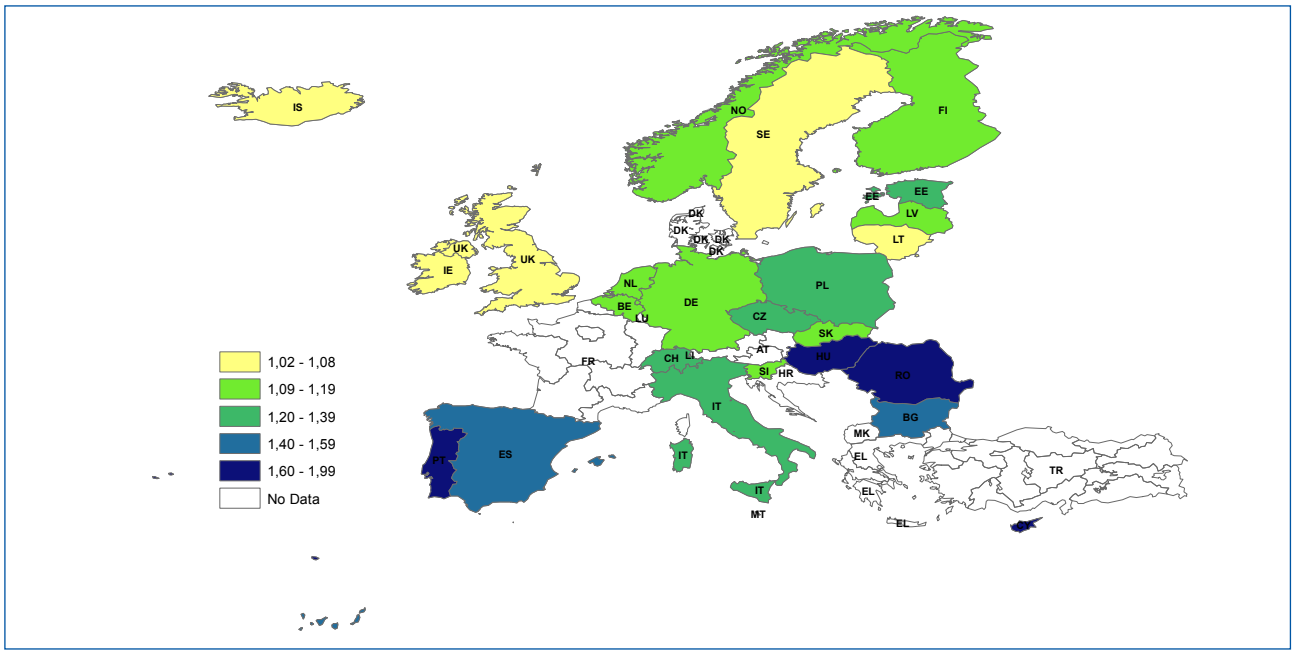
Alcohol-related harm is a major public health concern in the EU, accounting for over 7% of all ill health and early deaths[51]. Excessive alcohol consumption is the third most important cause of morbidity and mortality in Europe[52].

Episodic heavy drinking increases the risk of accidental injury or death, and the risk of being the perpetrator or victim of violence. It is often implicated in antisocial behaviour. Excessive alcohol consumption may also lead to negative outcomes for relationships, family, friendships, employment, and finances.

Per capita alcohol consumption in Europe is the highest in the world[53]. Although sex differences in alcohol consumption are decreasing in some parts of Europe, men are more likely than women to drink and to drink in harmful ways. Men are more likely than women to be dependent on alcohol, and alcohol related injury and mortality rates are significantly greater among men than women. Across Europe, deaths due to chronic liver disease are more common among men than women: in 23 out of 31 countries the male death rate is at least double that for women.

The proportion of men who have drunk alcohol

**Male to female ratio of proportion of drinking alcohol in past year**



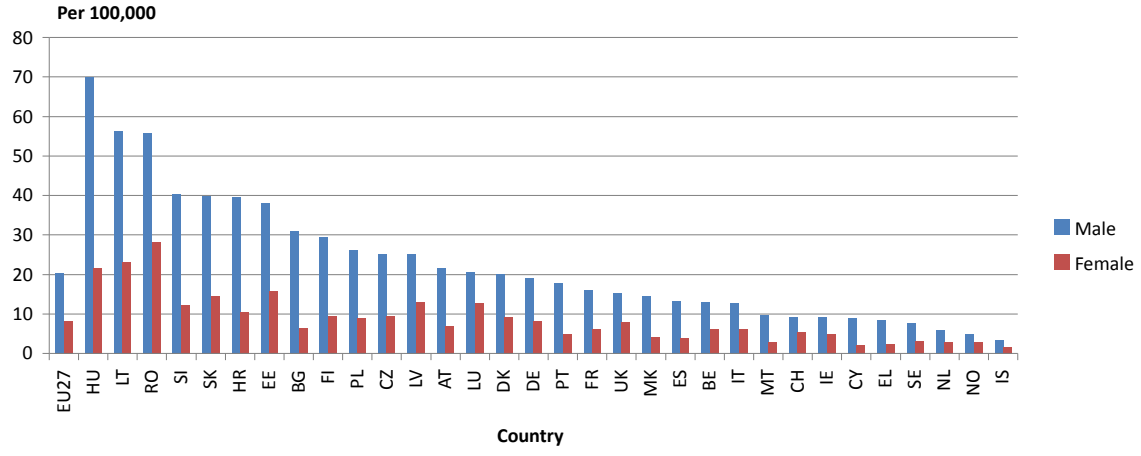

in the last 12 months ranges from a low of 68% in Romania to a high of 94% in Lithuania. Furthermore, the male to female ratio of drinkers ranges from just over 1 to nearly 2. In countries with high prevalence the male to female ratio is practically constant and close to 1:1, increasing as the prevalence decreases.

The proportion of drinkers increases with increasing education. This pattern is found for all men in Europe, and is observed within different age bands and across countries.

Among men, alcohol consumption also varies according to age. The 2007 ESPAD survey of over 100,000 16-year olds revealed lower levels of alcohol use than among adults, but did also find clear sex differences for most measures for alcohol use, particularly excessive and unhealthy levels of consumption. In all countries, the majority of 16 year old boys had consumed alcohol in the last year (ranging from a low of 52% in Iceland to a high of 96% in Denmark).

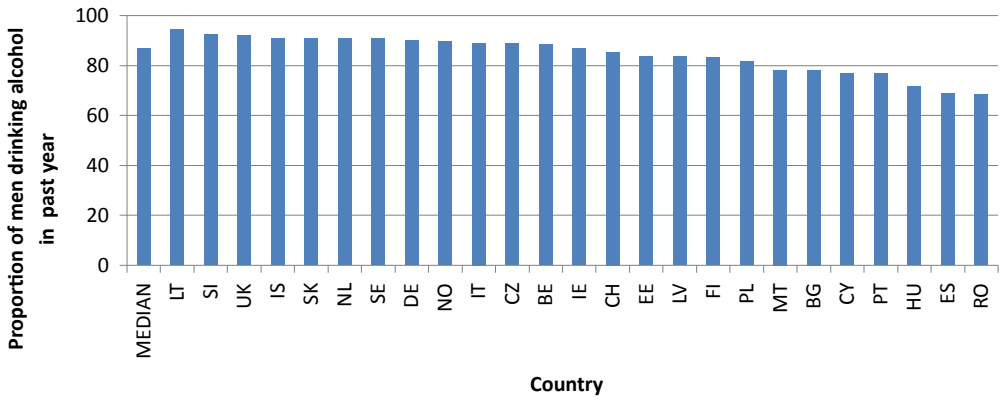
**Age standardised death rates for Chronic liver disease, by sex and country, all ages, latest year[1]**

*Source Eurostat hlth_cd_asdr. 2008 except: BE (2004). DK, LU, PT (2006). BG, IT, MT, PL, RO, FR, SE, UK, CH, EU27 (2007).*



**Proportion of men drinking alcohol in past year, by country, 2004**

*Source Eurostat hlth_ls_dk12me*




# Illicit drug use

Parity of drug use in men and women is only found in young people, and only in some countries: in general drug use is considerably more common among men than women. However, it is important to note that male to female use ratios vary for different drugs and that across Europe, there is wide variation in men's patterns of illicit drug use[54].

Men are more likely than women to have ever used cannabis and to have used cannabis within the last year. In no country were women more likely to have ever used cannabis, and in only one country (Ireland) were women more likely to have used cannabis in the last year.

Men are also more likely than women to have ever used ecstasy, with the exception being Latvia where equal proportions of men and women had used this drug. Among young people, there is less clear evidence that boys are more likely than girls to have ever used ecstasy. Large sex differences also occur in the use of cocaine, with about 2:1 more men using this drug.

The 2007 ESPAD survey of over 100,000 16-year olds in 35 European countries revealed that boys were approximately twice as likely as girls to have used steroids (ibid). However, the proportion of young men who had used anabolic steroids ranged from 1% or less in 9 countries to 7% of boys in the Czech Republic. A clear exception to the general finding of higher levels of drug use among boys was the finding that girls were markedly more likely than boys to have used tranquilisers or sedatives without a prescription.

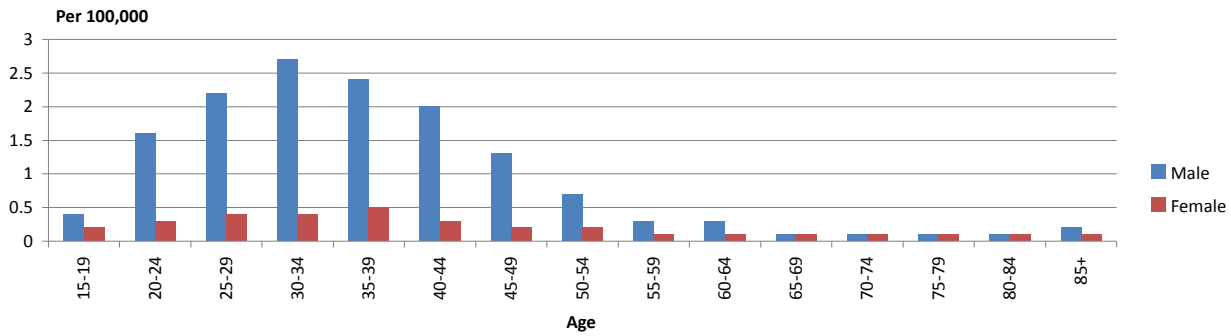
Sex differences in patterns of illicit drug use correspond to sex differences in attitudes and beliefs about drugs. A survey of 15-24 year olds revealed that although there were no sex differences in the perceived health risks of heroin and cocaine - the two drugs with the highest risk ratings - boys and young men perceived significantly less risk associated with use of ecstasy and cannabis[55].

# Drug-related harm

Reflecting the fact that men are more likely than women to use illicit drugs, there are clear sex differences in negative outcomes associated with illicit drug use. For example 82% of heroin overdose deaths occur in men, with men in their 30s most likely to die from heroin overdoses. In all European countries, drug-induced mortality rates are higher among younger people (15-39) than in the rest of the population. Furthermore, among younger people, drug-induced mortality rates and the proportion of all deaths attributable to drug use are greater among men. However, among young men there is enormous variation between countries in terms of absolute mortality rates and the proportion of all deaths due to drug use.

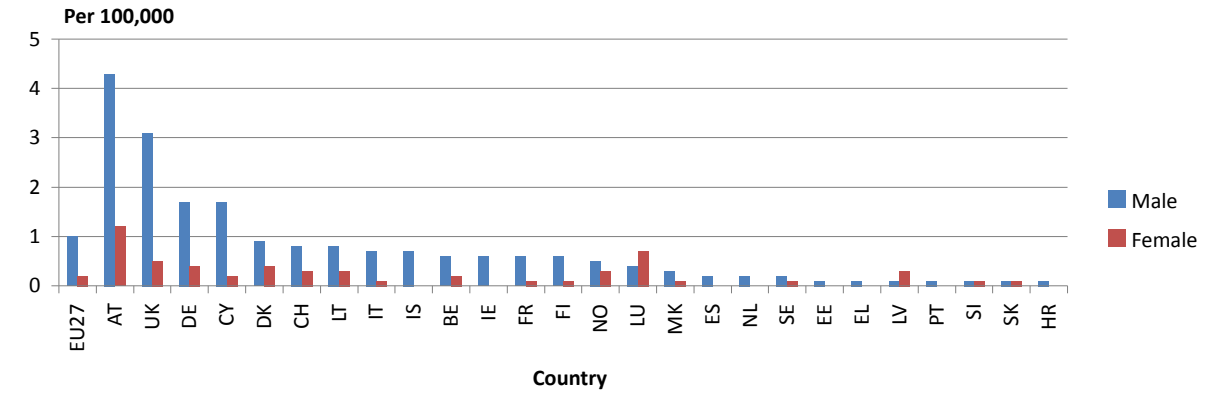
**Age specific death rates for Drug dependence, toxicomania, by sex, EU27, 2007**

*Eurostat hlth_cd_acdr*




**Age standardised death rates for Drug dependence, toxicomania, by sex and country, all ages, latest year[1]**

*Source Eurostat hlth_cd_asdr. [1] 2008 except: BE, SK (2004) EE, HU, RO, MK(2005). DK LV, LU PT (2006) BG, IE, FR, IT, CY, PL, SI, SE, UK, IS, CH, EU27 (2007).*

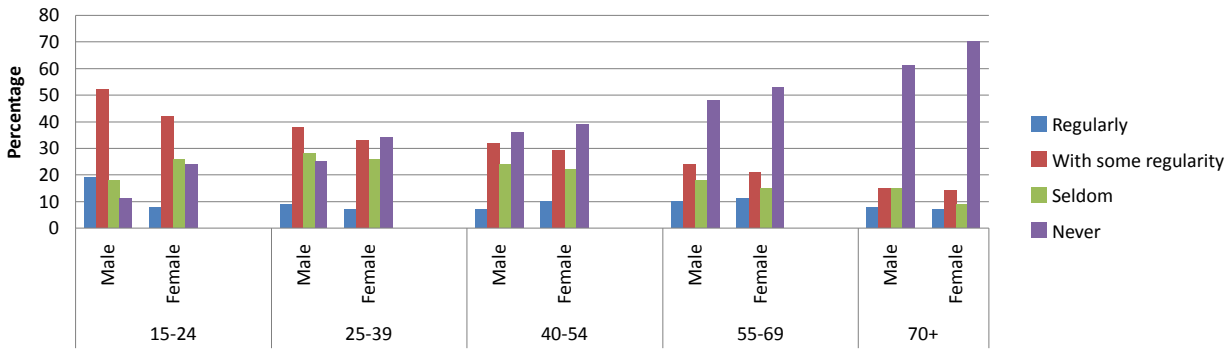


# Physical Activity

There is a long established positive relationship between physical activity[56] and health. Physical activity prevents a range of chronic diseases, including cardiovascular disease, type 2 diabetes, some cancers, and obesity. It has a positive effect on musculoskeletal health and psychological wellbeing[57]. Physical activity also modifies other risk factors such as hypertension, total cholesterol and high-density lipoproteins and is associated with other healthy behaviours such as healthy diet and non-smoking[58]. Physical inactivity, on the other hand, is recognised as a major independent risk factor for chronic non-communicable diseases, accounting for 3.5% of the disease burden and up to 10% of deaths in the European Region[59]. In the 21st century, there are fewer opportunities for physical activity in everyday life, with the result that sedentary lifestyles have increased: Over half of men in the European Union do not reach recommended levels of activity, whilst approximately one in three are sedentary. This has been paralleled by a fivefold increase in obesity between the

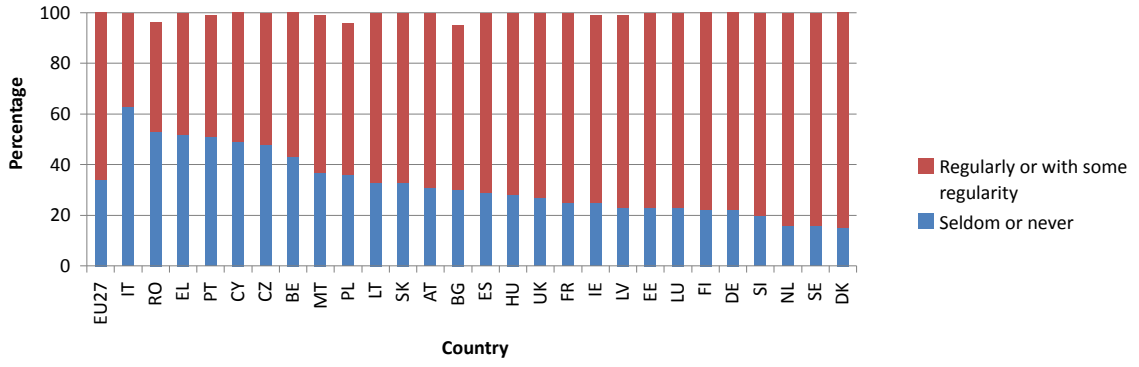
**How often do you exercise or play sport, by sex and age, EU27, 2010**

*Source Eurobarometer 2010*




**Non-sport related physical activity, by country, 2010**

*Source Eurobarometer 2010*



beginning and end of the last century[60]. A study focusing on physical activity prevalence in 20 countries (including 7 countries from the EU), reported that age-related declines in physical activity were much more frequently observed among men than among women[61].

A recent study[62] found that men in the EU were found to exercise or play sports more than women; nevertheless, 56% of men in the EU were found not to engage in exercise/sport weekly.

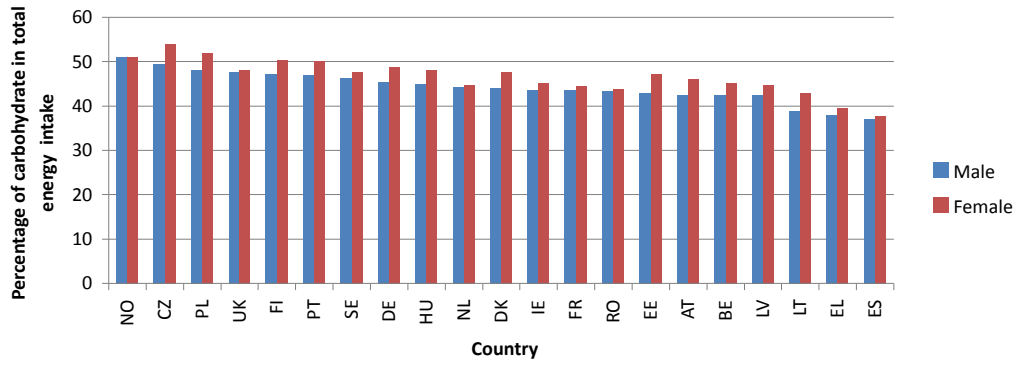
With regard to non-sport related physical activity, the same study showed that 34% of men in the EU were found not to engage in physical activity weekly and this ranged from 15% in Denmark to 66% in Italy. Their findings also suggest women are motivated to exercise more for health reasons, to improve physical appearance and to lose weight; the motivating factors for men are to have fun, to improve physical performance and to be with friends.

# Diet

Unhealthy diets and physical inactivity are among the leading causes of the major non-communicable diseases including cardiovascular disease, type 2 diabetes and certain types of cancer, and contribute substantially to the burden of disease, death and disability within the EU[63] . Men's diets are generally less healthy and less nutritiously balanced than women's diets. Despite the high prevalence of overweight/obesity within the EU, daily energy intake for men is below reference values[64] in most of the participating countries[65]. The share of protein in total energy intake is within or slightly above the recommended range of the WHO[66]. Only men from Norway are within the recommended range for carbohydrate intake.

**Intake of carbohydrates in adults (ages 19-64), by sex and country, 2009**

*Source Elmadfa[67], 2009. HU ≥ 18, UK = 25-64.*



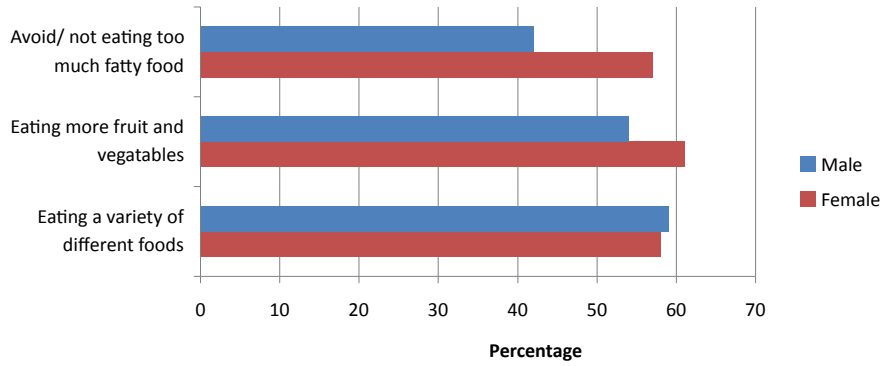

Likewise, the Eurobarometer[68] report shows only German, Norwegian and Polish men meet the recommended daily dietary fibre intake. The majority of European countries are above the recommended range of the WHO share of fat in total energy intake and saturated fatty acids (SFA) for males, with the share of polyunsaturated fatty acids (PUFA) below the recommended intake range in most of the participating countries. Intake of cholesterol is higher in men than in women and above recommended levels in most countries.

There are a number of instances of vitamin deficiencies among men in the EU and the intake of certain minerals is at odds with recommended levels.

Men tend to be less likely than women to associate a healthy diet with eating more fruit and vegetables or with not eating too much fatty foods (ibid). Whilst the vast majority of EU citizens report

**What do you think eating a healthy diet involves?**

*Source Eurobarometer 2006*




having a healthy diet, there are quite striking east/ west differences between Member States. For example, whilst almost all citizens in the Netherlands (95%) and Denmark (91%) consider that they have healthy eating habits, this is much lower among citizens in Latvia (58%) and Lithuania (55%).

The Eurobarometer report (ibid) also highlights that, with the notable exception of having attempted to reduce alcohol consumption, men were less likely than women to have attempted to change their diet over the past 12 months. Motivation for making dietary changes was prompted more by the desire to lose weight for women (39% v 26% for men) compared to staying healthy for men (34% v 27% for women).

Men's nutritional knowledge tends to be more limited than women's[69], and men are less likely than women to read food labels[70]. This may have particular negative consequences for the dietary habits of single men living alone[71]. Men also tend to lack control over their diet, as the purchasing and the preparing of food have traditionally been women's responsibility[72]. This may reinforce more traditional gendered norms for men, depicting them as naïve about healthy food choices. Dietary habits are also influenced by working hours, in particular for those working shift hours, and commuting long distances, which tend to be associated with an increased reliance on convenience foods, snacking and eating out[73].

# Obesity

The relevance of weight to men is that they tend to deposit fat intra-abdominally leading to the apple-shaped android form of obesity, compared to pear-shaped gynoid form of obesity in women[74], whose fat tends to be deposited in their hips and thighs. Though this position is changing with more women developing central obesity, especially from premenopause on[75].

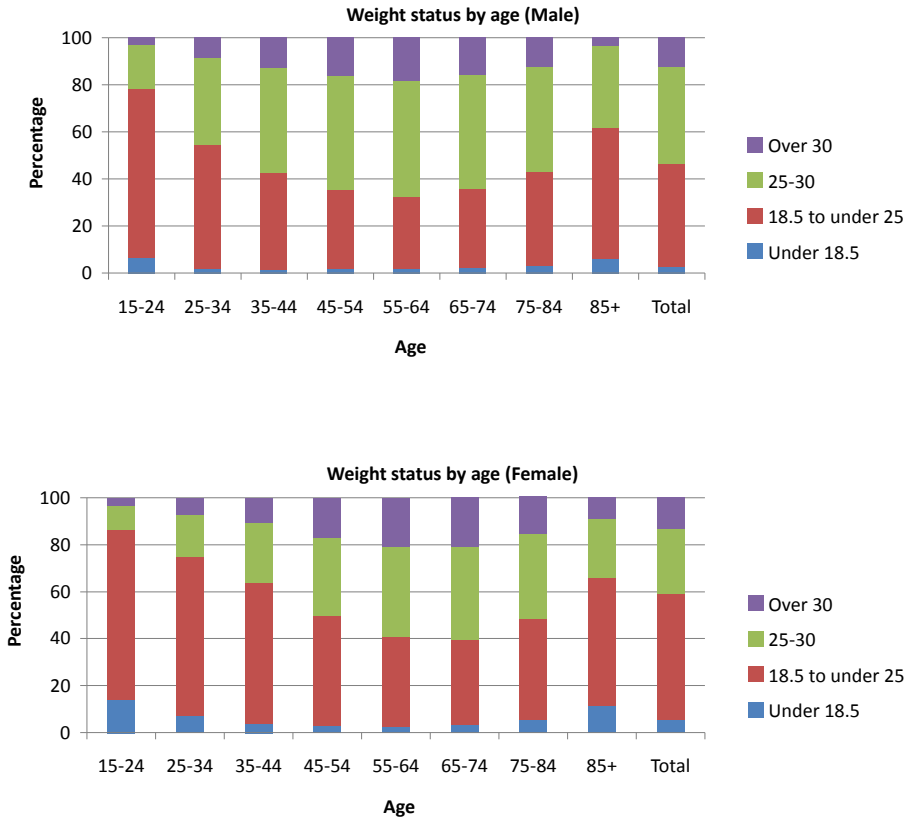
This visceral fat is not an inert substance. It has its own endocrine function, with the creation of fat toxins that can lead to the fat related cancers, such as prostate, testis, bowel, liver, kidney, oesophagus. It also leads to a higher risk of hypertension, hyperlipidaemia, and diabetes as a result of the metabolic syndrome. Other consequences of excess weight include an increased risk of erectile dysfunction, dementia and sleep apnoea.

The growing number of overweight men across Europe is partially attributed to societal changes such as:

- Increasingly sedentary lifestyle
- Decline in manual labour
- Reduction in walking
- Reduced opportunity for exercise
- Changes in eating patterns
- Alcohol consumption
- Long working hours

## Weight status by age and sex, 2004

*Source Eurostat hlth_ls_bmia*

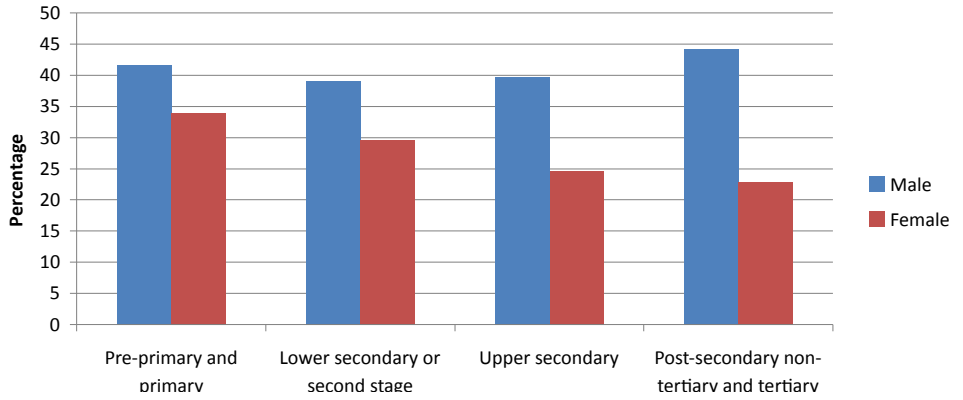



## Weight status for males, by country, 2004

*Source Eurostat hlth_ls_bmia*

**Median percentage of population overweight (BMI 25-30), by sex and educational attainment, 2004**

*Source Eurostat hlth_ls_bmie*




Men's weight tends to be accumulated at a faster rate than women; there are already more men overweight by age 15-24 than women, with a mean of 22% over a BMI of 25 in men and 14% in women. The rate of increase in overweight in men is also noticeable, with an increase to 46% over BMI25 in the 25-34 age range in men compared to 25% in women.

Across Europe, the burden of overweight varies. In Germany, UK, and Greece over 60% of men have a BMI greater than 25. In Norway, Estonia, Latvia and France, fewer than 45% of men are ovrweight or obese.

It appears that the level of educational attainment seems to have a different relationship with levels of obesity and overweight in men as compared to women. With regard to overweight (BMI 25-30) it appears that the higher the educational attainment in men the greater the proportion who are overweight, and the converse for women.

These seemingly anomalous trends may be due to men in lower socioeconomic situations being engaged in more manual work and therefore having greater energy expenditure, or due to lifestyle factors, including higher smoking levels. There may also be issues in relation to greater social acceptance of overweight in men than overweight women. Persistent obesity is not been associated with any adverse adult social outcomes in men, though in women it is associated with a higher risk of never having been gainfully employed and not having a current partner[76]. There is also a strong cultural component, with being big being seen as a sign of strength and prosperity.

# Sexual behaviour and condom use

Men place a greater value on the role of sex in their lives: they give higher ratings of the importance of a range of aspects of their sexual lives, and to the importance of sex in general with regard to their overall wellbeing[77,78].

Sexually Transmitted Infection (STI) rates are affected by a range of factors: age of first sexual experiences, higher rates of change of sexual partners, more diverse sexual networks, and inconsistent patterns of condom use. In the absence of vaccines or effective cures for many STIs (including HIV/AIDS), an important aspect of epidemiological control entails promoting safer sexual behaviour. It is therefore important to monitor risk behaviour. However, it is often difficult to make simple comparisons because of variations in sampling, modes of data collection, and measurement methods.

Studies of patterns of sex differences indicate more risk behaviour among men[79,80,] especially with regard to three key behaviours: age of initiation of sexual activity; patterns of partnering; and condom use.

## Age of sexual initiation

In the second half of the 20th century the median age of first sexual encounter declined by 3-5 years in men and women to be within the 16-18 year old range in most countries[81]. The decline had been larger among women, such that sex differences in the median age at first intercourse have reduced over recent generations. Less educated men tend to be the most likely to report early initiation of sexual activity.

Men tend to report a younger age at first intercourse, and a greater proportion of men than women report first having intercourse before the age of 15. However, in line with data reported above, there was also variation between men in relation to the age of first sexual encounter[82].

## Patterns of partnering

Data from a range of surveys indicate that in most countries, men are markedly more likely than women to report multiple sexual partners: approximately one-third of men and one-quarter of young women report having sex with more than one person in the year prior to data collection[83 84], but there is quite wide variation between teenagers and young adults in each country and between countries.

Men are more likely than women to report casual sexual encounters - i.e., sex with someone other than a spouse or steady boyfriend / girlfriend.[85,86,87] However, again, there is wide variation between countries. Recent research suggests that sex differences may be narrowing for numbers of sexual partners and the prevalence of casual sex, with increasing numbers of women reporting these behaviours[88]. Within countries, there is wide variation according to age, region of residence, and sexuality in the likelihood of reporting multiple partners and having casual sex, but there is evidence to show that this tends to be greater among younger men, men living in cities, homosexual and bisexual men.

## Condom use

In addition to being influenced by the numbers of sexual partners men have, the likelihood of STI infection is influenced by patterns of condom use. Consistent findings from studies of men in different countries are that men are more likely than women to report condom use, and that condom use is more likely among young men and men with higher levels of education[89,90,91].

A survey of 15 year olds across 20 countries in Europe found higher rates of condom use than are found among older age groups. However, there remained a sex difference: 80% of boys reported condom use during their most recent sexual encounter compared to 70% of girls[92]. Although these rates of condom use are quite high, it must be noted that young people are more likely than older adults to use condoms: to some extent this difference may be influenced by the greater likelihood that older men will be in stable relationships and less likely to report multiple sexual partners. Furthermore, there is some concern that patterns of condom use may be in decline[93].

## Sexualities

Men who have sex with men (MSM) often face unique health issues. This term represents a broad spectrum of men from those who identify as homosexual or gay, to men who identify as bisexual, to men who engage in sexual activity with other men but who identify themselves as heterosexual rather than homosexual or bisexual. In addition to variations in terms of sexual identity, MSM may vary according to the contexts and circumstance of their sexual activity, from committed relationships, to opportunistic sex (e.g., in clubs or other public spaces), to coerced or forced sex. Therefore, the health challenges vary considerably due to the risky nature of some sexual encounters. Although sexual health is an obvious focus for concerns about the health of MSM, it is important to note that MSM health needs are not restricted to sexual health. MSM commonly have higher levels of alcohol and drug use[94], [95], and are more likely to experience psychological ill-health[96].

Transgendered men often face particular issues in relation to physical and psychological well-being[97]. Obvious challenges arise for both men and women who find themselves trapped in a physical body that does not represent who they feel themselves to be. Recognition of the physical and emotional health challenges faced by individuals as they come to terms with their dissociation and as they go through possible therapy options by both practitioners and policy makers is important, not least as this is a significant equalities issue.

## Summary

The way men live their lives has a major effect on their overall health and well-being. From childhood onwards the lifestyles that many men develop are building up problems for their future, whether it's smoking, excess alcohol intake, illicit drug use, poor diet or limited physical activity the effect is seen in their high rates of premature death and chronic morbidity.

Young men feel they are living invulnerable lives, able to eat, drink and take risks without fear of the consequences; sometimes the reality is immediate, through the sudden death of alcoholic poisoning, or it may be cumulative effect as in the rising incidence of ischemic health disease or cancer in their early adult years. The risks men face are not only the consequence of the life choices they take, there are anatomical and physiological, social and environmental, and service provision factors that can compound the problems. An instance of this relates to the health problems men have when they are overweight, which are a complex blend of the availability of the right food, a socialisation process of boys with regard to their body size and their diet, an increasing sedentary lifestyle coupled with the male form of obesity comprising central (or visceral) fat deposition increasing the risk of the metabolic syndrome and the fat related cancers. This is then linked to the tendency for weight-loss health promotion and services being focused onto women.

There is difficulty in agreeing the extent of sexually transmitted diseases, but it is apparent that the number of cases is increasing. However the targeting of men with regard to Chlamydia is showing that if the screening is done appropriately then men will engage. Getting men to use condoms is more effective in the young.

Understanding men's lifestyles is a significant factor in the development of health strategy aimed at supporting men to lead less damaging lives.

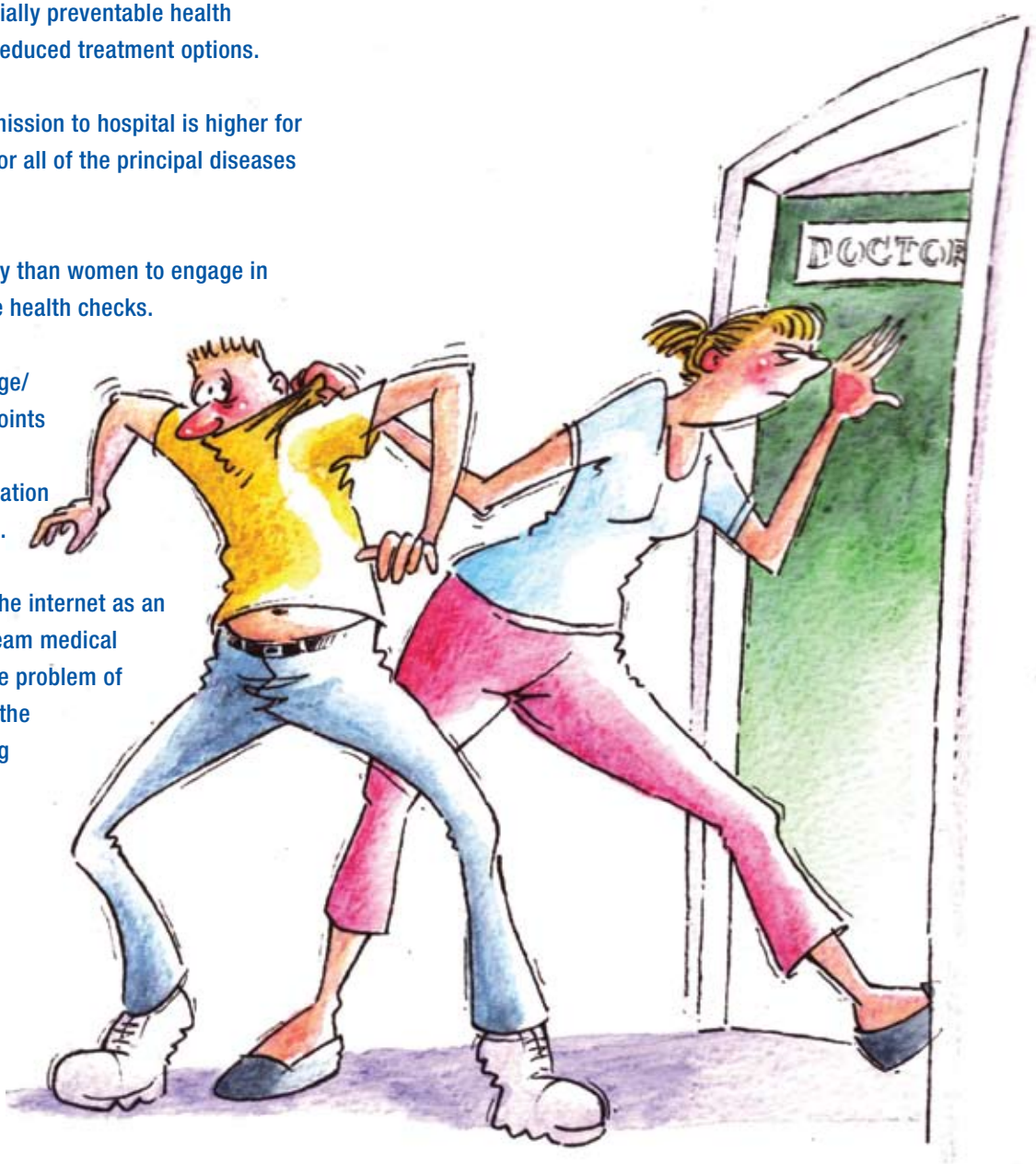
## Headline recommendation for action:

- **Men's health promotion, health literacy and symptom recognition programmes should be developed with the men whom they are targeted at, disseminated through the places where they are to be found, real or virtual, using the techniques of social marketing.**

# Accessing Health Services

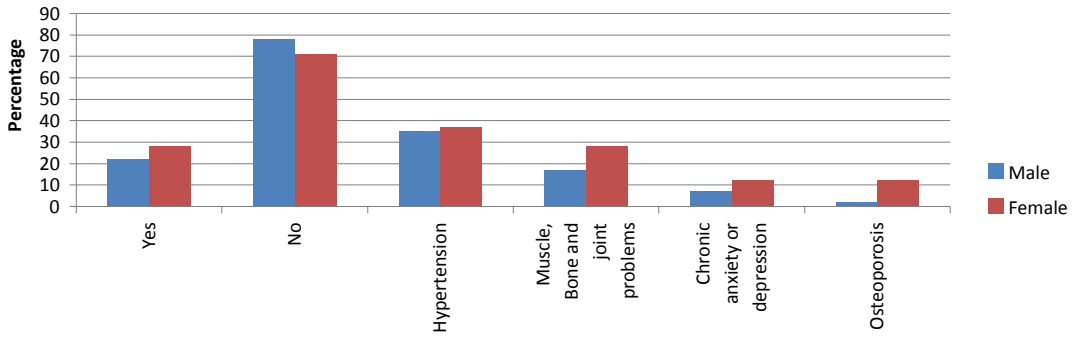
# 4

- Infrequent use of and late presentation to health services are associated with men experiencing higher levels of potentially preventable health problems and having reduced treatment options.
- The overall rate of admission to hospital is higher for men than for women for all of the principal diseases and health problems.
- Men are also less likely than women to engage in routine or preventative health checks.
- Men's poorer knowledge/ awareness of health points towards the need for targeted health information to be delivered to men.
- Men's preference for the internet as an alternative to mainstream medical services can create the problem of missed diagnosis and the possibility of accessing potentially dangerous counterfeit drugs.



**Are you undergoing a medical long-term treatment?**

*Source Eurobarometer 2007*




Analysis of men's use of health services offers insight into the relation of health systems to the overall health status of men. It also allows the effect of men's health promotion and disease prevention strategies to be compared across countries (especially those with more sophisticated measures in place).

Men are less likely than women to report a long-standing illness or health problem (26% v 31%) or to be undergoing long-term medical treatment (22% v 28%)[98]. Hypertension (35% for men, 37% for women) and muscle, bone and joint problems (17% for men, 28% for women) are cited as the most common reasons for medical long-term treatment. There is a higher incidence of all reported health problems in women than in men. Hypertension is more of a problem in East-Central Europe and the Mediterranean, whilst muscle, bone and joint problems are more prevalent in East-Central Europe.

Not surprisingly, men are less likely than women to report long-term disruption of activities due to health problems (26% v 31%); to report pain in the past week that affected their daily living (27% v 37%), or to report chronic restrictive pain (22% v 28%)(ibid).

# Hospital admissions

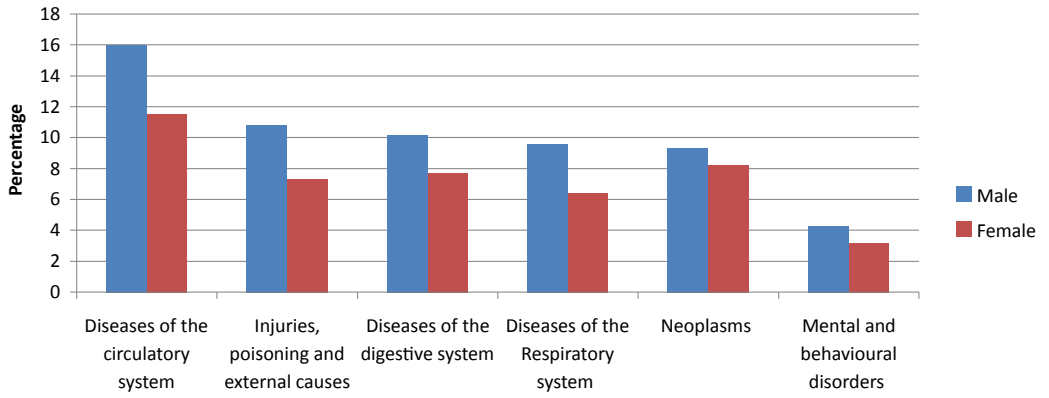
Despite reporting less ill-health and less disruption to normal activities due to ill-health, the overall rate of admission to hospital is higher for men than for women for all of the principal diseases and health problems. Diseases of the circulatory system (16%), injuries, poisoning and external causes (11%) digestive system (10%), respiratory system (10%), neoplasms (9%) and mental and behavioural disorders (4%) account for the highest proportion of hospital admissions for men.

There is considerable variability between countries, with differences in age standardised admission rates per 1,000 population for the six main health categories for men ranging from 10.7 (Cyprus and Portugal) to 40.6 (Lithuania) for Circulatory Diseases; 7.2 (Portugal) to 31 (Austria) for Injuries, Poisoning and External Causes; 9 (Netherlands and Cyprus) to 24 (Austria) for Digestive Diseases; 8 (Netherlands) to 33.6 (Lithuania) for respiratory problems; 5.3 (Cyprus) to 26 (Hungary) for neoplasms; and 1 (Poland, Cyprus, Netherlands) to 17.5 for mental and behavioural disorders.

There are some notable male/female differences in admission rates within countries. For example, the age standardised admission rates

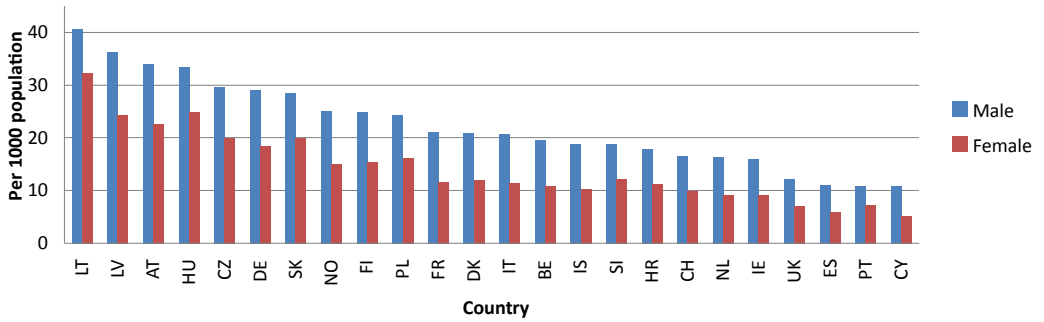
### Diseases as a percentage of all in-patient admissions, by sex, EU_V[1].

*Source HMDB [1] EU_V aggregate which varies according to countries available*



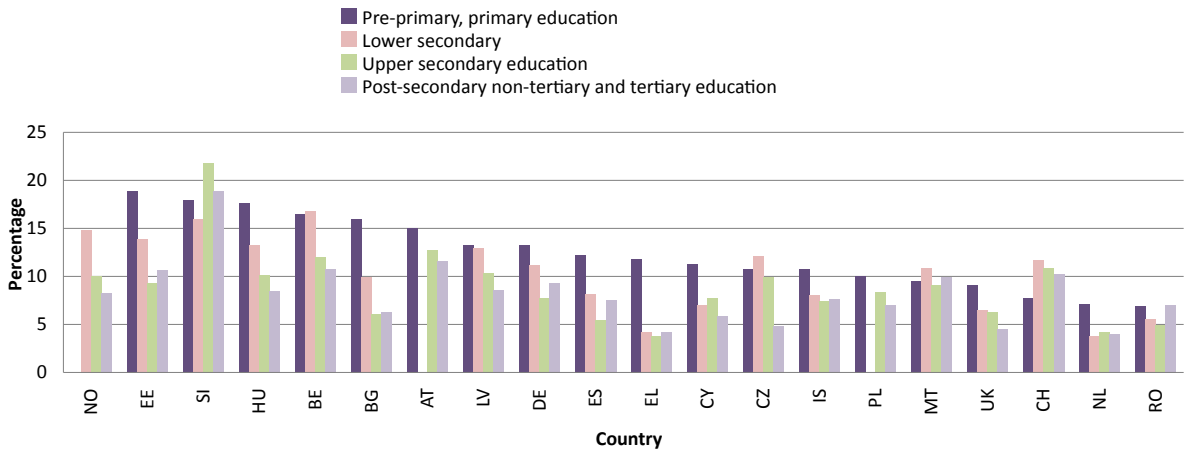

### Age standardised admission rates per 1000 population for Diseases of the circulatory system, by sex, and country, latest year [1]

*Source HMDB. [1] 2007 except HR, DK, IS, IT (2006). NL, PT, ES (2005)*




### Percentage of male inpatient hospitalisations in past 12 months, by level of education and country, 2004

*Source Eurostat hlth_co_inpe*



for neoplasms are considerably higher in Hungary for men than for women (26/21), whilst a reversal of this pattern is seen in Latvia (15/20). Mental and behavioural disorders are notably higher for men than for women in both Latvia (18/10) and Lithuania (14/8). These same countries have the highest rate of admissions and the largest male/female differences in rate of admissions for respiratory diseases (34/24 for Lithuania and 32/25 for Latvia)). Whilst admission rates for injuries poisoning and external causes are higher for males than for females across all countries, the gap is particularly pronounced in Austria, Latvia and Lithuania.

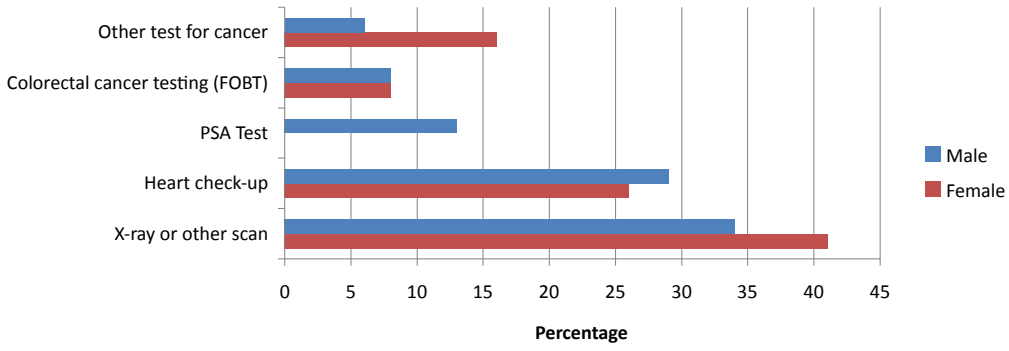
# Preventative Health

Different patterns emerge between men and women in terms of engaging in other health checks (scans, heart tests and cancer checks;). Men are more likely to have had a heart check-up (29% vs 26% of women), but less likely to avail themselves of x-ray or other scans (34% vs 41% of women). Whilst colorectal cancer testing is similar between men and women at 8%, men are far less likely to undertake other tests for cancer (6% vs 16% of women).

Men are less likely than women to have had their blood pressure checked in the past year (55% vs 62% of women) or to have had a cholesterol screening test (35% vs 39% of women. Overall, the testing rates for blood pressure range from 70% or above in Luxembourg, Estonia and Portugal to 46% in Ireland, with just over half of blood pressure checks being carried out upon doctors' initiatives. Among those with hypertension, similar proportions of men (48%) and women (50%) had recently made lifestyle adjustments with the aim of reducing their blood pressure. The overall rates of reported cholesterol testing were highest in Luxembourg (57%), Portugal (56%) and Greece (55%) and lowest in Romania (21%) and Bulgaria (23%). The main initiative for cholesterol testing comes from doctors (20%) followed by patients themselves (13%) and screening programmes (5%). Some 13% of respondents reported having changed their lifestyle in order to lower their blood cholesterol.[99]

**Have you received any of the following tests in the last 12 months? EU25, by sex and test type**

*Source Eurobarometer 2007*



# Men's usage of primary health services

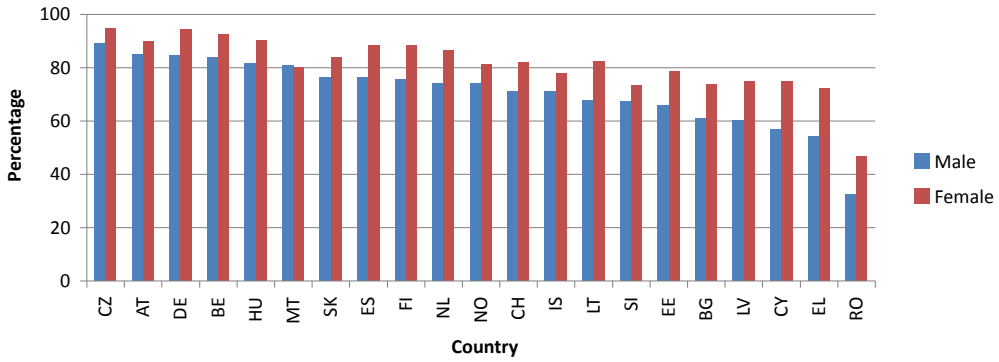
Across Europe, men access primary care services less frequently than women do, with this sex-differences gap ranging from approximately 5 percentage points in the Czech Republic and Austria to approximately 18 percentage points in Cyprus and Greece. There are also considerable variations between men in different countries, with the percentage of men attending a doctor within the past 12 months ranging from 89.2% in the Czech Republic to just 32.6% in Romania.

A Danish Study that was based on 35.8 million GP contacts and 1.2 million hospitalisations in 2005 demonstrated an overall pattern among men of lower contact rates with GPs but higher hospitalisation and mortality rates[100]. This, in the authors view, is consistent with the hypothesis that men react later than women in seeking help for severe symptoms, resulting in higher rates of hospitalisations among men for the causative condition.

The proportionally greater use of primary care services by women in the early years reflects the provision of antenatal care, contraception and screening services that are more likely to habituate women into regular contact with health services. The general absence of male-targeted health care programmes hinders the surveillance capability for men's health problems and men's ability to identify as participants in health care.

**Percentage consulting a medical doctor during the past 12 months, by sex and country, 2010**

*Source Eurostat hlth_co_doca*




# Barriers within health services

A range of factors have been identified at a service level that can be described as barriers to men's more frequent or more prompt use of health services, particularly primary care services, such as weight loss groups, smoking cessation services, anger management groups, etc. as well as access to family doctors[101,102]. The reasons for such difficulties for men include cost of services, services only being available during traditional working hours, lack of flexibility in many men's working days, excessive delays for appointments, rushed consultations, a perception that GP waiting rooms and other services are designed around the needs of women, a lack of understanding of the process of making appointments and negotiating with female receptionists, and lacking the vocabulary required to discuss sensitive issues such as depression or erectile dysfunction. Conversely, the provision of services that have been found to be more effective are those that offer flexible opening hours, longer consultation times, individualised and male-specific health assessments and the provision of lifestyle and behaviour modification programmes [103 104]. The importance of doctor-male patient communication has also been highlighted[105,106].

## Well man clinics and community-based health initiatives for men

The more successful well man clinics have been those that offer flexible opening hours, longer consultation times, at sites that are separate from primary care, and offer individualized and male-specific health assessments[107]. Other characteristics of successful clinics include the use of targeted advertising, the provision of personalized letters of invitation to prospective male patients, the provision of lifestyle and behaviour modification programmes, and the inclusion of a comprehensive referral system.

In response to the reluctance of some men to access more conventional health services, there have been increasing attempts to develop community based services that specifically target men. In this context of bringing health services to men, pubs (ibid) , sports clubs[108], schools[109] and other settings (e.g. work environments, youth centres, places of worship and barber shops[110] ; have been identified as settings in which to target those men who may be less likely to use more conventional services (ibid).

Targeting men's health in leisure time has been successfully achieved through associations with professional sports teams. The Premier Football League Health initiative[111] for example is a £1.68m programme funded by the UK New Football Pools, in which Premier League football clubs help to improve the state of men's health in deprived areas. The Leeds Rhinos Rugby League club in partnership with the Centre for Men's Health, Leeds Metropolitan University and the Regional Department of Health ran a season long campaign at the ground on match days offering free health checks and a weight loss group[112].

## Men's use of the internet and the problem of counterfeit medications

There are a worrying number of men who are failing to go for medical assistance or are turning to the internet for medication. This both removes the possibility of diagnosis of the underlying problem and also opens them up to the risk of potentially dangerous counterfeit[113] drugs. Growth of the counterfeit medication market is attributable in large part to phosphodiesterase type 5 inhibitor (PDE5i) medications for erectile dysfunction (ED), which account for the bulk of all counterfeit pharmaceutical product seizures. It has been estimated that up to 2.5 million men in Europe are exposed to illicit Sildenafil[114], which would suggest that there may be as many illegal as legal users of Sildenafil. In recent years, there has been an alarming increase counterfeit seizures in the European Union[115], with counterfeits becoming increasingly difficult to distinguish from their genuine counterparts.

A recent directive from the Pharmaceutical Group of the European Union (PGEU[116]) which refers to the application of control and safety features regarding the sale of internet medicines, is to be welomed.

## Summary

Men's usage of health services has been long recognised as a possible contributing factor in their high rate of premature morbidity and mortality. There is evidence that some men use primary health services less frequently and are more likely to need hospitalisation for the principal causes of disease. There is also evidence that men do not use preventative services at the same level as women, which may be due to the availability of services only being available during the working day so inaccessible to many men. Men have higher levels of usage of the internet for health advice and are more likely to buy drugs through this route (and therefore more vulnerable through missed diagnosis and the rise of counterfeit drugs). Conversely men tend to show no difference to women with regard to presenting with symptoms of illness. Where services have been set up in ways that make access easier then men have used them and many have been shown to have high levels of hidden problems, both physical and emotional.

Against a background of higher premature death rates among men for nearly the whole range of non-gender specific disease and illness, there is an urgent need for more targeted measures that enable boys and men to recognise their health risks and to take increased responsibility for managing their own health.

There is a need for the provision of training for GP's and other healthcare professionals on the gendered aspects of health and illness and, in particular, on best practice in engaging men with health services. There also needs to be an increased focus on how health services can be configured to be more successful at targeting men.

## Headline recommendations for action:

- **Develop 'male-friendly' health services that provide flexible opening hours and that have the capacity to be offered in more accessible community and workplace settings**.
- Adopt more stringent regulatory and legislative measures to counteract the sale of counterfeit drugs through the Internet.
- Integrate programmes on men's health into the training syllabi of all health and allied health courses and offer short courses targeting existing service providers in the health, allied health and community sectors.
- Research into how and when men use health services
- Family doctor organisations should have men's health as a specific curriculum item for both training and continuing professional development (CPD).

## Detailed recommendations:

**Access:**

- Utilise the workplace to promote health and access to services:
  - Introduce workplace health assessments, but note that the motivation for doing these may be considered to be suspect, so will need to work with employers on framing these assessments so that they are seen as helpful, rather than potentially harmful.
- Provision of male friendly health services, in the same way as health and wellbeing services are provided for women and children
  - Ensure services are provided at more accessible places/locations, with flexible hours, and male staff available to facilitate and encourage communication
- One stop shops – there is a need to ensure that all of men's health concerns can be tackled at the same time.

**Human Resources for health:**

- Incentivise receptionist and pharmacist roles for men
- Bring Trade Unions in to support men's health
- Role models are required to support peer education processes, and give messages that men should attend preventative check-ups, screening, etc.
- Encourage men's health through their partners.
- Work with NHS and health service staff to ensure that they understand and are oriented towards addressing the particular barriers faced by male clients
- See men as a resource for health, working with them to identify and address the barriers and strengthen and promote opportunities, rather than as a problem.

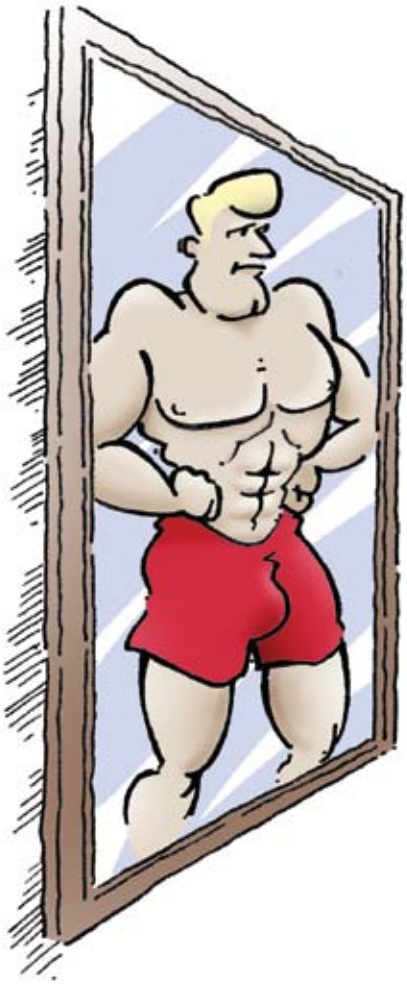
**Information:**

- Support and encourage health literacy initiatives, ensuring that health concepts are explained in a way which is accessible to and understood by men.
- Social marketing approaches to transmission of information – men are not a heterogeneous group. Cultural, ethnic and age differences can affect the way in which information is received and processed. Work with men to identify appropriate messages and media.
- Take a broad approach to health care information settings, ensuring information is displayed where men tend to congregate, i.e. sports clubs, pubs.
- Counter message bombardment on single issues by ensuring that health information which is displayed in non NHS settings is accurate and covers a range of health issues. This will encourage more appropriate risk assessment by men by balancing health media noise, and make is easier for men to understand health risks and opportunities.
- Ensure that messaging is clear, targeted and explicit – re what men need to do and when.

# Health Status

# 5

- Men generally identify themselves as having better health than women, though this may not accurately reflect their actual level of health and wellbeing.
- Life expectancy is lower for men than for women across all the EU Member States, ranging from 66.3 yrs for men in Latvia (77.6 yrs for women) to 80 yrs for men in Iceland (83.3 yrs for women). However, there are more variations found between men's life expectancy between different countries and regions than between men's and women's life expectancy.
- The rate of premature death in men still far exceeds that for women, and is evident across the majority of disease states.
- Over 630,000 male deaths occur in working age men (15-64 years) as compared to 300,000 female deaths.
- Cardiovascular disease is the biggest cause of premature death, but this is rapidly being replaced by cancer.



An analysis of morbidity and mortality data gives an indication of those conditions where men seem to be particularly vulnerable and a key observation is that the majority seem to fall within what could be classified as avoidable or deaths that are amenable to health interventions[117]. These are conditions where an alteration in either the risk factors that cause the problem or in the way the disease is managed would see a marked reduction in the mortality rates. With age and socioeconomic circumstances being such an important component in men's increased vulnerability it would appear that more concerted efforts to reduce men's preventable risk factors in their early life would have considerable effect on their overall health and wellbeing.

## Self perceived health status

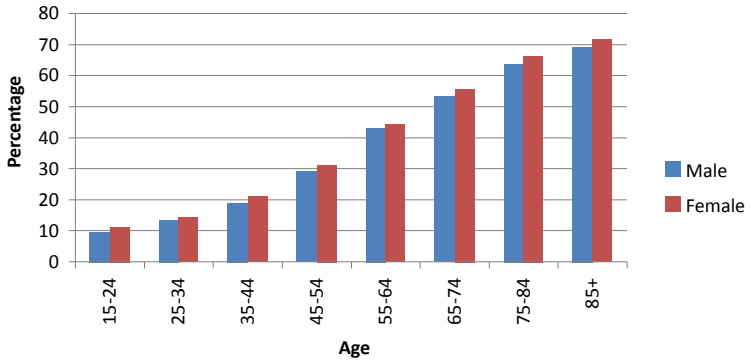
Despite high levels of premature mortality among men, it is surprising that many have high levels of satisfaction with their own health. The reasons for this apparent anomaly may reflect how questions are worded and the meaning of health being different between men and women[118]. A further possibility is that men may have a poorer perception of their own health status then women[119]. It is also likely that although women live longer than men, the quality of life and well-being they experience may not be always satisfactory[120]. Women suffer from a raft of conditions that do not necessarily become life threatening in their early years. This can lead to a clustering of health conditions and multi-morbidities that contribute to their poorer self perceptions of health.

## Self reported chronic morbidity

For all ages, 33% of women and 29% of men classify themselves as having a long term condition. The number of men reporting a long-term condition increases with age, rising from 9.6% of 15-24 year old men, to 43% of 55-64 year old men, and 64% of 75-84 year old men reporting having a long term condition. For young, men Norway stands out with nearly a fifth of their 15-24 year old men reporting a long standing condition as compared to 2% of young men in Greece.

**Self perceived chronic health problems, by sex and age, EU27, 2008**

*Source Eurostat hlth_silc_05*



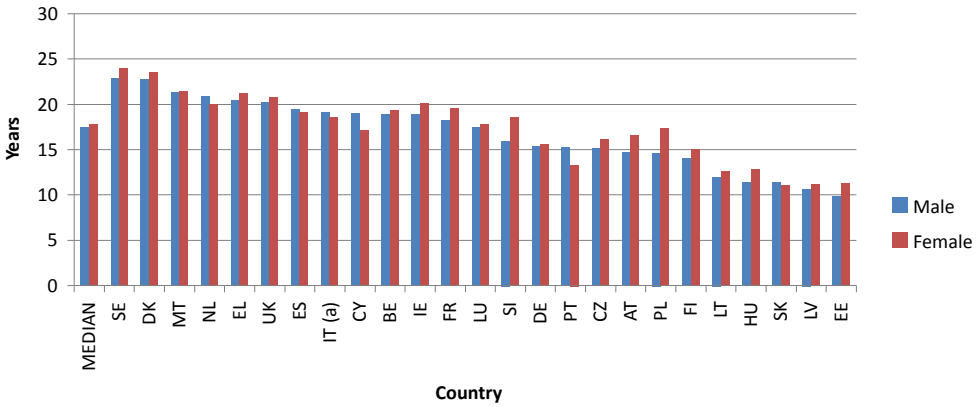
# Healthy Life Years (HLY)

For the majority of countries, men and women have very similar life expectancy without activity limitation. However, women have a longer life expectancy with severe activity limitation, meaning that they can expect to live more of their lives with chronic health difficulties as compared to men.

Differences exist for men between countries with life expectancy without activity limitation having a similar pattern to overall life expectancy. There are five countries where men of 50 can enjoy over 20 more years of life without activity limitation, but in 5 countries men cannot expect to live more than 12 years past their 50th birthday before experiencing limitations.

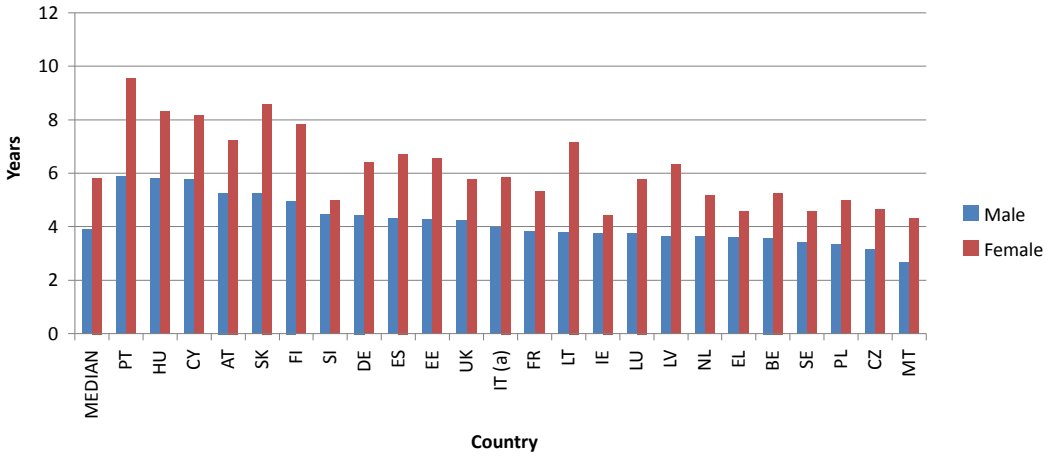
**Life expectancy for 50 year olds without activity limitation, by sex and country, 2008**

*Source www.healthy-life-years.eu (a) estimated value*



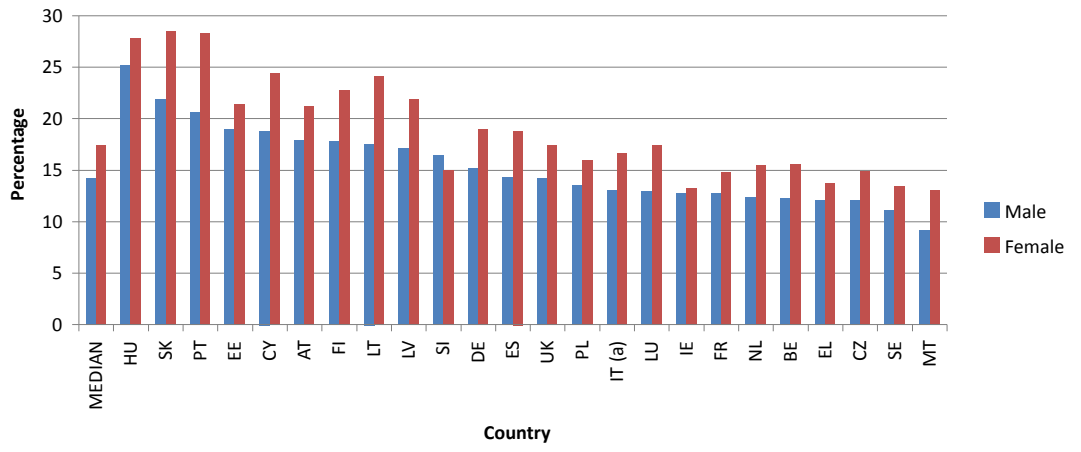

**Life expectancy for 50 year olds with severe activity limitation, by sex and country, 2008**

*Source http://www.healthy-life-years.eu/ (a)Estimated value*



**Percentage of 50 year olds with severe activity limitation, by sex and country, 2008**

*Source: http://www.healthy-life-years.eu/ (a) Estimated value*



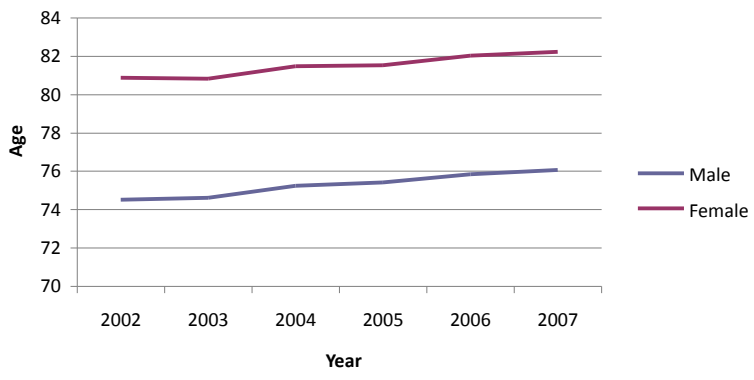

# Life expectancy

The average life expectancy for men in the EU is 76.1 years as compared to 82.2 years for women (6.1 years difference). Life expectancy across Europe as a whole is increasing. It is increasing at a slightly faster rate for men (2.1%) than for women (1.6%) over the period 2002 to 2007.

There are marked differences in life expectancy between countries, with Latvia having the lowest life expectancy for men at 66.3 years (and also the biggest gap between the male and female population (11.3 years). Liechtenstein and Iceland have the greatest average male life expectancy at 80 years. Iceland has the lowest gap between men and women with 3.3 years. It is noticeable that the difference between the highest and lowest life expectancy for men (13.7 years) is considerably more than the corresponding figure for women (7.8 years).

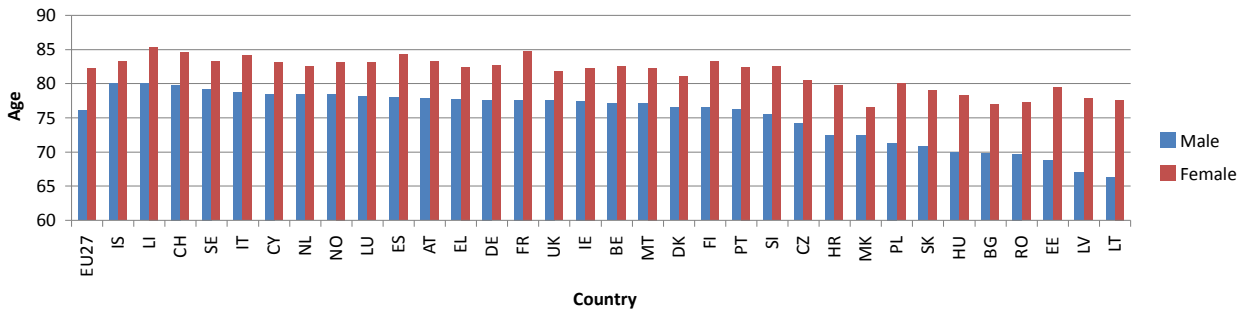
**Time trends in life expectancy, by sex, EU27, 2002-2007**

*Source: Eurostat demo_mlexpec*



**Life expectancy at birth, by sex and country, latest year[1]**

*Source: Eurostat demo_mlexpec. [1] 2008 except EU27, BE, FR, IT, UK (2007)*

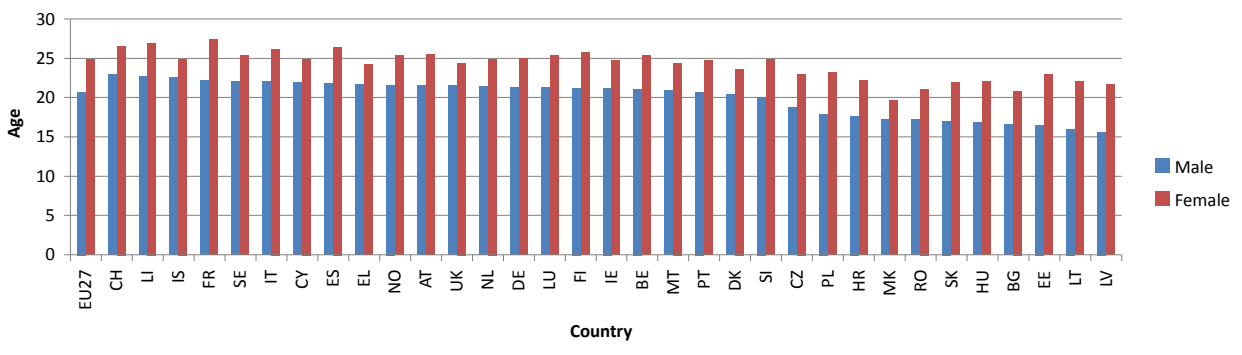



With each passing year of life there is a change in the estimated life expectancy as each successful year of survival means that a longer life can be expected. At the age of 60 the pattern is similar in that Eastern European men have the lowest life expectancy (Latvia 15.6 years, Lithuania 16 years) and the biggest gap between the sexes (6.1 years and 6 years respectively), whilst Switzerland, Lichtenstein, Iceland France, Sweden and Italy can all expect to have another 22 years of life or more. Such that at age 60 a man in Latvia could expect to live to 76 years as compared to a similar aged man in Switzerland living to 82 years – a 6 year difference.

These aggregations of data do not do justice to the large intra-country variations that exist. Averages can mask inequalities that paint a quite different picture of the problems some men face. At the NUTS2 (regional data) level, we can see that in the Itä-Suomi region of Finland the average life expectancy is 75yrs as compared to 81.8yrs in Åland, which has the distinction of being the only region in the EU that has a higher average life expectancy than women[121] (80.8yrs). It is notable that the difference in life expectancy between the highest and lowest regions is 10.3 years for women and 15.5 years for men, offering a far greater challenge than tackling any differences between the sexes.[122]

**Life expectancy from aged 60 years, by sex and country, latest year[1]**

*Source: Eurostat demo_mlexpec [1] 2008 except EU27, BE, FR, IT, UK (2007)*

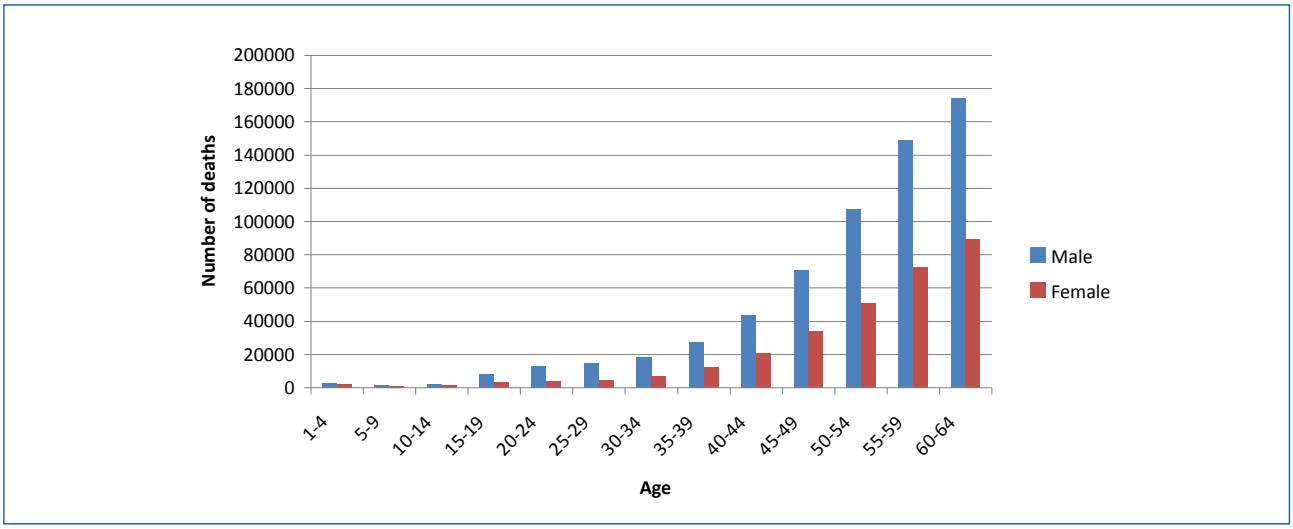


# Male mortality across the lifespan

In order to explore the impact of mortality across the lifespan a numerical analysis of the number of deaths occurring at each age was undertaken. This revealed that the higher burden of death in men appears to occur at every age until the age of 80.

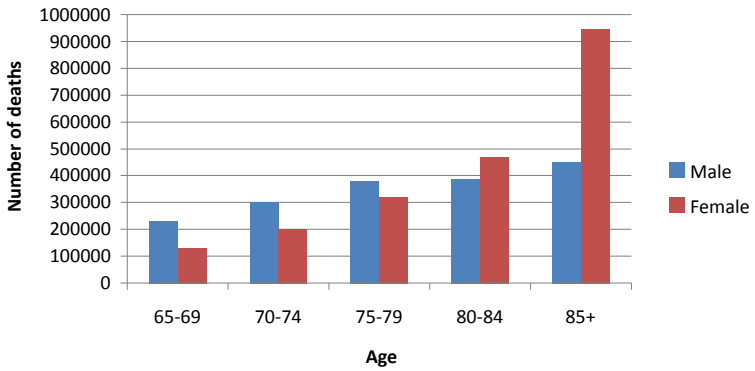
What is noticeable is the high number of deaths that occur in the working age population of 15-64 years, with nearly 630,000 men dying across the EU27 in these years, as compared to 300,000 deaths for women.

**Total number of deaths, ages 0 to 64 years, EU27, 2007**




**Total number of deaths, ages 65+ years, EU27, 2007**

*Source: Eurostat hlth_cd_anr*



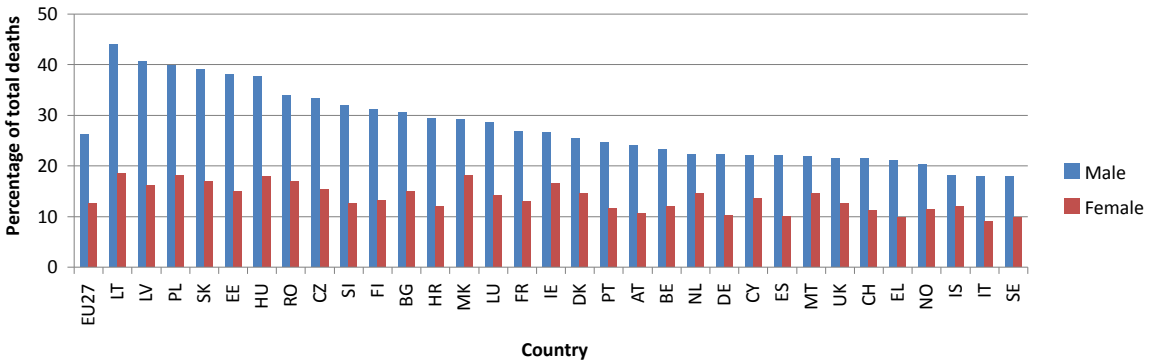

For the working age population the number of deaths occurring in the age range 15-64 years was compared to the overall total number of deaths for men to show the percentage that occur in this age range. For some countries, over 40% of male deaths occur at an age when men should be at their peak of activity. Even across the majority of the Western European countries over a fifth of Male deaths are occurring within this age range.

The ratio of deaths suggests that the biggest differences between men and women are found in the younger age ranges, with over 3 times more men than women aged 20-29 dying, but the excess extends right up until age 75-79.

Rates of death between men and women were calculated for 5 age groups: 0-14 years, 15-44

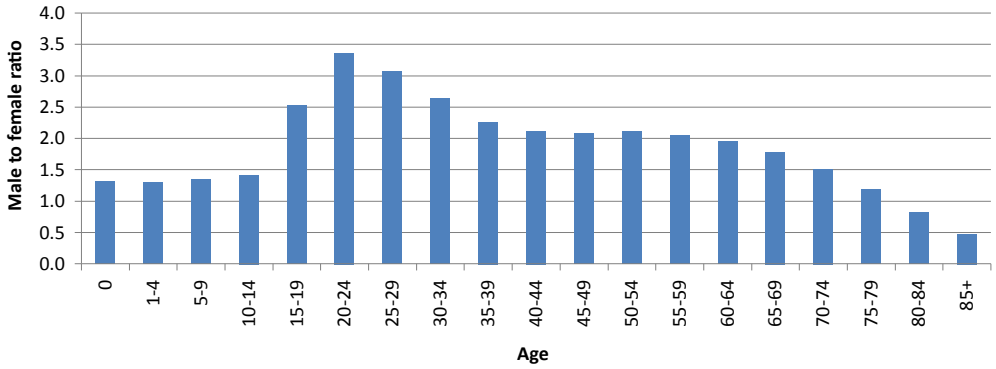
**Deaths in 15-64 age range as a percentage of total deaths, by sex and country, latest year.** [1]

*Source: Eurostat hlth_cd_anr. 1 2008 except EU27, BG, CH, FR, IT, MT, PL, RO, SE (2007). DK, LU, PT (2006). BE (2004).*




**Sex ratio of total number of deaths, by age, EU27, 2007**

*Source:calculated from Eurostat hlth_cd_anr*

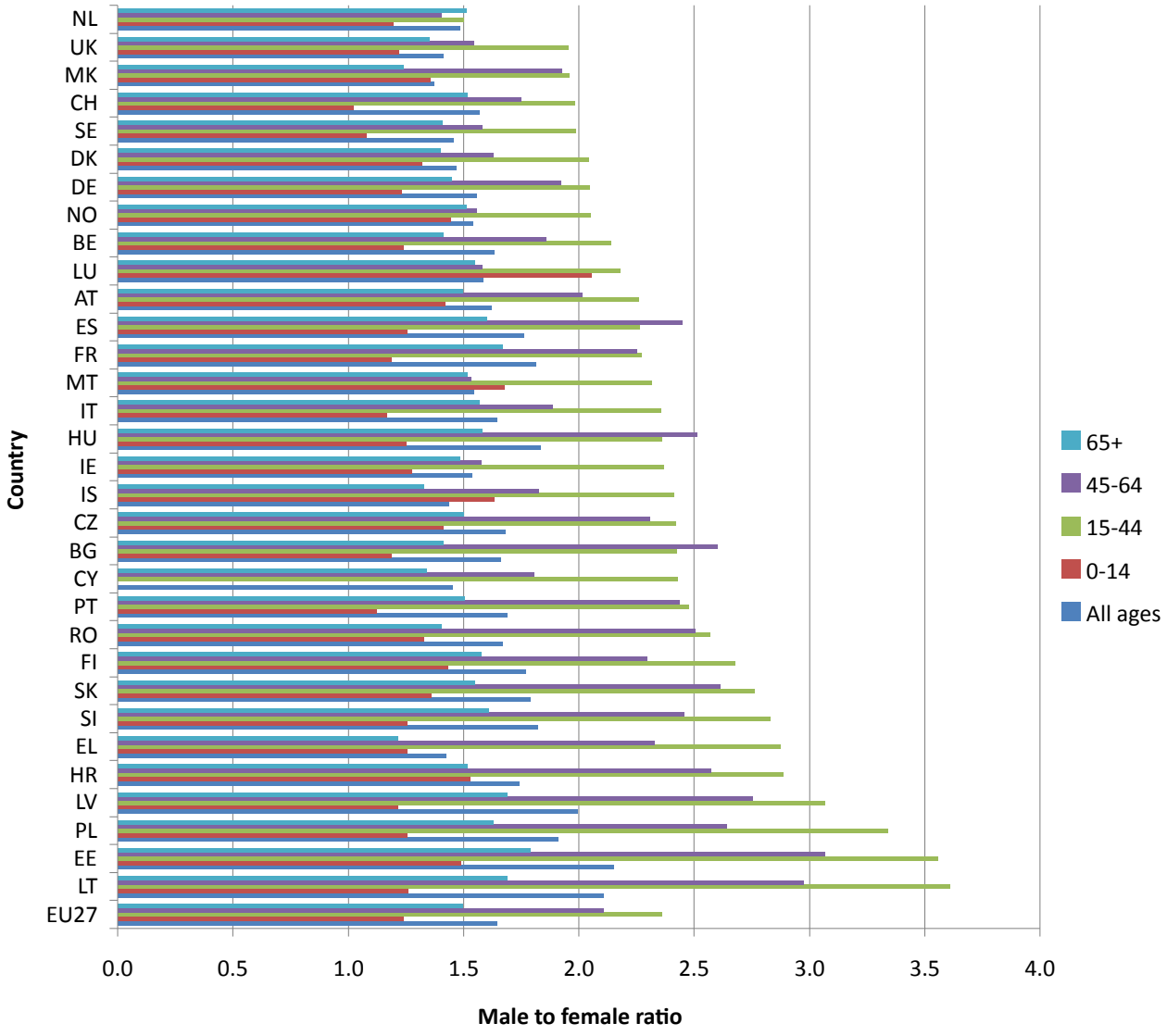



years, 45-64 years, 65+ years and all ages. For the EU27, it can be seen that overall men have a 64% higher rate of death for all ages than women with that rate ranging from 24% higher rate in the 0-14 year age range, 2.36 time higher rate in the 15-44 age range and just over twice as high a rate in the 45-64 age range. In the over 65 age range there is now a 50% higher rate of death in men, such that though numerically there are fewer male deaths in this older age group, the lower number of men in this age group means that the rate is greater for men.

In the 0-14 year age range, Luxembourg stands out as having over twice as many male than female deaths. Malta and Iceland both have over 60% more deaths among boys. There are more marked differences between countries in the 15-44 years age range. Lithuania and Estonia have over 3½ times more male deaths as compared to 1½ times higher in the Netherlands for the same age range. In the 45-64 year age range, Estonia has over 3 times more male deaths. In the over 65 age range Lithuania, Latvia and France have nearly 70% higher male death rates.

**Sex ratio of rates of death, for all conditions, by age and country**

*Source:rates calculated from Eurostat hlth_cd_anr*



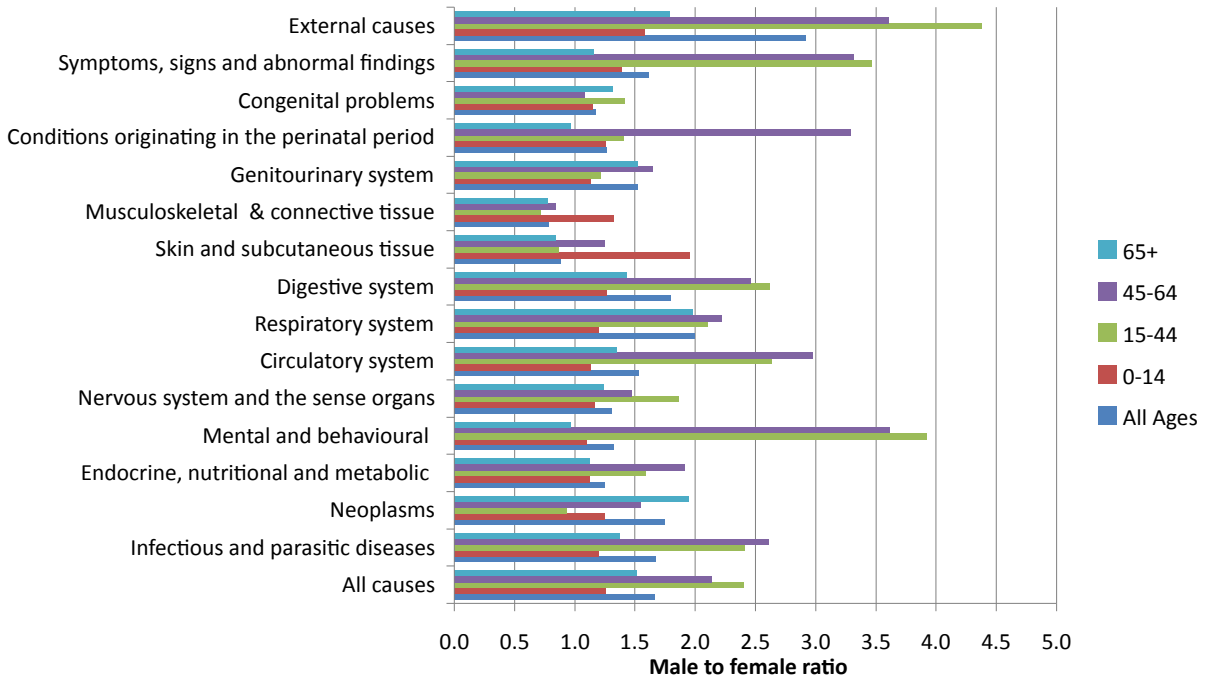
# Overall burden of disease

There is a marked age effect on mortality data for men when compared to women. Across all the classification groups males have a higher ratio of rates of death in the 0-14 age range and a similar, but more marked picture is seen for the 15-44 and the 45-64 age ranges (the exceptions being deaths as a result of Diseases of the musculoskeletal system and connective tissue and Certain conditions originating in the perinatal period for the 15-44 age group. A further exception is in relation to Neoplasms, where there is an excess of female deaths in the 15-44 age range, though it must be noted that the majority of the sex specific cancers only affect women in this age range and for the other cancers there is a male excess. In the over 65 age group the higher rate of death persists across the majority of the classification groups.

Following on from a previous study an analysis was undertaken for the EU27, with the same selection of causes of death but over the 15-49 age range. What can be seen is that Transport Accidents are the main cause of death in men in the 15-29 age range, with suicide having the highest rate of death in the 30-39 age range. Large increases are seen in the deaths as a result of ischaemic heart disease and cancer between the ages of 30-34yrs and 45-49 (over 11 fold increase and 9 fold increase respectively). Liver disease

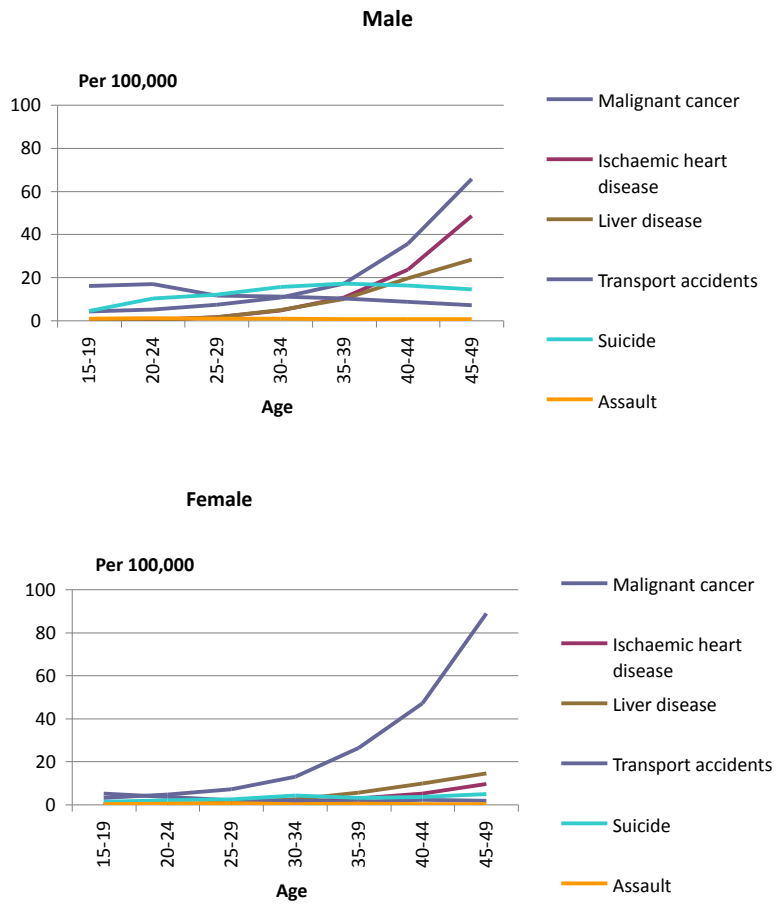
**Sex rate ratio, main classification groups[1], by age, EU27, 2007**

*Source:calculated from Eurostat hlth_cd_anr [1]Excluding Pregnancy, childbirth and the puerperium (O00-O99) as this only relates to female mortality.*



**Age specific death rates, for selected causes, 15-49 years,EU27, 2007**

*Source: Eurostat hlth_cd_acdr*



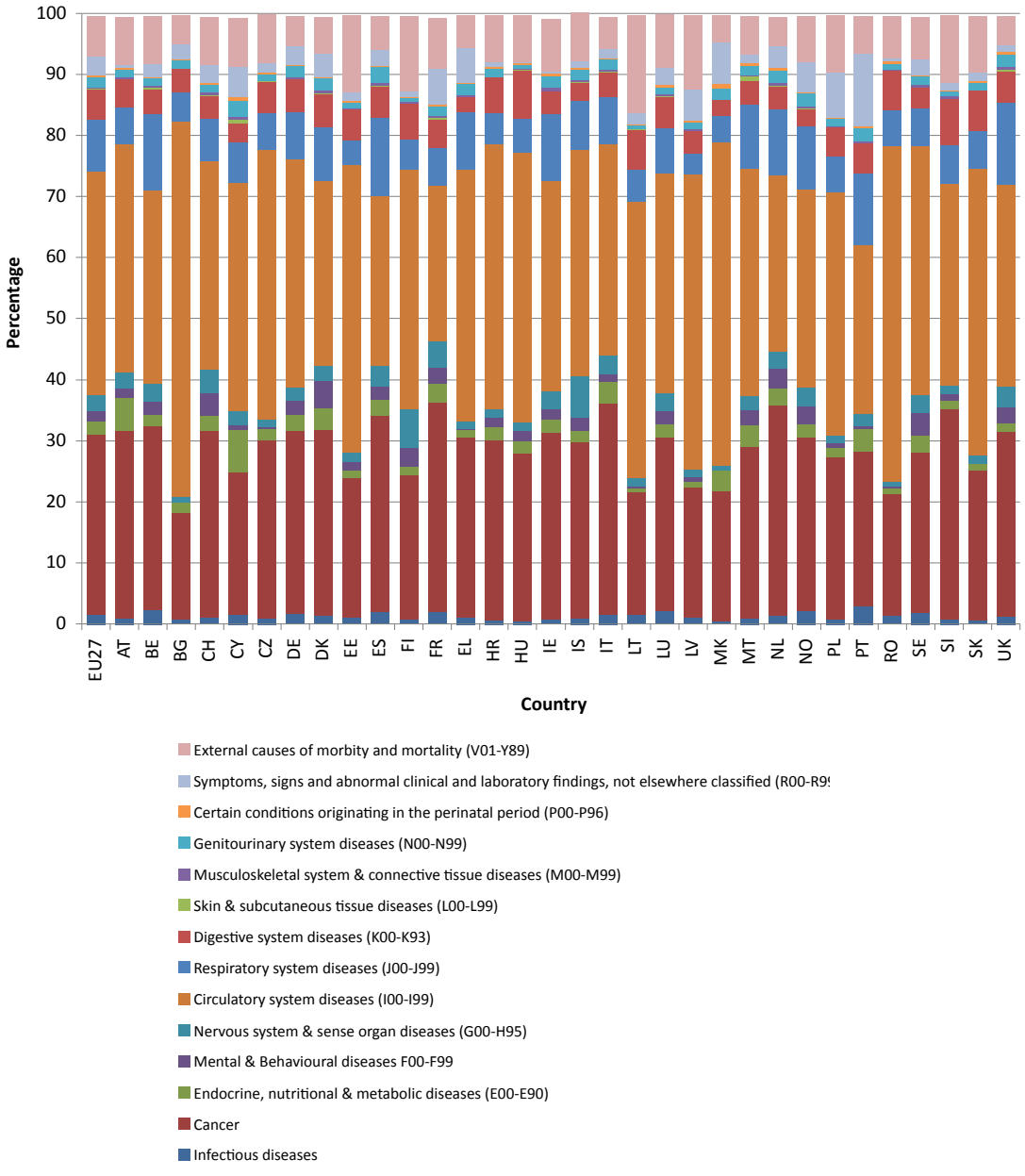

is also seen to be increasing (a 6 fold increase). Assault is not a major contributor to men's high death rates.

The impact of cancer on women's premature death is noticeable, but it is also important to note suicide remains the second highest cause of death from 25-39 years of age across the EU27 for women, with more deaths from liver disease than ischaemic heart disease.

Breaking down the causes of death for men within each country shows that different diseases take on a greater or lesser impact on the total deaths. For example, deaths as a result of cardiovascular disease account for a greater proportion of deaths in Eastern European countries than in Western Europe (i.e. 62% in Bulgaria vs 26% in France). Deaths as a result of neoplasms are more common in the West (e.g., 35% in Italy and the Netherlands). It is notable that nearly 12% of male deaths in Portugal are assigned to the classification 'Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified'.

## Male deaths from specific classification groups as a proportion of total deaths, by country

*Source: Eurostat hlth_cd_anr. 1 2008 except EU27, BG, CH, FR, IT, MT, PL, RO, SE (2007). DK, LU, PT (2006). BE (2004).*



## Summary

Men report better health than women and have lower levels of self reported chronic morbidity, but their life expectancy remains lower across all the countries. The gap between male life expectancy across different countries and regions is more marked than that between males and females suggesting that men are more vulnerable to social circumstances. The biggest challenge facing men with regard to the mortality figures is in relation to their higher levels of premature death, with over 2.5 times more young men (aged 15-44 years) dying than young women across EU27. These deaths are also seen across nearly the whole spectrum of those health conditions that could affect men and women equally as they are not sex-specific.
The burden of death appears to differ across the countries with those in Eastern Europe having higher rates of death as a result of cardiovascular disease, whereas the predominated cause of death in the West are due to cancer.

## Headline recommendations for action:

- **All health data should routinely be broken down by age and sex**
- The working age male population should be monitored to assess the extent of preventable deaths.
- Research should explore men's increased vulnerability to those conditions that should affect men and women equally

# Cardio-Vascular Disease

# 6

- There have been marked reductions in cardiovascular morbidity and mortality. Nevertheless, Cardio-Vascular Disease (CVD) is still one of the biggest risks to men's health and in the older population it is the principle cause of death.
- Whilst CVD accounts for a mortality rate of 36% of all deaths for men, the differences across Europe are marked ranging from 61% of total male deaths in Bulgaria to just 25% in France.
- Ischemic Heart Disease, (IHD) is responsible for 360,000 deaths among men in the EU27, about 15% of all mortality.
- Cerebro-Vascular Disease (stroke) constitutes 8% of all male deaths or nearly 200,000 lives lost.

Although there have been great improvements in cardiovascular health, marked differences exist between different parts of the EU. In some countries cardiovascular disease (CVD) accounts for half of all premature male deaths. In the most vulnerable regions, such as the Baltic States, CVD premature mortality is almost 6 times higher than in those countries with the lowest risk rates such as Switzerland, Iceland and Italy. These inequalities are found not just at the national level: a significant degree of social stratification with regard to CVD is also seen within countries across Europe[123].

## Cardiovascular disease

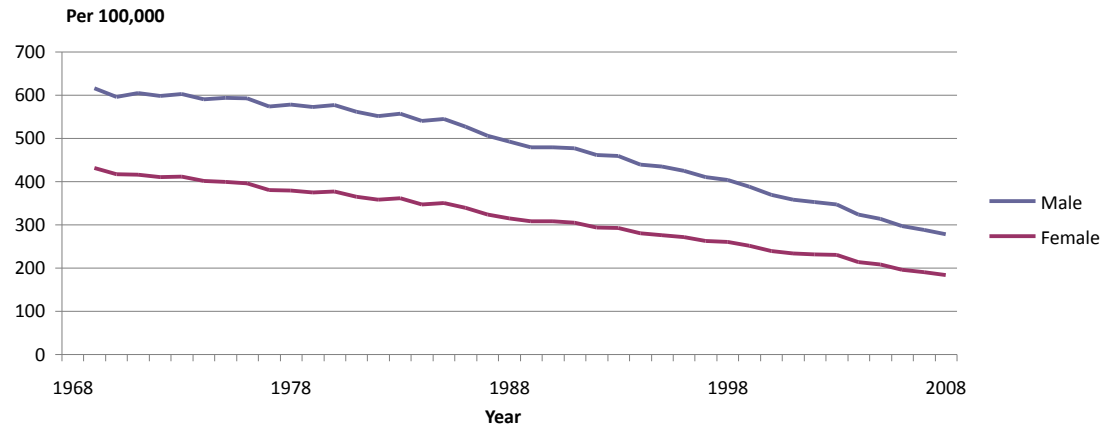
There has been a decline in CVD mortality in both sexes and all age groups in most countries of Western Europe since the beginning of the 1970s and in Eastern Europe since the 1990s. This has reduced the influence of CVD on premature mortality. Among women, CVD has ceased to be the number one cause of premature mortality (before age 65). A similar phenomenon is occurring with a time delay for men. This is leading to a more concentrated CVD mortality in the oldest age groups[124].

CVD constitutes 36% of all mortality among men (900,000 deaths) and 44% among women (1 million deaths). The percentage of male deaths resulting from CVD is very different across the EU27; it is the highest for Bulgaria (61%) and the lowest for France (25%). Generally, in the countries of the Eastern part of the EU, CVD constitutes around 50% of all death causes, while in the Western part of the EU they amount to about one-third. Similarly, age-standardised mortality rates from CVD by country are much higher in Eastern Europe.

There is, however, a marked age effect. In 2008, CVD caused 160,000 deaths among men and 60,000 deaths among women before 65 years of age. It accounted for around 1/4 of all male deaths in this age group in Eastern Europe, and around 1/5 of all male deaths in Western Europe.

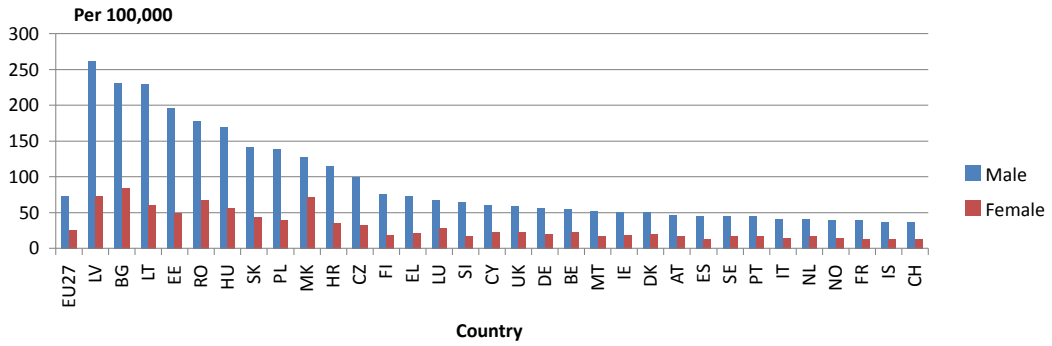
### Time trends of cardiovascular disease mortality, by sex, EU27, 1969-2008

*Source: WHO Morticd10*




### Age standardised mortality for premature CVD, by sex and country, ages 0-64 years, all ages, latest year[1]

*Source: WHO Morticd10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*

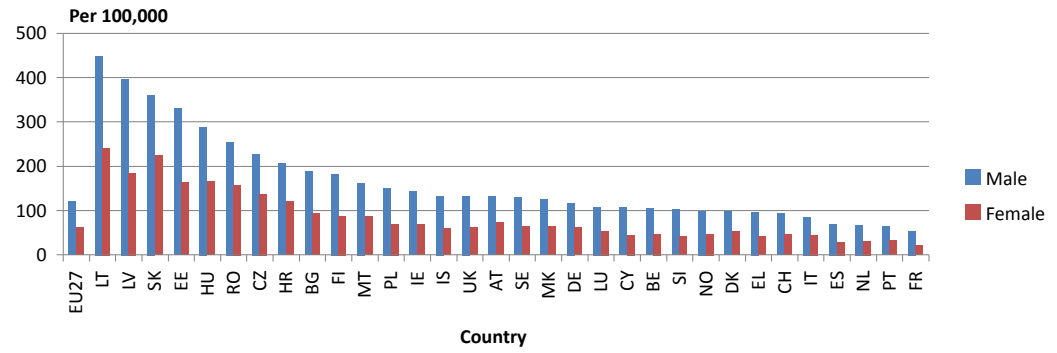


# Ischemic Heart Diseases (IHD)

Ischemic Heart Diseases (IHD) was responsible for 360,000 deaths among men in the EU27 in 2008. This amounts to almost 15% of all mortality (among women IHD accounted for 330,000 deaths, equivalent to 14% of all mortality), in 2008, IHD caused almost 80,000 deaths before age 65 in the EU, constituting 12% of all mortality (among women the figures are respectively 20,000 and 6%). There are wide variations between countries broadly reflecting an east–west disparity across Europe. The highest mortality rates are in the Baltic States of Lithuania, Latvia and Estonia together with Slovakia and Hungary. The historical trend of low IHD mortality in the Mediterranean region is today much less apparent.

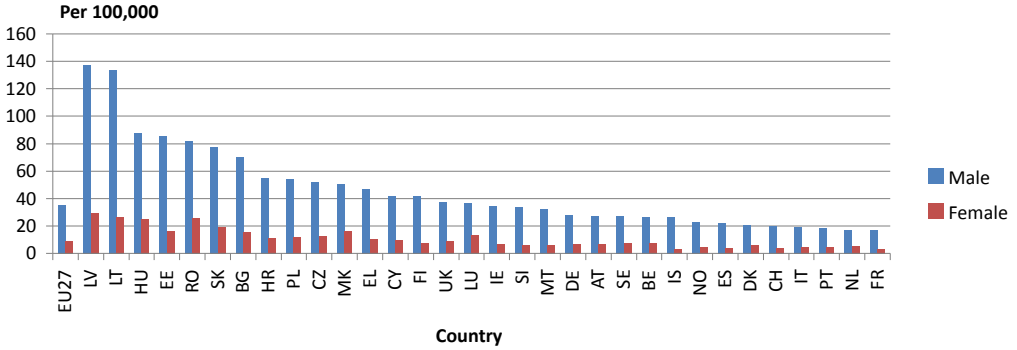
**Age standardised mortality for Ischemic heart disease, by sex and country, all ages, latest year[1]**

*Source: WHO Morticd10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*




**Age standardised mortality for Ischemic heart disease, by sex and country, ages 0-64 years, latest year[1]**

*Source: WHO Morticd10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*

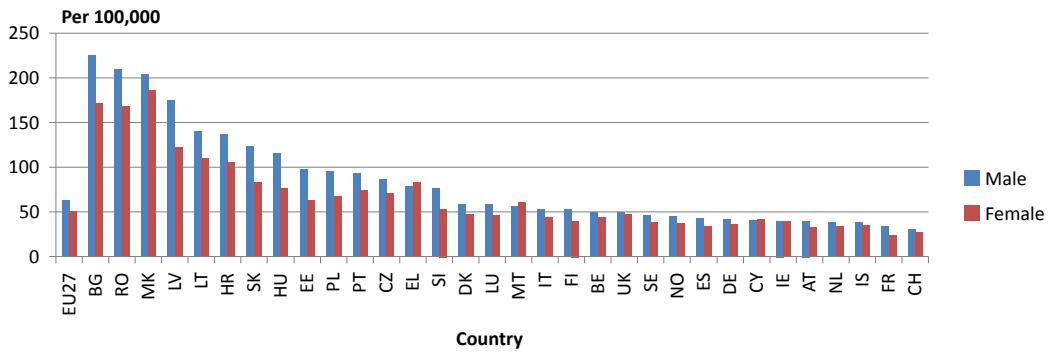


# Cerebro-Vascular Diseases (Stroke)

Stroke leads to the death of almost 200,000 men in the EU every year, accounting for 8% of all deaths (among women the rate is 270,000 deaths, constituting 11% of all mortality). Stroke accounts for about 28,000 deaths among men under age 65, which constitutes 4% of all premature mortality (among women the figures are 16,000 and 5%). The Balkan regions of Bulgaria, Macedonia and Romania have the highest rates of stroke mortality. Greece and Portugal exhibit the highest stroke mortality in Western Europe.

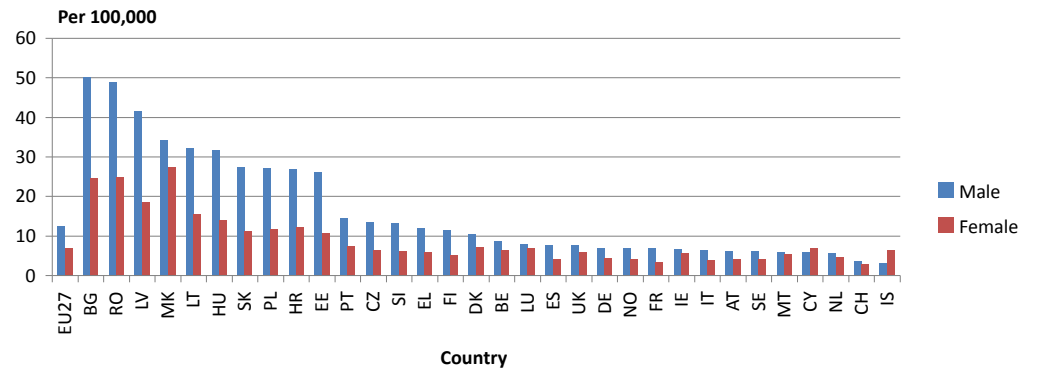
**Age standardised mortality for Stroke, by sex and country, all ages, latest year[1]**

*Source: WHO Morticd10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*




**Age standardised mortality for Stroke, by sex and country, ages 0-64 years, latest year[1]**

*Source: WHO Morticd10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*



## Summary

Although there have been great improvements in cardiovascular health, marked differences exist between different parts of the EU. In some countries cardiovascular disease (CVD) accounts for half of all premature male deaths. In the most vulnerable regions, such as the Baltic States, CVD premature mortality is almost 6 times higher than in those countries with the lowest risk rates such as Switzerland, Iceland and Italy. These inequalities are found not just at the national level: a significant degree of social stratification with regard to CVD is also seen within countries across Europe (Mackenbach et al., 2003). A prime example of this is found in Polish young adult males (15-44) for who, at the beginning of the 21st century, the risk of dying from cardiovascular diseases was some six times higher for those with primary education than for those with university education (Mackenbach et al., 2003; Zatoński et al., 2008). The historical trend of low IHD mortality in the Mediterranean region is today much less apparent with Greece having one of the highest rates in Western Europe. Stroke accounts for 200,000 deaths among men in Europe but as with IHD, the Balkan region, Bulgaria, Macedonia and Romania have the highest rates of stroke mortality.

Educational attainment has a direct impact on the risk of CVD mortality, up to six times higher for those without a University education. Smoking of tobacco is the single most preventable cause for poor cardiovascular health.

One of the most important challenges in vascular disease control in Europe is the huge gap between Eastern and Western Member States of the EU. As the single most controllable cause of this gap, cardiovascular diseases are one of the most important areas in which the European Union that can achieve significant results in equalising the health of Europeans. Targeted action in the form of special programmes of activity within these Countries would hasten the process of health transformation in the Eastern part of the EU.

A further challenge in the management of cardiovascular disease across all the Member States of the European Union is the inequality in access to appropriate health services determined by socioeconomic factors.

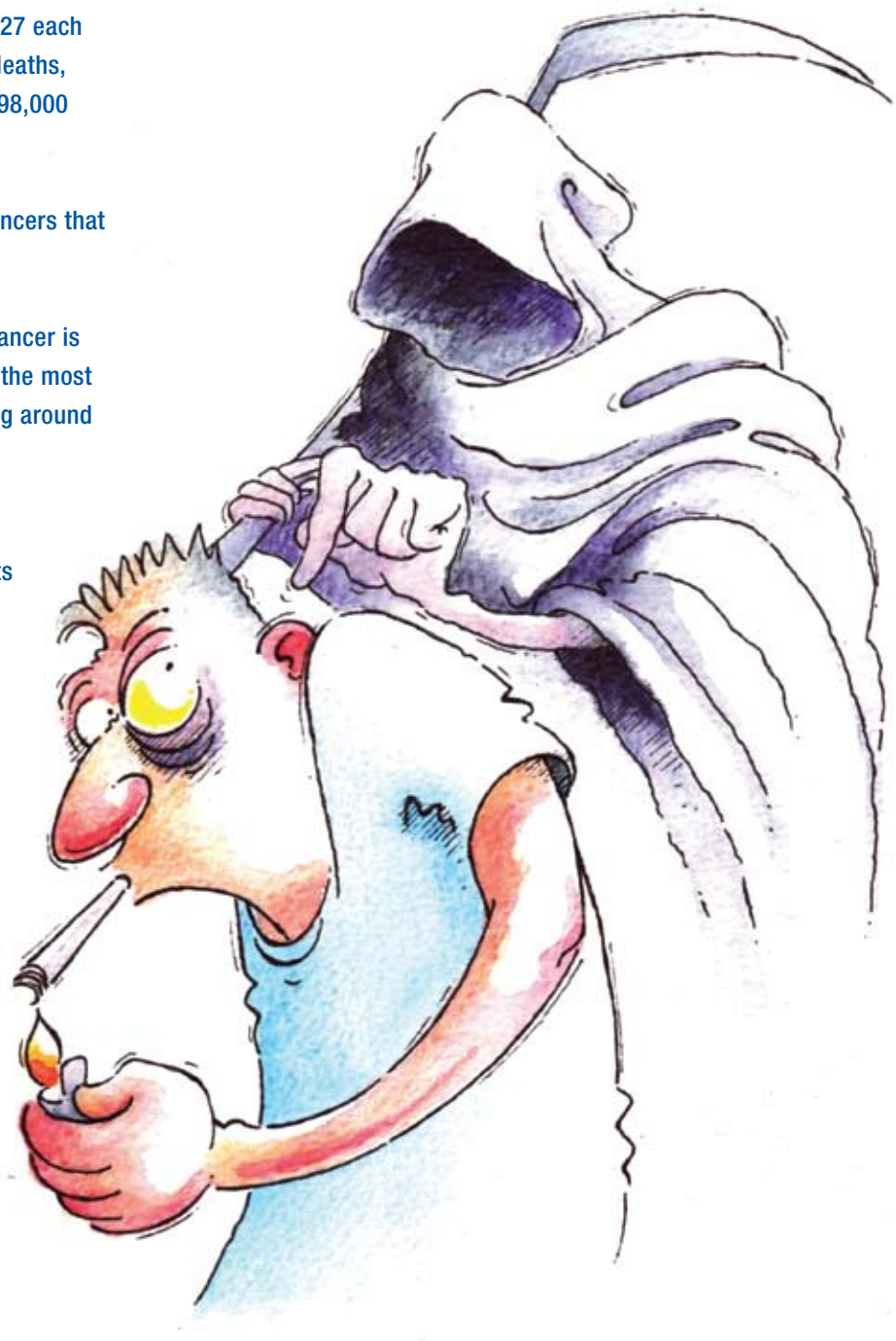
## Headline recommendations for actions:

- **Gender sensitive national cardio-vascular strategies - including vascular checks coupled with appropriate counselling and follow-up for all men over the age of 50 years - should be introduced**
- Efforts to curb smoking and excessive alcohol consumption (including pricing) across Europe should be prioritised
- Legislation should be directed at the causes of cardio-vascular disease including the salt and fat content in food, for example, should be introduced.

# Cancer

7

- Cancer kills around 700,000 men in the EU27 each year which accounts for a 1/3 of all male deaths, with premature mortality affecting some 198,000 males under the age of 65 years.
- Men develop and die sooner from those cancers that should affect men and women equally.
- Male cancer patterns are changing; lung cancer is declining but prostate cancer has become the most diagnosed among European males affecting around one million men.
- Lung cancer will remain a major cause of premature mortality while tobacco products remain so freely available.
- Colorectal cancer is a leading cause of cancer death in Europe and requires population-based screening.
- Testicular cancer, despite effective treatment, still remains the first cause of cancer death among young males (20-35 years).



With an ageing European population and advances in both the prevention and management of cardiovascular disease, cancer is becoming the most significant cause of premature death in men. Around 700,000 men and over 540,000 women die every year, which account for 29% and 22% respectively of all male and female deaths across the EU27. In those aged under 65, some 198,000 men and 143,000 women die every year from cancer, 31% and 45% respectively of total deaths from all causes. Given that there are no significant sex-specific cancers for men during the early adult years (in contrast to the situation for women), male deaths are from cancers that should affect men and women equally. Men are more likely to develop and also more likely to die prematurely from these cancers[125].

There are many causes of cancer. Some originate through inherited factors, but most are as a result of lifestyle or the environment in which men live and work: smoking, alcohol, diet, lack of physical activity and exposure to industrial chemicals especially in factories and on farms[126]. In addition, there is growing awareness of the risks the male form of overweight and obesity play in the development of fat-related cancers[127]. There may also be issues relating to delay in presentation with symptoms, which reduces the treatment options.

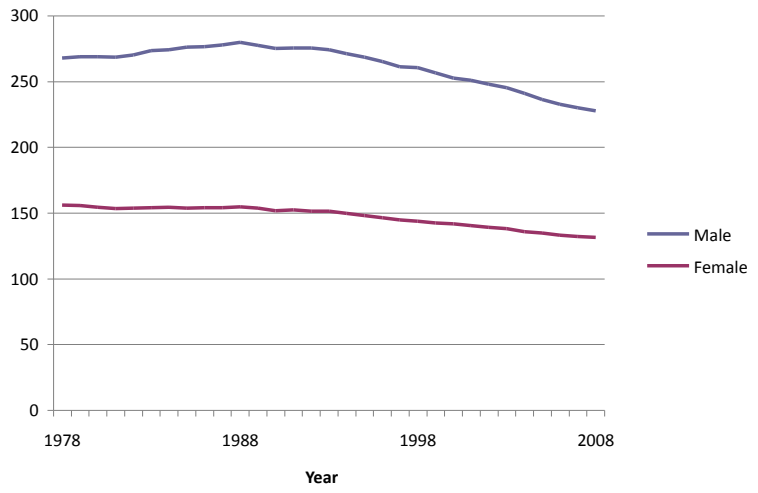
Another relevant factor when considering cancer mortality data is that men and women's ability to survive cancer differs across Europe[128]. During the period 2000-2002, the average survival rate in Europe is 47% among men and 56% among women. The same study found that women have significantly higher survival rates than men for all cancers combined in each age class[129]. Age at diagnosis is a major determinant of women's advantage. A strong link to sex hormone patterns is implicated: with increasing age, differences between men and women almost disappear.

Male cancer mortality rates in the EU27 are showing a twofold difference. The highest mortality rates are observed mainly in the eastern part of the EU (Hungary, Latvia and Slovakia). The lowest mortality rates are observed in Sweden, Finland, Malta and Luxembourg.

The male to female profile of cancer deaths changes with age: more young men and boys dying (mainly of cancers related to congenital problems); more women dying in the middle years; more men than women die in older age. If the sex specific cancers are removed from the data, the profile shows a far higher proportion of men dying from other cancers. The male excess of cancer death rates for non-sex specific cancers persists across the age range.

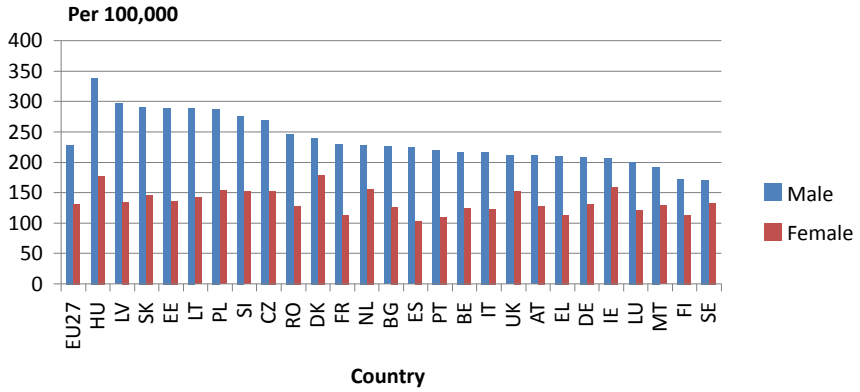
**Time trends of all cancers mortality, by sex, EU27, 1978-2008**

*Source: WHO Morticd10*



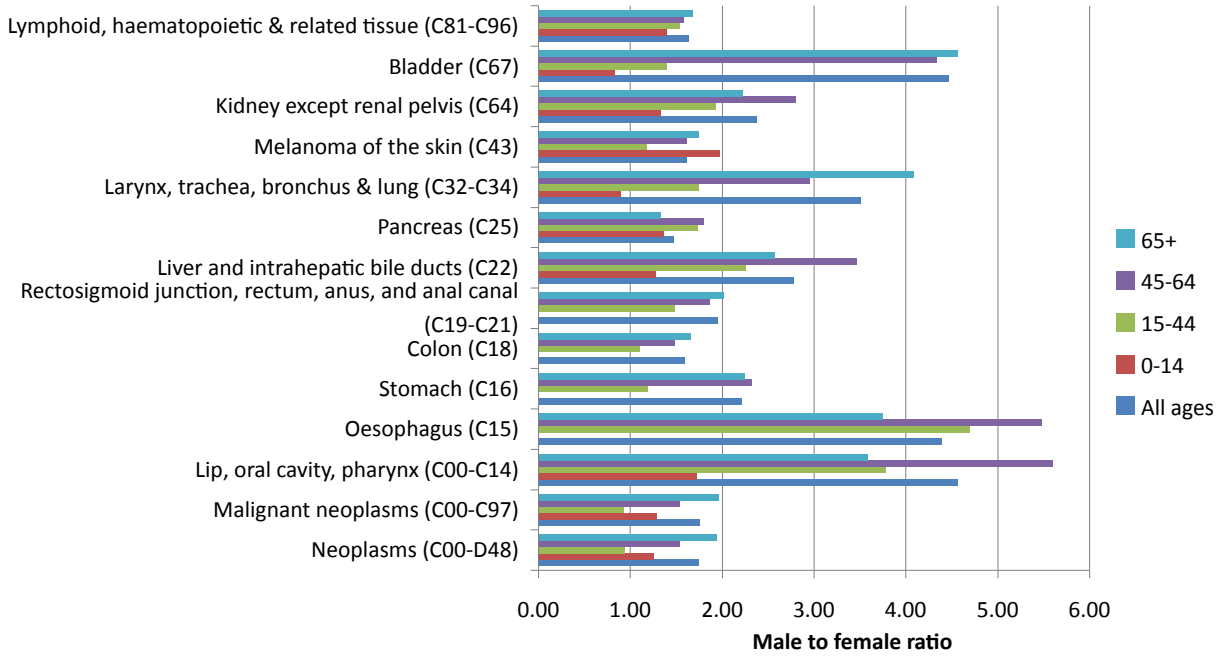
## Age standardised death rates for cancer, by sex and country, all ages, latest year[1]

*Source: WHO Morticd10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*



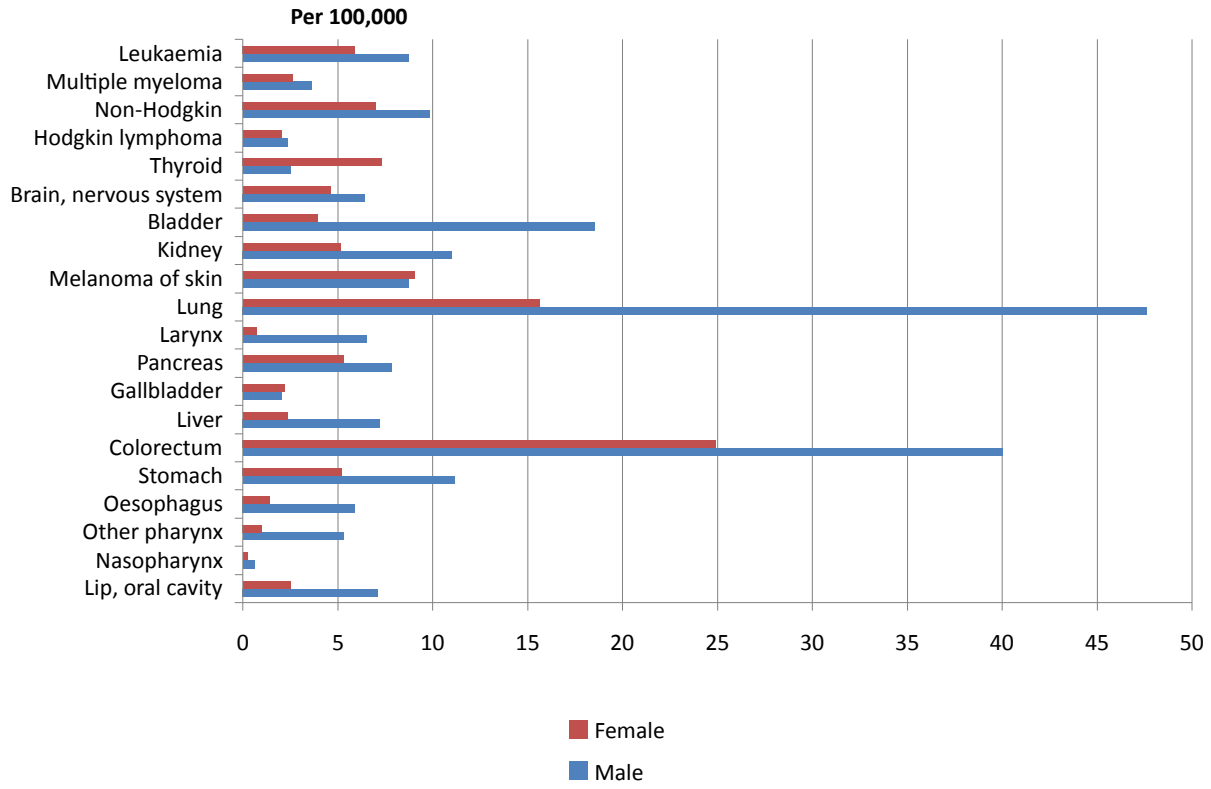

## Sex ratio of standardised death rates as a result of Cancer, by age, EU27, 2007

*Source: calculated from Eurostat hlth_cd_anr*



**Age standardised incidence rates for the major cancers, by sex, EU27, 2008**

*Source: Globocan*[130]




This high level of premature mortality is mirrored in incidence rates for all the major cancers that are not sex-specific. As many of these are not directly associated with tobacco consumption, this higher incidence suggests that the problems of men and cancer are influenced by other lifestyle factors. It also compounds problems men may have with accessing services: they are not just more likely to die from the cancer but more likely to develop them as well.

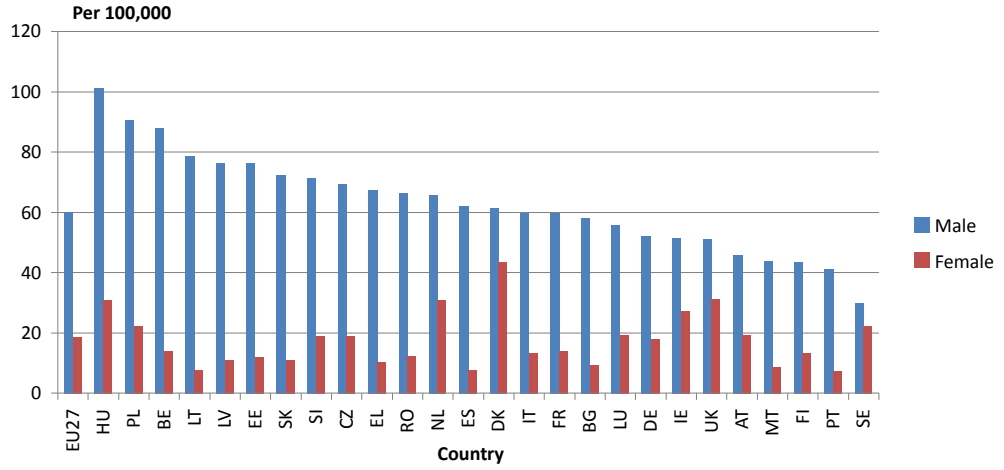
# Lung cancer

The current incidence rate for lung cancer is 47.6/100.000 for men and 15.6/100,000 for women. Lung cancer death rates in some Eastern European countries are 3 or 4 times greater compared to the lowest incidence rate in Sweden. It is noticeable that in some countries the female incidence rate is approaching that of males (e.g., Denmark, Iceland and Sweden). In 2008 around **180,000** males died from lung cancer in the EU27, with around **60,000** of these deaths being in men under the age of 65 years, which constitutes circa 10% of all deaths for all age groups before 65 years of age. Lung cancer deaths for women in the same year amounted to **70,000** for the entire female population and **23,000** for women under 65 years of age. This constitutes circa 7% of all deaths. Lung cancer male/female ratio is 3.3:1. The sex ratio ranges from 8-10:1 in Latvia, Lithuania and Spain; while it amounts to 0.9 in Iceland.

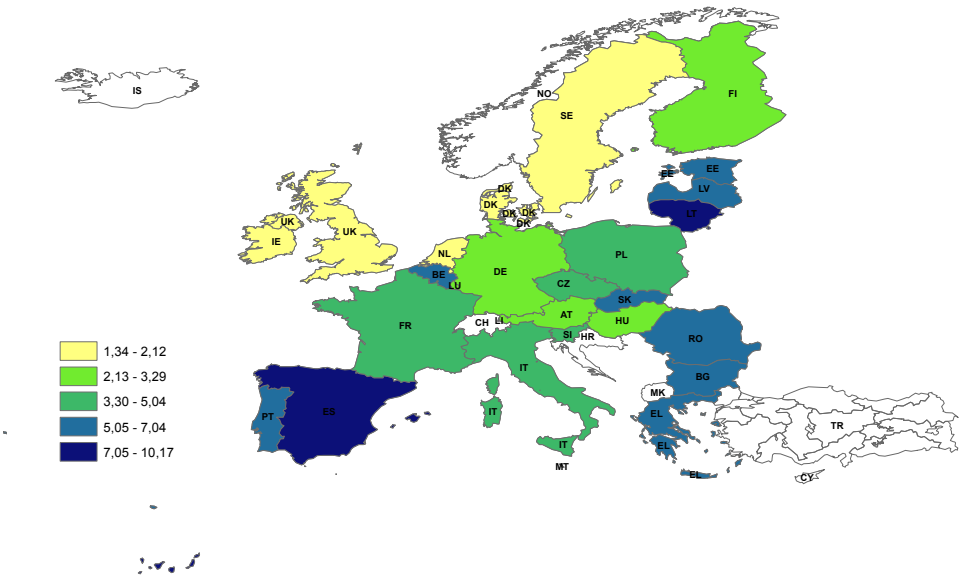
Large differences in death rates between men and women are evident across the life span.

## Age standardised death rates for Lung cancer, by sex and country, all ages, latest year[1]

*Source: WHO Morticd10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*

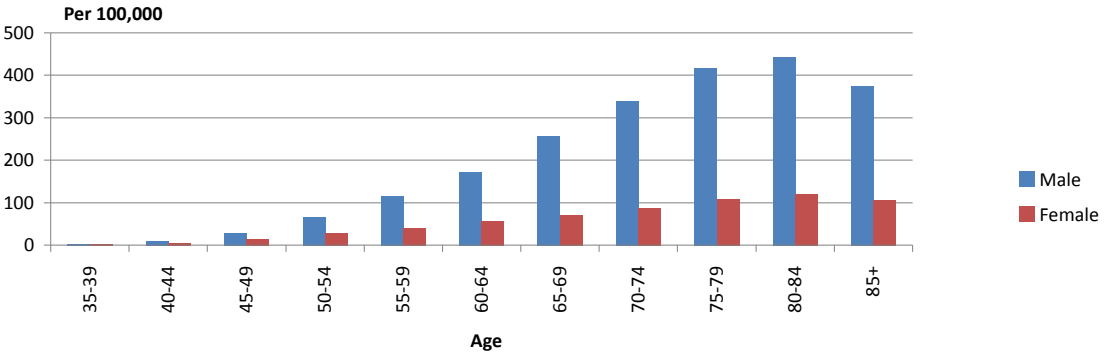



## Male to female ratio of standardized death rates of malignant neoplasm of lung




## Age specific death rates for Lung cancer, by sex, EU27, 2008

*Source: WHO Morticd10*



# Colorectal cancer

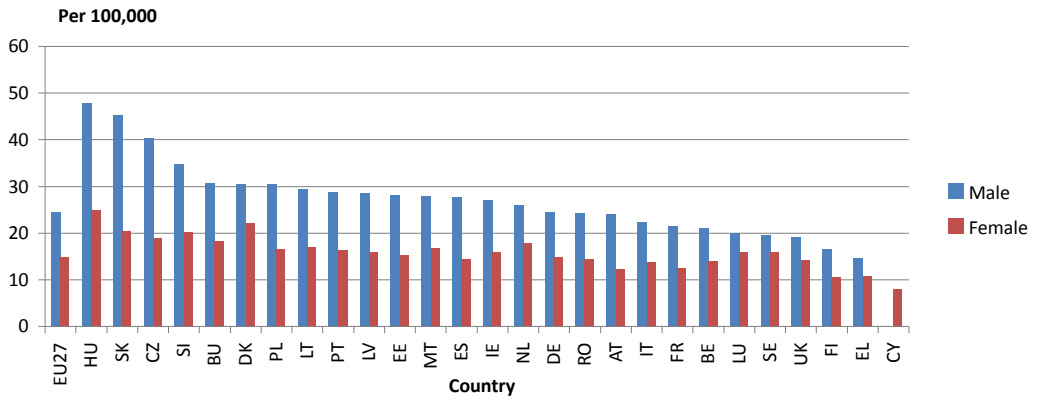
Cancers of the colon and rectum (colorectal cancer) constitute a significant proportion of the male burden of cancer morbidity and mortality. Annually in the European Union 183,000 men and 150,000 women are diagnosed with colorectal cancer: 78,000 men and 67,000 women die from this disease. This constitutes around 11% of all cancer mortality (12% for women). There is a marked age effect for men.

Generally, colorectal cancer rates have fallen since the early 1980s in Western European countries. In Eastern Europe, mortality rates were generally higher until the early 2000s, when the rate of increase started to fall. The prevalence and preventable nature of colorectal cancer make it one of the primary focal points of cancer control[131].

The average age-standardised colorectal mortality rate for the EU27 in 2008 was 25/100,000. However, the mortality rates range from around 48/100,000 in Hungary, Slovakia and

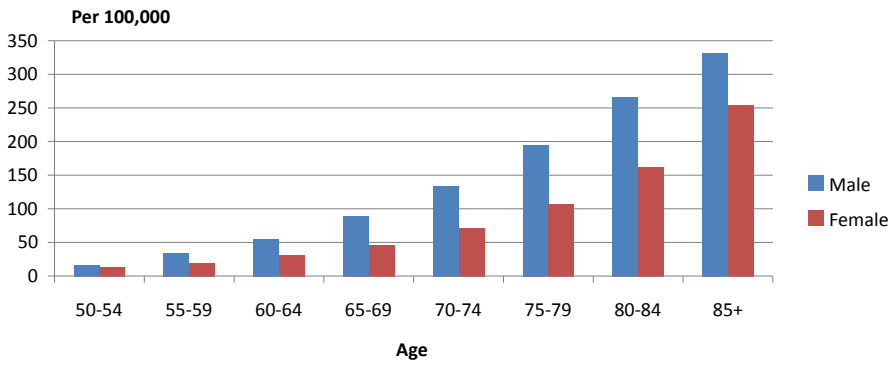
**Age standardised death rates, colorectal cancer, by sex and country, all ages, latest year[1]**

*Source: WHO Morticd10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*

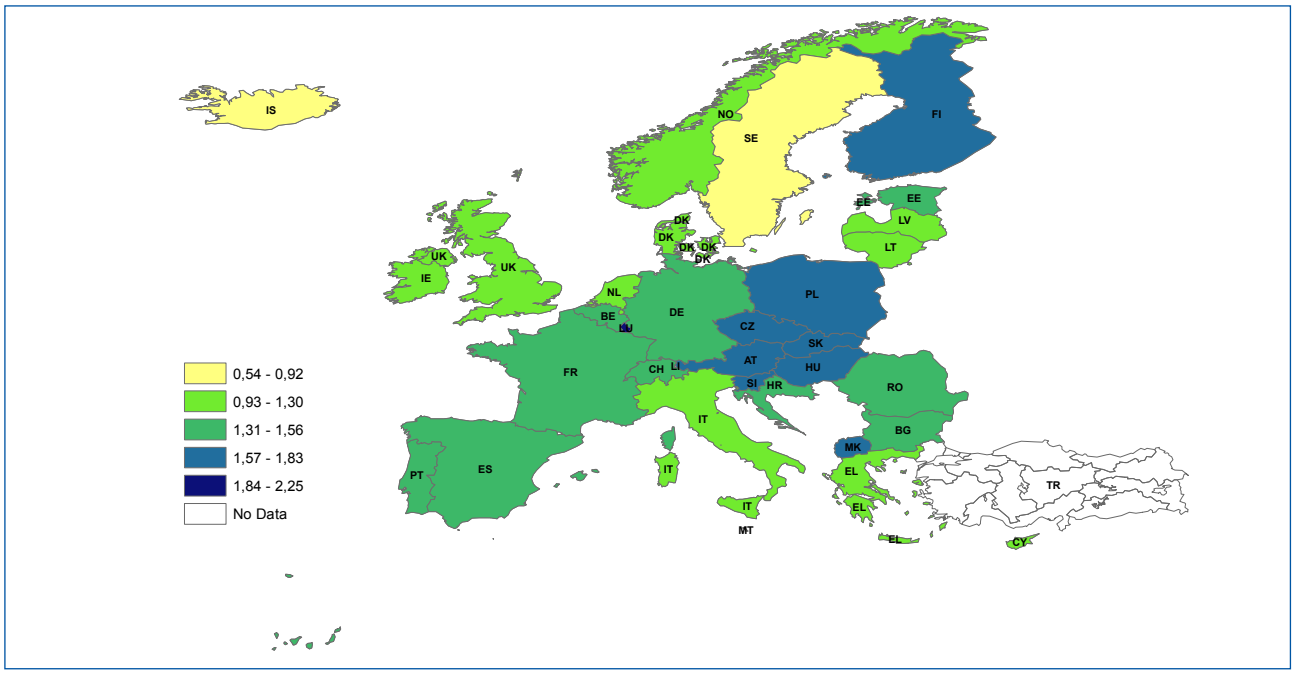



**Age specific death rates for Colorectal cancer, by sex, EU27, 2008**

*Source: WHO Morticd10*



**Male to female ratio of standardized death rates of malignant neoplasm of colon**




the Czech Republic to 16/100,000 observed in Greece and Finland.

The higher rate of death mirrors the incidence data at being about 5-10 years ahead of women, which has implications for the age screening programmes begin.

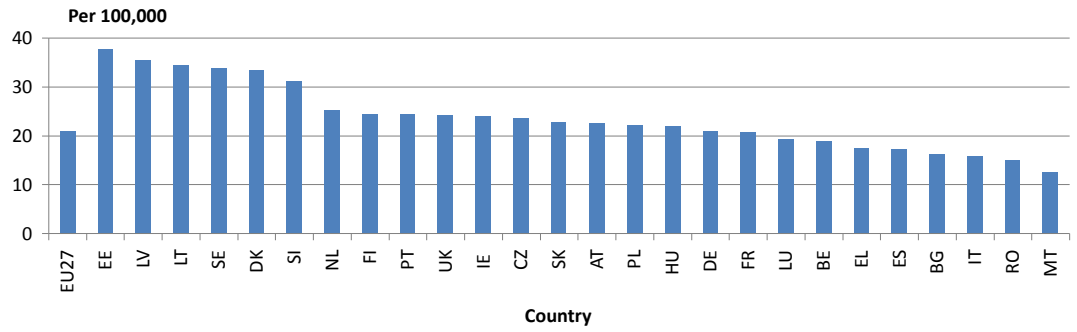
# Prostate cancer

Despite significant advances in the treatment of prostate cancer, it remains a growing problem for men's health. In 2008 around 70,000 men died of this disease. This constitutes about 10% of all male cancer deaths and 3% of all male deaths.

Over 92% of these deaths occurred in the oldest age group (65+). Mortality rates vary across the EU27, ranging from over 35/100,000 in Estonia and Latvia to 15/100,000, in Malta and Romania. Of the Western European states Sweden and Denmark

**Age standardised death rates, malignant neoplasm of Prostate, all ages, latest year[1]**

*Source: WHO Mortic d10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). BE (2004).*



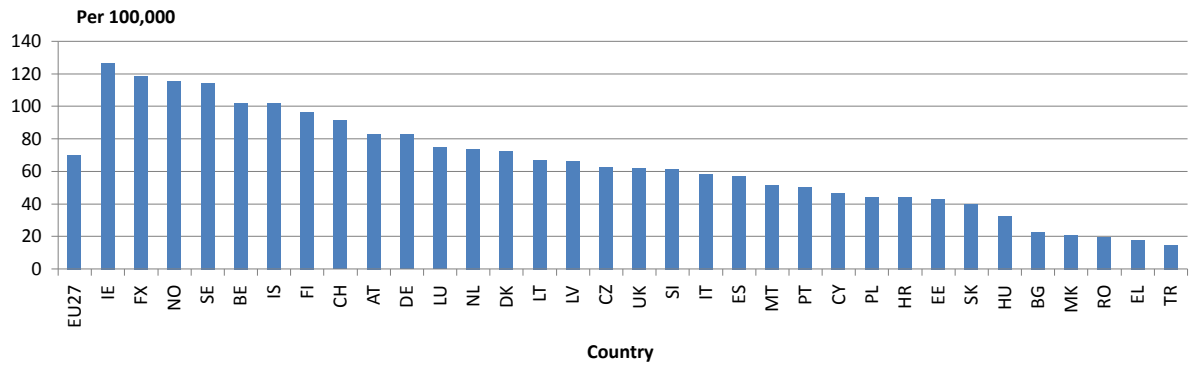
are noticeable at both having a rate of over 33/100,000, nearly a ¼ higher than the nearest other Western state.

Currently, around 3 million European men are living with prostate cancer and this number will grow due to population ageing. There were 350,000 new cases of prostate cancer diagnosed in the EU27 in 2008, which amounts to about 70 new cases per 100,000 men across the EU27 each year. However, this varies considerably between states, ranging from 14 per 100,000 in Turkey to over 123 per 100,000 in Ireland. Prostate cancer has a higher incidence in certain ethnic groups, most prominently African-Caribbean men. The incidence is also higher in first degree relatives of men with prostate cancer: such men have up to 5 times higher risk of developing the disease[132].

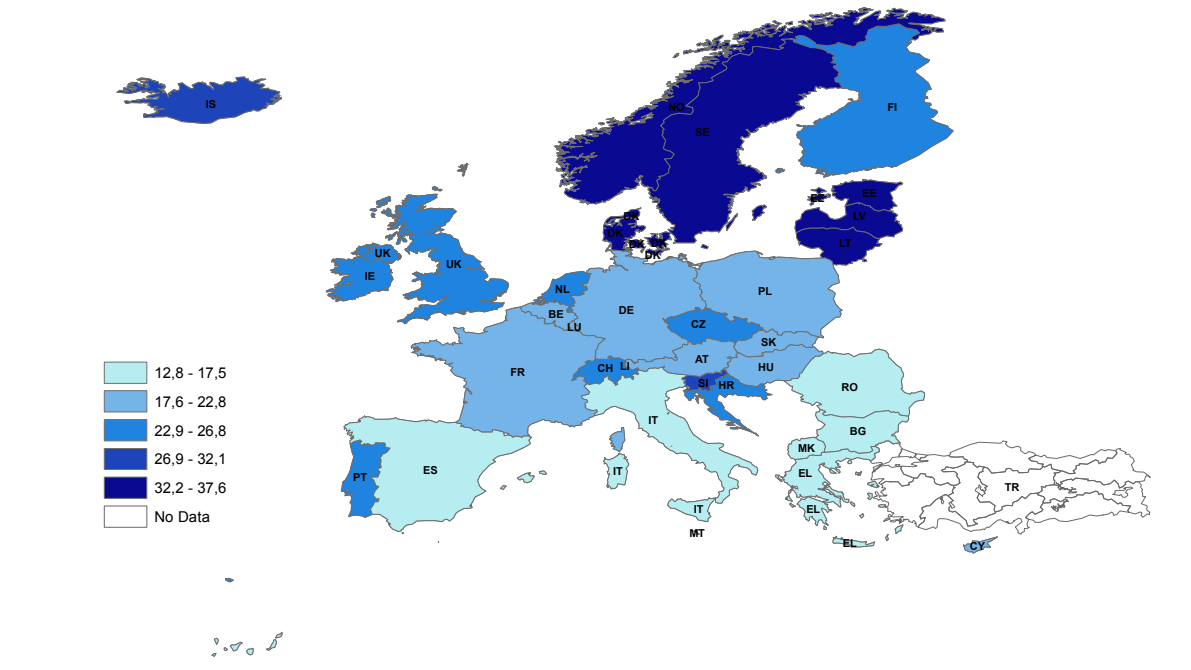
From the beginning of 1960s there has been a slight growth of prostate cancer incidence (but not mortality). The reason for this apparent discrepancy is that the majority of prostate cancer cases are slow growing and do not pose an immediate threat to the

**Age standardised incidence rate for Prostate cancer, by country, 2008**

*Source: Globocan[135]*




**Male standardized death rates of malignant neoplasm of prostate**



individual. Many men die with the disease rather than of it. There is, however, a type of prostate cancer that can occur in younger and older men which is more aggressive and leads to a more rapid death if not detected early enough. These 'tiger tumours' are very different from the majority of slow growing tumours that affect the majority of men.

The increased use of Prostate Specific Antigen (PSA) screening during the last decade resulted in a problem of too many non-life threatening prostate cancer cases being identified. This led to unnecessary treatment with long term side effects[133]. Although large-scale US and UK epidemiological interventions are available, some governments have decided against national screening programmes for prostate cancer[134].

# Testicular cancer (TC)

Testicular cancer (TC) is the most common malignancy amongst young adult men (20-44 age group) in Europe. On a population scale, testicular cancer deaths are, however, quite rare: fewer than 1000 deaths out of over 15,500 new cases annually in Europe and constitutes 1%-1.5% of all male cancer deaths.

Comprehensive treatment - including chemotherapy, radiotherapy and surgery - is characterised by excellent cure rates: 95% cure for early stages of TC, and slightly less in more advanced stages of the disease. It is the best example of a controllable human cancer. The availability of specialist centres is of paramount importance for successful testicular cancer treatment[136].

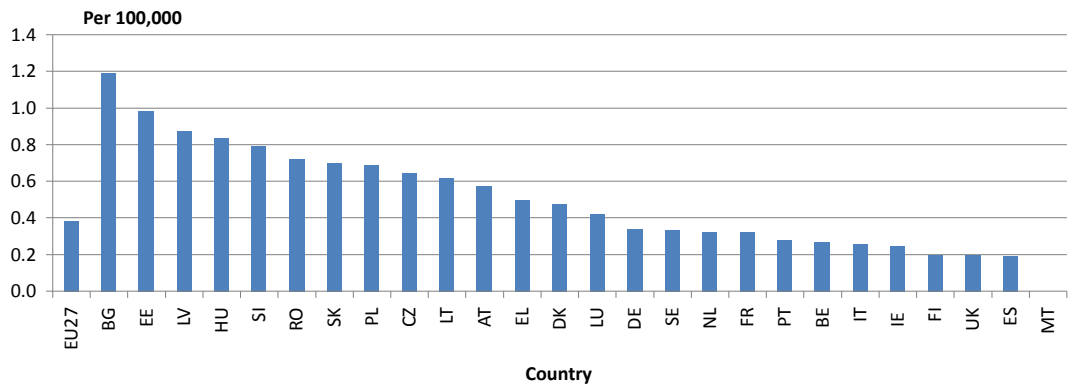
Because the causes of testicular cancer are still unknown, the only effective control is through early diagnosis and treatment. Testicular cancer incidence and mortality/age curves display a bimodal pattern, which is different to other cancers. The frequency increases after the age of about 15 years to reach the first peak at the age 25-30, after which it declines to about age 60, when it increases again.

Over the last 60 years there has been a steady increase in testicular cancer morbidity in almost all countries. Testicular cancer incidence in Europe oscillates around 3 to 6/100,000, with the highest rates in Denmark and Norway (over 11/100,000). The reasons for this difference are not clear.

In 2008 mortality rates for the EU27 amounted to 0.4/100,000. The highest levels were observed in Bulgaria, Estonia and Latvia. The lowest mortality rates were observed in Spain and in the UK (Malta had no reported deaths).

**Age standardised death rates for Testicular cancer, by country, all ages, latest year[1]**

*Source: WHO Mortic10 [1] 2008 except CY, CH FR, IT, MT, NO, SE, UK (2007). DE, LU (2006). ES, PT (2005). E (2004).*



## Summary

Male Cancer patterns are changing with a reduction in deaths as a result of stomach cancer and now lung cancer, but with an increase in cases of prostate cancer. Marked differences exist between countries in relation to the male burden of cancer. Men generally have a higher incidence rate for those cancers that should affect men and women equally and a higher rate of premature death. The gender differences are also evident with respect to survival rates, which are generally improving but still poorer in men.

The reasons for men's higher risk of developing and dying of cancer are multifactorial but tobacco remains the largest source of exposure to carcinogenic substances for men. Tobacco causes numerous localised and systemic cancers (lung cancer, oral cancer, pharyngeal cancer, laryngeal cancer, oesophageal cancer, pancreatic cancer, kidney cancer, urinary bladder cancer, leukaemia's, etc). Tobacco is still the largest single preventive cause of cancer death among men across Europe.

## Headline recommendations for actions:

- **National Cancer plans should make specific recommendations with regard to monitoring and reporting on male cancer patterns, to male cancer susceptibility and lower rates of survival and to lower male cancer literacy**
- Screening needs to be better understood and targeted – for example, bowel cancer needs to be started at an earlier age for men and effort has to be made to ensure more men present for screening while research is needed into the development of an effective screen for prostate cancer.

# Accidents

# 8

- Throughout the EU, there is a clear and consistent pattern of higher mortality rates among males compared to females from accident and violence-related injuries.

- There are considerable differences between countries with male mortality rates from accident and violence related injuries being particularly high in Eastern Europe.

- Accidents account for the biggest proportion of deaths within this classification group (some 36,000 male deaths in EU27) with death rates from road traffic accidents being 3 times higher in men than women. Men account for 95% of fatal workplace accidents.

- Homicide accounts for 5,500 deaths annually in the EU27 with the rate of homicide being twice as high for males as for females.

- Road injuries and suicide are the principle causes of accidental fatality among all male age groups.

- Whilst the vast majority of both victims and perpetrators of violence are male, females are much more likely to be victims of intimate partner violence (IPV)

Deaths as a result of Injury/ External causes of morbidity and mortality accounted for over 156,000 male deaths (6.5% of all deaths) and 79,000 female deaths (3.3% of all deaths) for EU27 in 2007. Injury/ External causes of morbidity and mortality is the leading cause of death in all age groups below 60, and the fourth most common cause of death in the EU after CVD, cancer and respiratory disease. This broad category[137] comprises accidents (unintentional injuries, including road traffic accidents, workplace accidents, home and leisure accidents) and violence (intentional injuries, including interpersonal violence and self-harm. The biggest cause of death within this classification group is accidents accounting for 63% of male deaths (73% female deaths).

Despite improved surveillance systems and prevention strategies, accident and violence-related injuries continue to be a major public health problem in the EU. As well as being a major cause of death, accidents and injury cause a huge drain on health and societal resources, resulting in an estimated seven million hospital admissions and 60 million medical consultations annually[138]. The burden of healthcare costs associated with accident and injury in the EU is estimated at approximately €15 billion per year[139].

Boys and men are over represented in most fatal and non-fatal accident and injury categories. The burden of accident and injury varies widely between and within Member States. The prevalence of accident and injury-related mortality and morbidity is generally higher in Eastern European countries[140] and higher among lower socio-economic groups within countries.

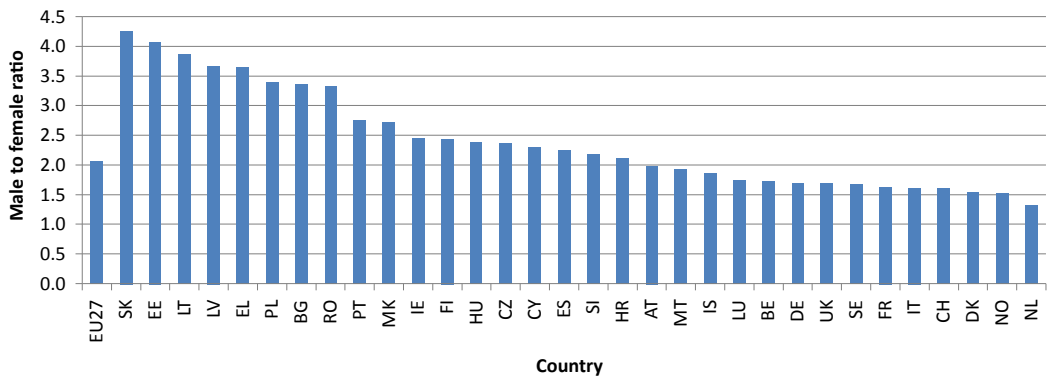
There are considerable differences between countries[141] with the standardised injury death rate being almost 7 times higher in Latvia (where 16% of all deaths result from accidents) than in the Netherlands. This is indicative of an overall pattern of much higher standardised injury death rates in Eastern Europe than Western Europe.

It is estimated that 100,000 lives could be saved each year if every country in the EU27 reduced its injury mortality rate to the level of the Netherlands[142]. If we were able to bring the male mortality rate down to that of females, then we would see over 82,000 male lives saved across the EU27. This equates to a potential decrease in overall mortality of 35 per 100,000 population across the EU27.

Unintentional injuries are responsible for about two-thirds (68%) of injury fatalities and intentional injuries represent one third (32%) of injury fatalities[143]. The vast majority of injury fatality is attributable to suicide (24%), road traffic accidents (21%) and falls (19%). Injuries affect men and women disproportionately throughout the lifespan, with overall risk of injury being approximately twice

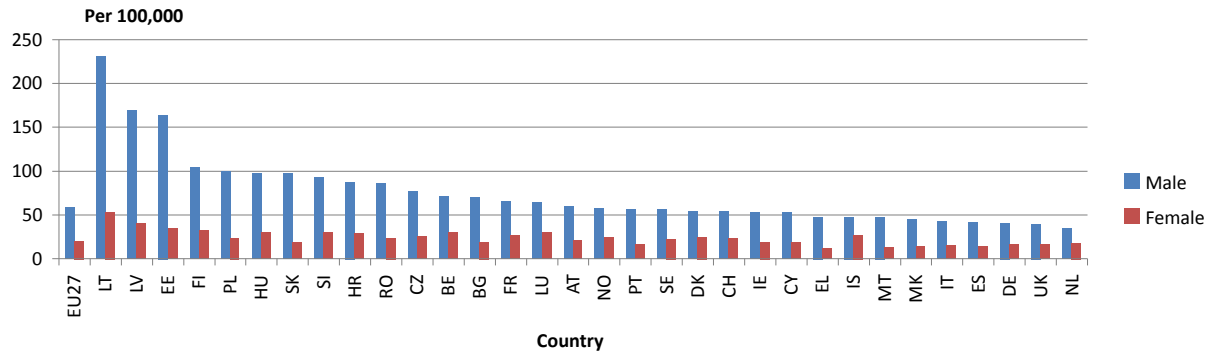
**Male to Female rate ratio of deaths due to injuries, by country[1]**

*Source: Eurostat hlth_cd_ycdrf; hlth_cd_ycdrm. [1] 2006 except BG, CH, FR, MT, PL, RO, UK (2005). DK, EU27, LU, PT (2004). IT (2001). BE (1997).*



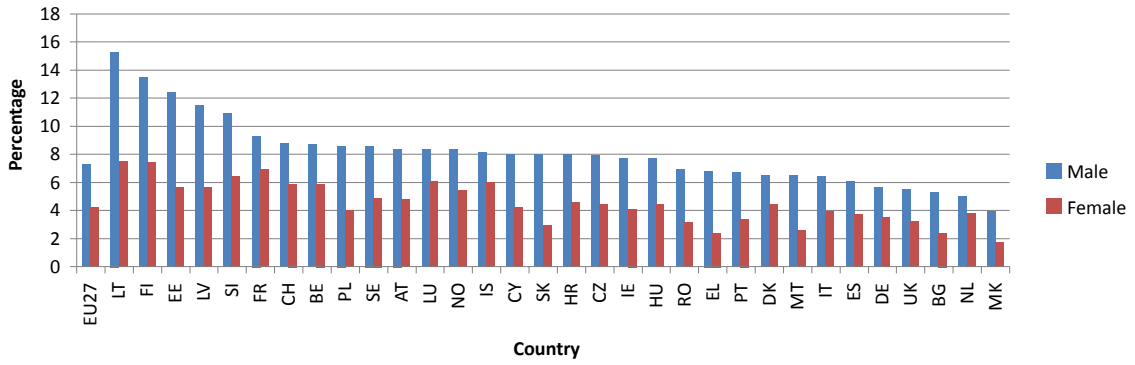
### Age standardized death rates and percentage of all deaths for External causes of morbidity and mortality, by sex and country, latest year[1]

*[1] 2008 except BG, CH, EU27, FR, IT, MT, PL, RO, SE, UK (2007). DK, LU, PT (2006). BE (2004)*



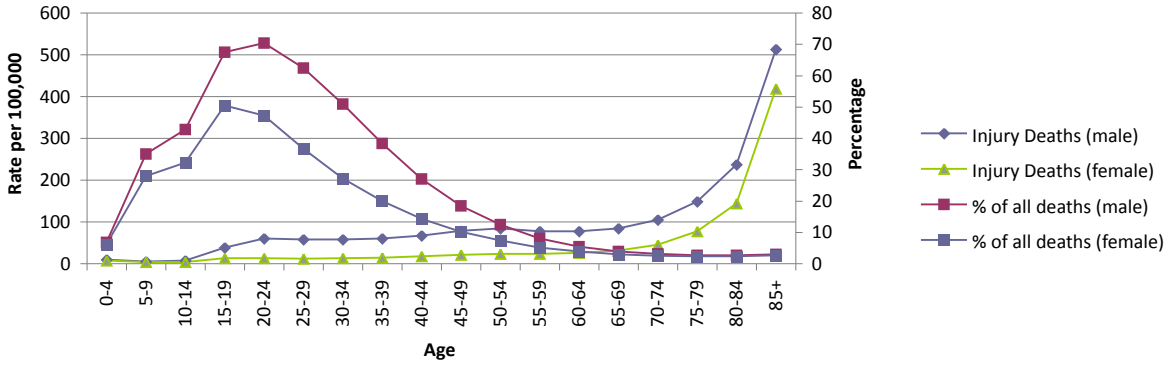

### The percentage of all deaths for External causes of morbidity and mortality, by sex and country, 2007

*Source: Eurostat hlth_cd_asdr*




### Age specific death rates per 100,000 and percentage of all deaths for External causes of morbidity and mortality, EU27, 2007

*Source: Eurostat hlth_cd_asdr*



as high in men (72 injury deaths per 100,000) than women (35 deaths per 100,000) (ibid). Fatal injury rates rise sharply up to the age of 15-19, are higher for boys/young men than girls/young women, and are much higher in older men than older women.

Road traffic accidents (48%) and suicide (20%) account for over two-thirds of all fatal injuries among adolescents and young adults (15-24 years) (ibid). In both cases, the death rates are approximately 3-4 times higher for men (transport: 24, suicide: 10) than women (transport: 6, suicide: 2). The result is a relative injury mortality rate of 70% in men aged 20-24 years (ibid). There are large differences between countries in injury fatality rates for young people. For example, injury accounts for 54% of all adolescent deaths in the Netherlands compared to 76% in Estonia. Each year, 8.4 million people aged 15-24 years require hospital treatment for an injury This represents 20% of all hospital injury related treatments, even though this age group represents only 13% of the total EU population.

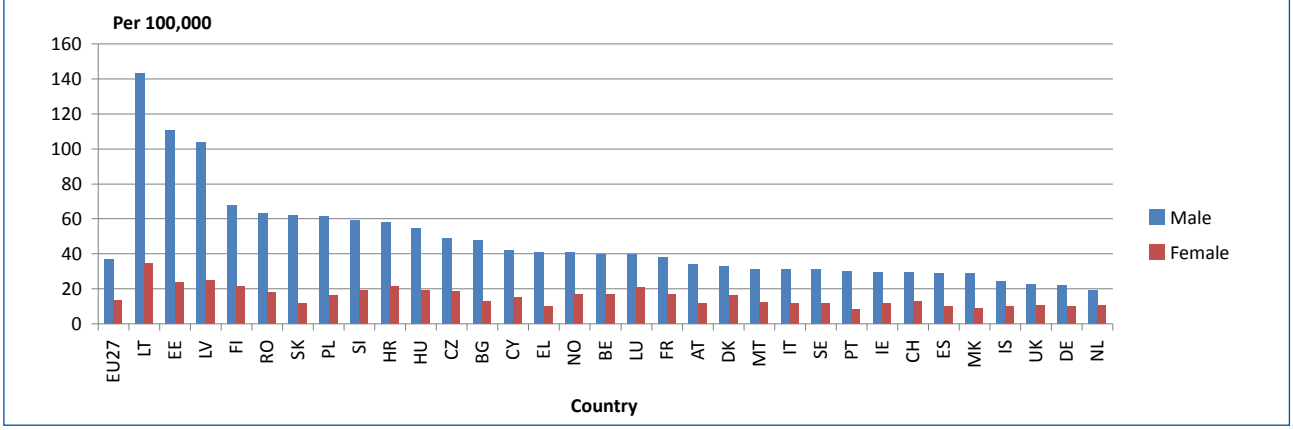
# Accidents

Mortality rates from accidents are consistently higher for men than for women across Member States, with the gap being most pronounced in Eastern European countries [144].

Deaths from road traffic accidents account for 23% of all deaths due to External causes within the EU27, with 36,166 men (11,1181 women) killed in the EU27 in 2007. Death rates are 3 times higher for men than for women[145]. An estimated 4.3 million road injuries per year are treated in EU hospitals, with approximately two-thirds of these being vulnerable road users. Considerable differences exist between countries, with higher rates in Eastern European countries. Although the disparity in road death rates across the EU has decreased since 2001, there is still a fourfold difference between the lowest (Malta) and the highest countries (Lithuania). Deaths from road traffic accidents are 1.5 times greater in lower and middle income countries than in higher income countries[146] and are also higher among men with lower socio-economic status and less education[147]. The higher death rates in Eastern EU countries are most likely associated with deficits in legislation on drink-driving, legislation governing the quality of motor vehicles and seat belt use, and government expenditure on roads[148]. The WHO estimates that more than 1 in 3 road traffic fatalities in the EU are due to alcohol, with men accounting for 15,000 of the 17,000 alcohol related traffic deaths[149]. Of these an estimated 10,000 deaths in drink-driving accidents are in people other than the driver. Property damage due to drink-driving is estimated to be €10bn.

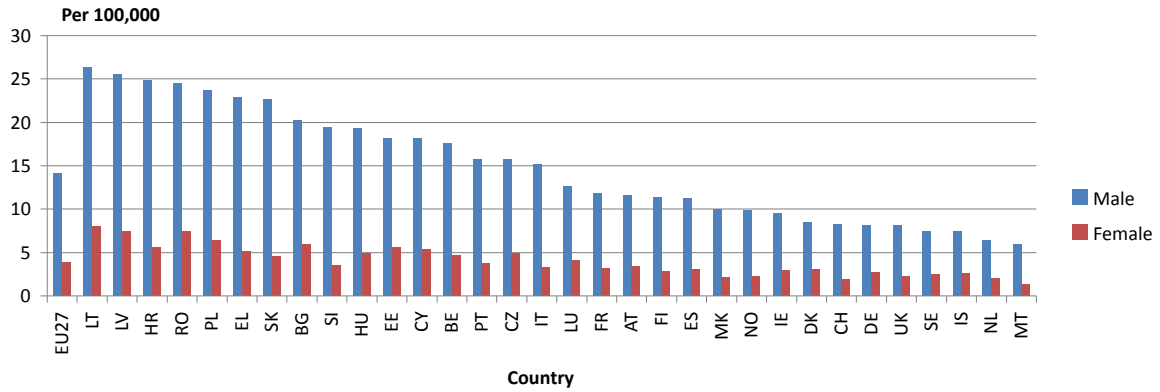
**Age standardised death rates for Accidents, by sex and country, all ages, latest year[1]**

*Source: Eurostat hlth_cd_asdr. [1] 2008 except BG, CH, EU27, FR, IT, MT, PL, RO, SE, UK (2007). DK, LU, PT (2006). BE (2004).*



**Age standardised death rates for Transport accidents, by sex and country, all ages, latest year[1]**

*Source: Eurostat hlth_cd_asdr. [1] 2008 except BG, CH, EU27, FR, IT, MT, PL, RO, SE, UK (2007). DK, LU, PT (2006). BE (2004).*




# Workplace Accidents

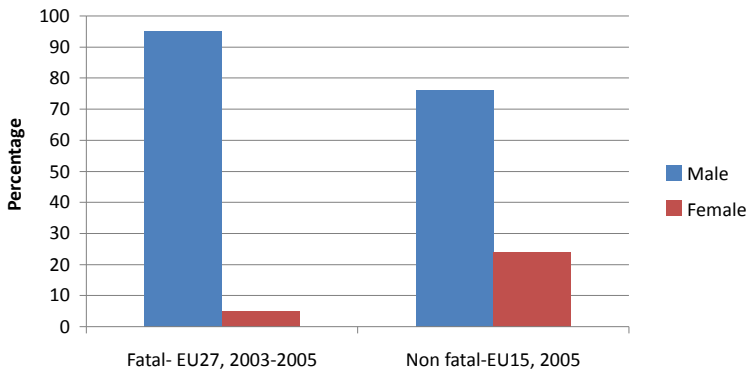
In 2005, 141 million work days were lost due to accidents at work (EU15), with an average 35 days of absence per accident (ibid) Although a large proportion of accidents entailed fewer than 14 days of absence (46%), the number of accidents leading to more than one month of absence accounted for a quarter of overall absence (ibid). Estimated Member State costs due to work accidents range from 1% to 3 % of gross national product (ibid).

Men account for 95% of fatal accidents and 76% of non-fatal accidents in the workplace.

There are considerable variations between countries, with the highest number of fatal accidents occuring in Italy and Germany. It is acknowledged that such differences are, to a large extent, the result of methodological differences in surveillance of workplace accidents. Construction, manufacturing and transport, storage and communication account for the highest proportion of fatal accidents

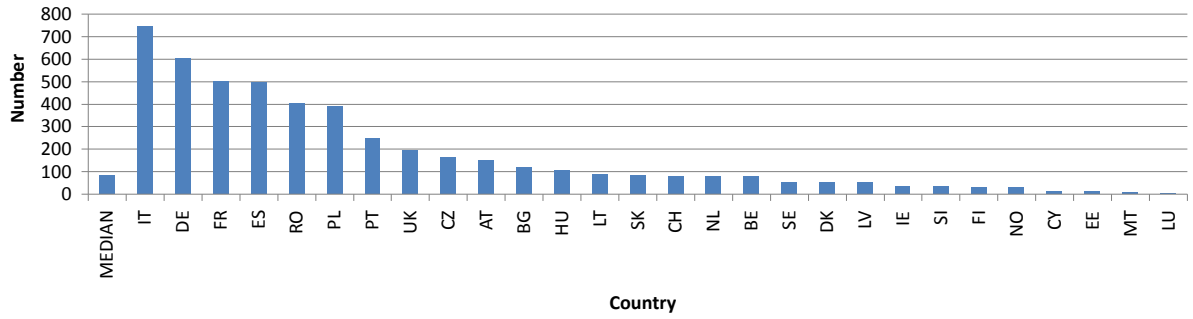
Construction and manufacturing also account

**Fatal and non-fatal accidents at work, by sex**



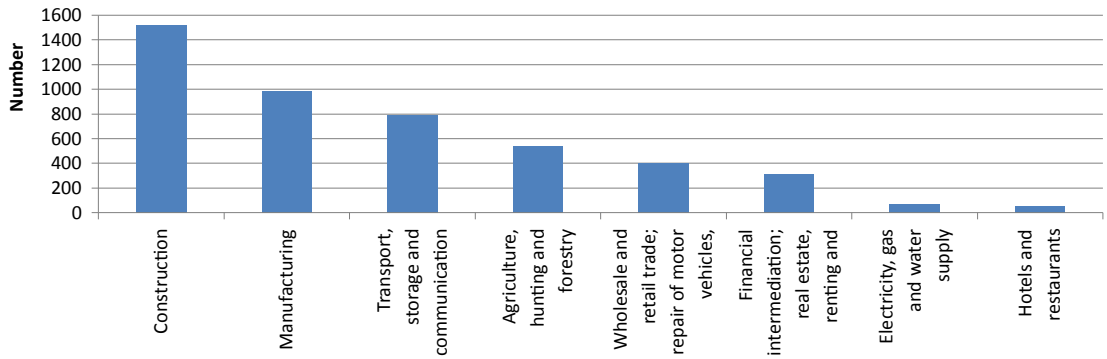
### Number of fatal accidents (NACE A_D_TO_K), by country, Male, 2007

*Source: Eurostat Hsw_aw_nnasx*

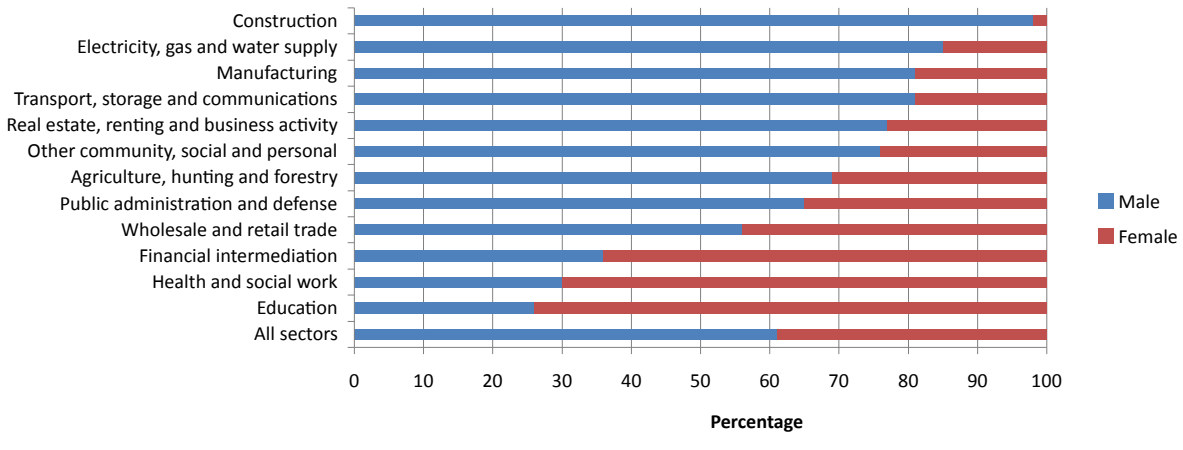



### Number of fatal accidents, Male, EU27, 2007

*Source: Eurostat Hsw_aw_nnasx*




### Distribution of non-fatal accidents by sex and by sector for victims of shock, fright, violence and aggression, 2005, EU27



for the majority of non-fatal accidents in men. Approximately two-thirds (68%) of non-fatal accidents occur among craft and related trade workers, machine operators, or workers employed in an elementary occupation[150].

Incidence rates for non-fatal accidents are highest among labourers in mining, construction, manufacturing, transport; stationary and mobile plant operators; and extraction and building trade workers. Over 70% of injuries arising from non-fatal accidents are sustained as wounds, superficial injuries, dislocations, sprains and strains.

Advances in occupational health and safety have resulted in reductions in the rate of accidents at work. Between 1997 and 2007, there has been a decline in the standardised incidence rate of fatal accidents at work, with Ireland having achieved the most notable reduction.

## Leisure Accidents and Injuries

Sport makes an important contribution to the health and physical fitness of society and to the EU's overall strategic objective of solidarity and prosperity[151]. Many sports, however, carry inherent risks. It is estimated that approximately 6 in 1000 unintentional fatal injuries are attributable to sports such as rock climbing, boating, or horse-related sports[152]. This equates to approximately 1,000 fatalities per year in the EU 27. When drowning (in natural water and swimming pools) and non-traffic bicycle accidents are included, 36 in 1,000 unintentional injuries can be attributed to sporting activities. This equates to an estimated 7,000 fatalities per year [143].

Adolescents/young people are over-represented in most categories of sports-related injuries. For example, in an audit of sports injuries in children attending an Accident & Emergency department in Scotland, the incidence of injury was much higher in boys (71%) than in girls, with football (39%) and rollerblading (14%) accounting for the highest proportion of injuries[153].

The overall incidence of sports-related injuries is higher in men (67%) than in women, reflecting, in part, men's higher participation levels in sport[154]. Men tend to engage in sports that are physically dangerous such as scuba diving, parachuting, hang-gliding and body contact sports[155], and take greater risks in sport than women[156]. For men, taking risks and foregoing safety through sport, have long been regarded as masculine, and are practices that are valorised and sustained through wider gendered systems and structures within sporting organisations[157,158].

## Interpersonal Violence & Assault

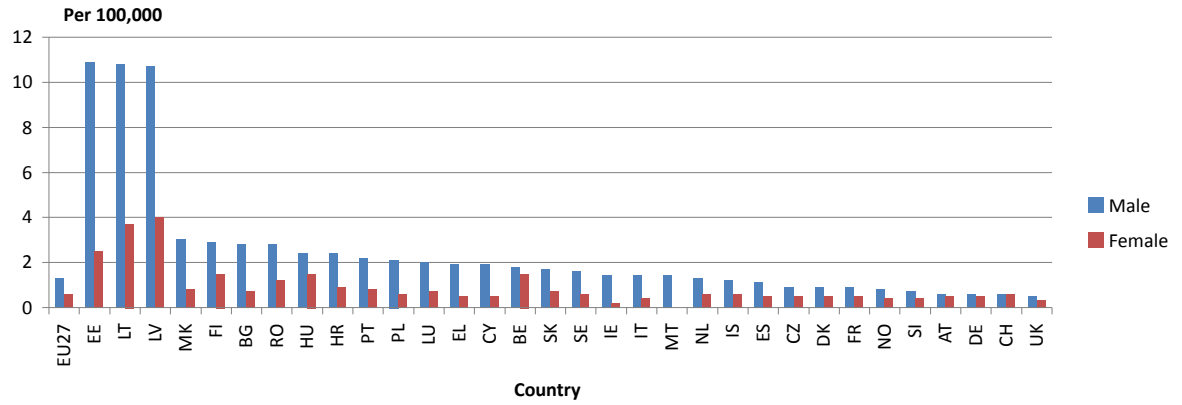
Approximately 2% of all fatal injuries in the EU 27 - about 5,500 deaths annually - are related to homicide[159]. Although the average rate of homicide is 1.5 per 100,000 for men (0.7 for women), it is higher in cities (1.9 for men). The homicide rate for men in the Baltic region is over 10 per 100,000.

There is a marked rise in the homicide rate for men after age 15, with another peak occurring in very old age (85+ years).

With the exception of sexual violence (for which 90% or victims are women), the vast majority of interpersonal violence victims are male and the perpetrators of violence are also predominantly male (72%)(ibid), although clearly, not all men are violent.

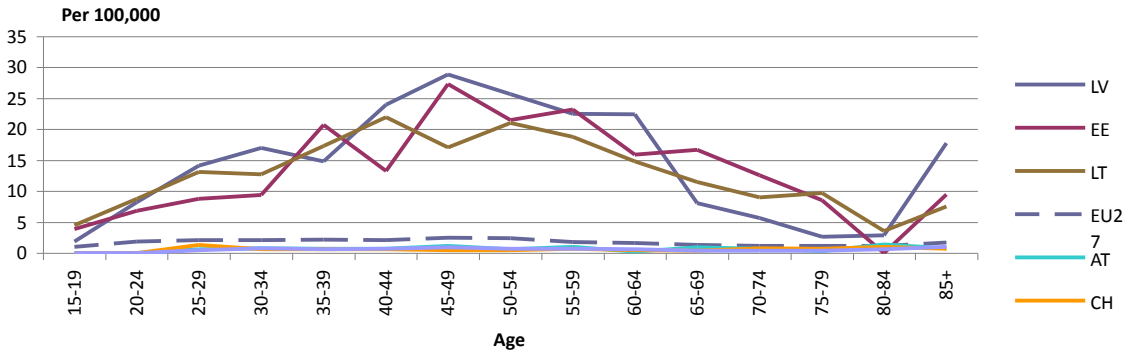
**Age standardised death rates for Assault, by sex and country, all ages, latest year[1]**

*Source: Eurostat hlth_cd_asdr. [1] 2008 except BG, CH, EU27, FR, IS, IT, MT, PL, RO, SE, UK (2007). DK, LU, PT (2006). BE (2004).*




**Age specific death rates for homicide, male, 3 year average, for selected countries**

*Source: Eurostat hlth_cd_ycdrf; hlth_cd_ycdrm*




# Workplace Violence

Violence in the workplace can take many forms, ranging from abusive language, threats and bullying to physical assault and homicide[160]. In addition to criminal intent incidents, violence can result from hostile customer/ client confrontations, conflict between co-workers, and personal relationship incidents involving expressions of domestic violence in the workplace (ibid). The occupations with the greatest risk of occupational violence include retail sales, law enforcement, teaching, health care, transportation and private security[161].

Evidence of from northern European countries[162] suggests that 2-10% of the population have been exposed to physical violence. In a German study of men's experiences of interpersonal workplace violence, psychological violence was found to be more common in the workplace than in other settings[163]. This took various forms and included being insulted, intimidated, shouted at aggressively by superiors or colleagues, having one's character defamed or being ridiculed, belittled or humiliated. Representative studies in European countries have identified bullying as a core element of workplace violence[164].

## Domestic Violence

Although domestic violence or intimate partner violence (IPV)[165] occurs in all countries and across all cultures[166], there is a dearth of information about the prevalence of IPV across the EU. Many methodological difficulties exist in relation to the collation of data within and between countries. Reporting of IPV is highly sensitive to the definitions used, how questions are asked, the degree of privacy in interviews and the nature of the population under study[167]. It must be noted that IPV can take many forms both between and within genders. Perpetration of violence against children seems to play a particularly significant role in the transmission of violence from one generation to the next[168].

Cross-cultural IPV data can be difficult to interpret because of differences in definitions or perceptions of IPV between countries[169]. Data from individual Member States suggest that the prevalence of domestic violence is somewhere between 5% and 20% of all current heterosexual relationships, with women being substantially more likely to be victims, and men substantially more likely to be perpetrators[170,171]. Not surprisingly, the focus of much research into IPV has been violence perpetrated against women[172]. One review of levels of domestic violence perpetrated against women in Eastern European countries reported levels ranging from 5% in Romania to 29% in Georgia for reported lifetime experiences of spousal physical abuse[173]. Physical abuse during the past 12 months ranged from 2% in Georgia to 10% in Romania (ibid).

## Male Perpetrators

The recent development of intervention work with male perpetrators of domestic violence within Member States[174] is founded on the understanding that IPV is unacceptable under any circumstances, and seeks to facilitate and enable men to work with other men to stop it. Underpinning such an approach is an explicit focus on the protection of women and children (and other men) as part of a multi-agency approach to programme delivery. The experience of programme delivery indicates that male participants often experience a cycle of adverse health outcomes, including mental health issues and addictions, arising from their violent behaviour[175].

## Male Victims

There is a lack of data on the impact of IPV on men in the EU. Population-based surveys in the USA indicate that 25% to 50% of victims of IPV are men[176]. Estimates from national family violence surveys in the USA show that approximately 12% of men are the targets of some sort of physical aggression from their partners, with 4% exposed to severe violence (ibid). Nevertheless, tackling IPV as an issue for male victims has been constrained in the past by a general consensus that men are the only perpetrators of IPV and women are its only victims and by reluctance on the part of male victims to report incidents of IPV to the appropriate authorities[177]. Male victims may be less likely to seek help for an issue that society deems they should be able to handle themselves[178] or because of fear of ridicule or embarrassment[179]. Data from the USA show that IPV by women against men is associated with a range of physical injuries and mental health problems in men, including depression, stress, psychosomatic symptoms and general psychological distress[180]. The literature indicates that criminal justice and social service agencies are often unsure of how to respond.

## Summary

Men's accidents, injuries and violence are a major public health problem within the EU. Male risk taking, the effect of male anti-social behaviour, male work and play activities and the management of mental and emotional conflict are all implicated in the higher rates seen in men. With the exception of sexual violence (for which 90% of victims are women) 72% of interpersonal violence victims and perpetrators are men. Homicide accounting for over 5,500 deaths each year also rises exponentially in young males after the age of 15 and peaks again in the 80 plus age group.

In light of the large intercountry variations in mortality rates from injury, it seems prudent that policy lessons and tried and tested preventive programmes established in low mortality countries could be used as a blueprint for good practice initiatives for countries with higher injury mortality rates. If all countries matched those with the lowest mortality rates, half of the lives lost to road traffic injuries and 9 out of 10 of those lost to drowning, poisoning, burns and falls could be saved each year. With men being vastly overrepresented in the injury statistics, such reductions would be particularly significant in reducing mortality and morbidity rates among men.

## Headline recommendations for actions:

- **Adopt the policy lessons and tried and tested preventive programmes established in countries with low mortality rates for Accidents & Injury as a blueprint for more co-ordinated and multisectoral action in those countries with high Accident and Injury mortality rates.**
- Provide an increased focus on research that seeks to unravel the underlying factors associated with Accident and Injury, particularly in regions with high mortality rates, and that support a strong evidence-based approach to injury prevention.
- Develop more stringent mechanisms for collating and tracking Accident and Injury data that are consistent between member states, and that lead to an increased focus on alignment of leadership, infrastructure and capacity building directed at reducing Accident and Injury rates.
- Provide increased resources towards the enforcement of regulatory and legislative measures targeted at Accident and Injury prevention
- At both an EU and member state level, provide an increased focus on violence prevention, addressing the root causes of violence and developing a better understanding of the structural and cultural conditions that help to foster lives free of violence.
- Provide increased intervention programmes for male perpetrators of domestic violence and ensure that male victims of domestic violence have appropriate access to information, support services and counselling services.

# Mental Health

# 9

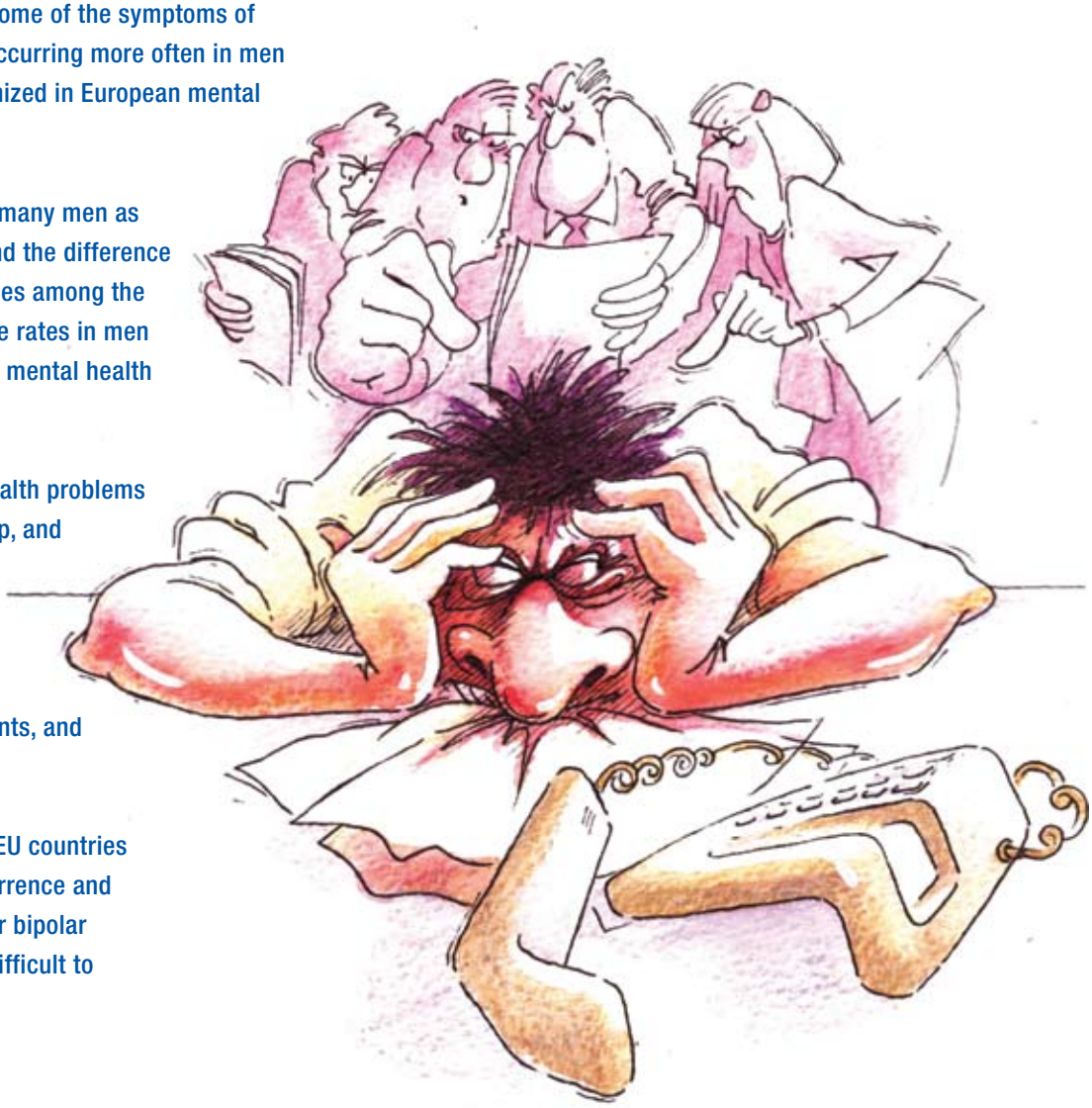
- Men's depression and other mental health problems are under detected and under treated in all European countries. This is due to men's lack of seeking help, lack of appropriate mental health services for men, and men's different presentation of symptoms to women with higher levels of substance abuse and challenging behaviours. Some of the symptoms of mental health problems occurring more often in men tend not to be fully recognized in European mental health services.

- More than three times as many men as women commit suicide and the difference increases to up to five times among the elderly. The higher suicide rates in men are linked to undiagnosed mental health problems.

- Many men with mental health problems find it difficult to seek help, and health services tend to be limited in their capacity to reach out to men, to provide adequate assessments and treatments, and appropriate referrals.

- Sex differences between EU countries regarding incidence, occurrence and admission to treatment for bipolar disease are evident, but difficult to explain.

- Schizophrenia onset is earlier in men than women. Men have poorer long term outcomes, longer inpatient stays and extended periods of impaired functioning. longer inpatient stays and extended periods of impaired functioning.



Mental ill-health in European men is under-diagnosed and under-treated. Many men seem to find it challenging to seek help when it comes to mental or emotional health problems. It may be difficult for health professionals themselves as well as individual men to identify changes in health behaviour as signs of mental disturbances. There is a lack of adequate assessment tools suitable to diagnose men's symptoms, and a lack of suitable ways of referral for gender specific treatment.

In order to address mental health issues more effectively in men, there is a need to address gendered patterns in the upbringing of boys, and to improve our understanding of gendered dimensions to mental health disorders, mental health service delivery and in the behaviours of men themselves.

One very important change that has emerged is in relation to more contemporary approaches to fatherhood. Greater numbers of men attending the births of their children and participating in caring may enhance men's awareness of their own and their family's mental and emotional well being. This may also sensitise men to be more aware of their own mental helth and to seek help more promptly[181].

## Men and Mental Health

Mental ill health includes mental health problems and strain, impaired functioning associated with distress symptoms, and diagnosable mental disorders such as schizophrenia and depression. The mental health and wellbeing of people is determined by a multiplicity of factors, including biology (e.g., genetics, sex differences), individual differences (e.g. personal experiences), family and social factors (e.g. social support) and economic and environmental factors (e.g. social status and living conditions). Data from the WHO-5 mental well-being score show that in all countries, men report better mental well-being than women[182]. However, although more women are diagnosed with depression and anxiety (or internalizing disorders) men commit suicide more often, and men have higher levels of substance abuse and antisocial disorders (or externalizing disorders)[183].

Analysis of health service usage demonstrates that men have less contact with health services in general and even less with mental health services. It is unlikely that this is an indication that women suffer so much more from psychological problems.

When men do contact health services, they tend to be less likely than women to discuss psychological problems[184]. This is reflected by fewer men being known to the health care system prior to suicide, and often not being regarded as depressive or suicidal. Men may be compelled to use other coping strategies such as acting aggressively, being uncooperative with health professionals, rejecting help that is offered to them and, in some cases, reverting to alcohol abuse. However, men with such behaviour often suffer feelings of powerlessness, desperation and depression. In men these feelings are more often combined with aggressive 'acting out' behavior and a lack of impulse control. It is often in such cases that men's psychological or psychiatric symptom emerge: namely where men embody a problem, for example in connection with actual or threatened violence, rape, indecent exposure, child abuse, and drunken driving.

When asked about feeling well or distressed numerous studies show that men report higher levels of well-being and much less distress: across the EU, one in five women compared to one in ten men report psychological distress[185]. However, the findings of two other European Reports[186,187] revealed that men report work-related stress more frequently than women. Mental stress symptoms, such as overall fatigue and irritability, were also slightly more frequently reported by men. Anxiety and sleeping problems were reported by similar numbers of men and women. Their findings, however, revealed great differences among EU countries, with the new Member States showing markedly higher figures than the old Member States. Large differences were also seen from country to country with the highest level reported in Greece (55%), and in Slovenia, Sweden, and Latvia (all around 38%). Lowest stress levels were reported in the UK, Germany, Ireland, and the Netherlands (all around 15%).

# Depression

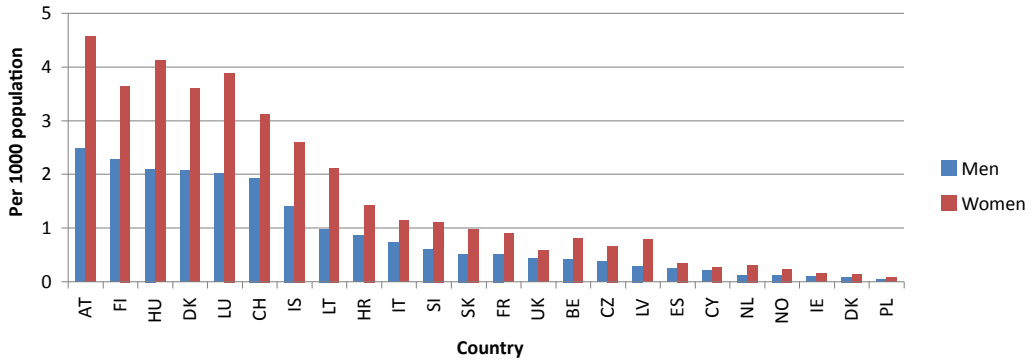
Depression (mood affective disorder) is one of the most prevalent health problems in many European countries and there are marked gender differences, with hospital admission rates and attendance at a general practice showing women outweighing men by a ratio of 2:1. The reason for these large differences between European countries with regard to admission rates is not explained by current research.

Sex differences in the prevalence of depression have been shown to be much smaller than the figures from hospital admission and general practice attendance[188]. The study showed that particularly among men, depression is under treated. This partly reflects known sex differences in help-seeking behaviour.

One important example of this is the existence of post natal depression in men. This is hardly recognized health services although European and international[189,190] studies show that between 7 and 10 percent of all new fathers suffer from this.

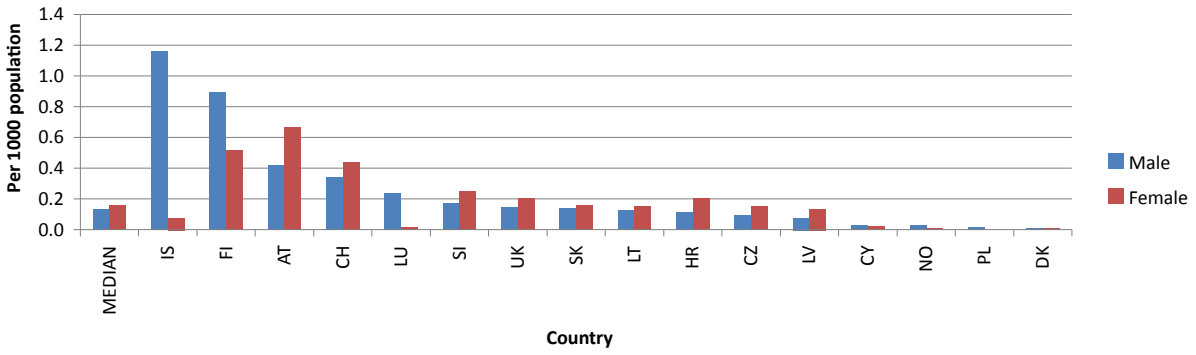
**Age standardized hospital admission rates per 1000 population due to Mood affective disorder, by sex and country, latest year[1]**

*Source: HMDB. 1 2007 except LV, LT (2008). HR, DK, IS, IT (2006). NL, ES (2005).*




**Age standardized admission rates per 1000 population for Bipolar affective disorder, by sex and country, latest year[1]**

*Source: HMDB. [1] 2007 except LV, LT (2008). HR, DK, IS, IT (2006). NL, ES (2005).*



# Bipolar affective disorder

When looking exclusively at Bipolar Affective Disorder more women are treated and there are large variations among the European countries for hospital admission rates, despite this being an inherited genetic disorder. The gender differences are explainable but it is surprising that there is a 5- to 10-fold greater occurrence of the affective gene leading to this disease in Austrian, Finnish, and Icelandic populations, as compared to the populations of Denmark, Cyprus, Norway, and Poland. Alternatively, such differences may be explained by social, economic and cultural factors, which will only be determined through future research."

# Anxiety disorders/ Schizophrenia / Psychotic disorders

Anxiety disorders are the largest diagnostic group of Neurotic, stress-related and somatoform disorders (ICD-10 F40 & F41). There are marked sex differences in their occurrence: 12 month prevalence in men is around 8%, but around 17% in women[191]. Although there are differences between anxiety and depression, many of the reflections written above about gender differences in depression are also relevant for the data on anxiety.

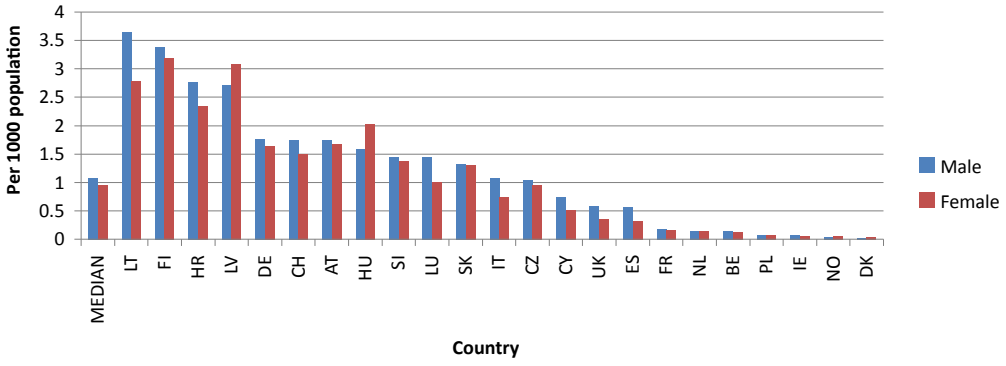
Men and women have similar occurrences of schizophrenia and other psychotic disorders: 12 month prevalence is 2.6% in men and 2.5% in women[192]. There are major differences, however when African Caribbean men are compared both to other men and to women[193].

There are large differences between countries in hospital admissions. This is probably caused by differences in treatment policies, where some countries prefer social and district psychiatry than hospital treatment.

Average age of onset is earlier for men than for women. Women also tend to have better functioning, more periods of recovery, fewer long-term adverse outcomes, and fewer and shorter stays in hospital[194]. This might be due to social or biological differences as well as to gender differences that have been discussed previously.

**Age standardised admission rates per 1000 population for Schizophrenia, by sex and country, latest year[1]**

*Source: HMDB. [1] 2007 except LV, LT (2008). HR, DK, IS, IT (2006). NL, ES (2005).*



# Suicide and self-inflicted injury

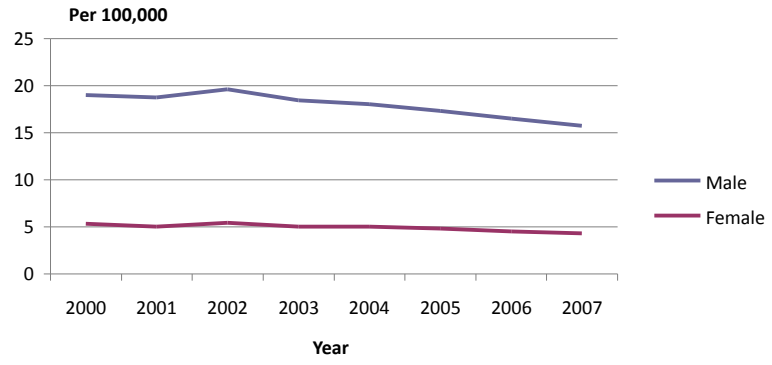
Across the EU27, suicide is a major cause of death accounting for 54,756 deaths in 2007 (41,924 male, 12,822 female), with over 76% of these committed by men. Suicide accounts for 1.75% of total male deaths and 0.54% of total female deaths. The numbers of suicides in the EU27 have decreased from 11.8 per 100,000 in 2000 to 9.8 in 2007 - a decrease of around 15%, but in males this is still the principle cause of death in men aged 30-39 years.

Eight Member States are amongst the 15 countries with the highest male suicide rates in the world. There are large differences between the countries with the highest and lowest rates.

The data suggest that many men who commit suicide suffer from undiagnosed depression and that depressed men may have symptoms other than those typically prescribed among women. It is crucial to improve detection of depression in men in order to prevent the unacceptably high numbers of male suicides. One area for exploration is that the economic status of a country is inversely related to the suicide rate in men but not women[195].

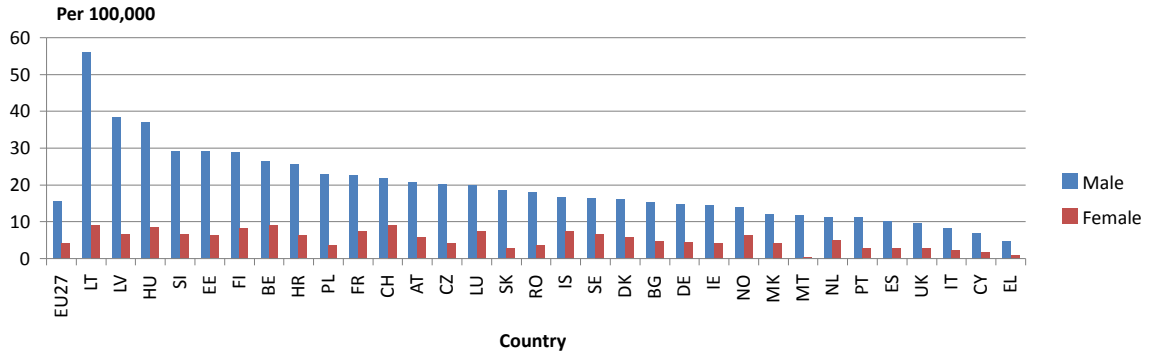
**Time trends in Suicide mortality, by sex, all ages, EU27, 2000-2007**

*Source: Eurostat hlth_cd_asdr*



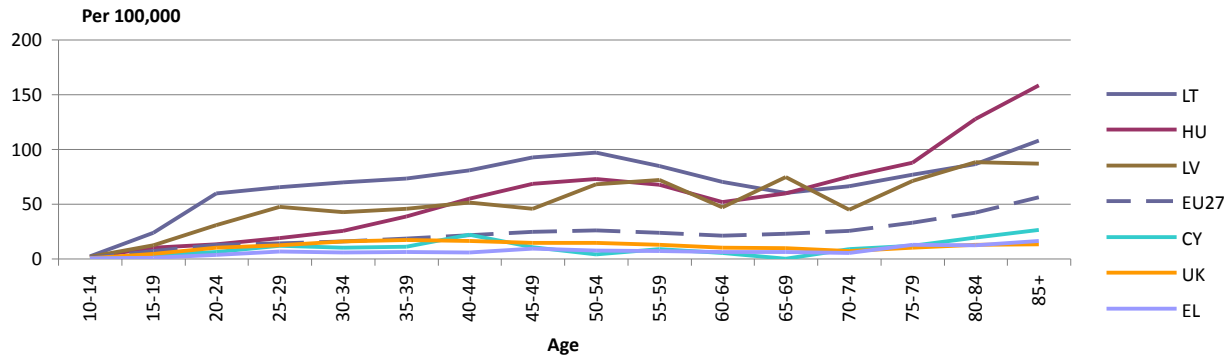

**Age standardized mortality rates due to Suicide and intentional self harm, by sex and country, all ages, latest year[1]**

*Source: Eurostat: hlth_cd_asdr. [1] 2008 BG, CH, EU27, FR, IT, MT, PL, RO, SE, UK (2007). DK, LU, PT (2006). BE (2004)*

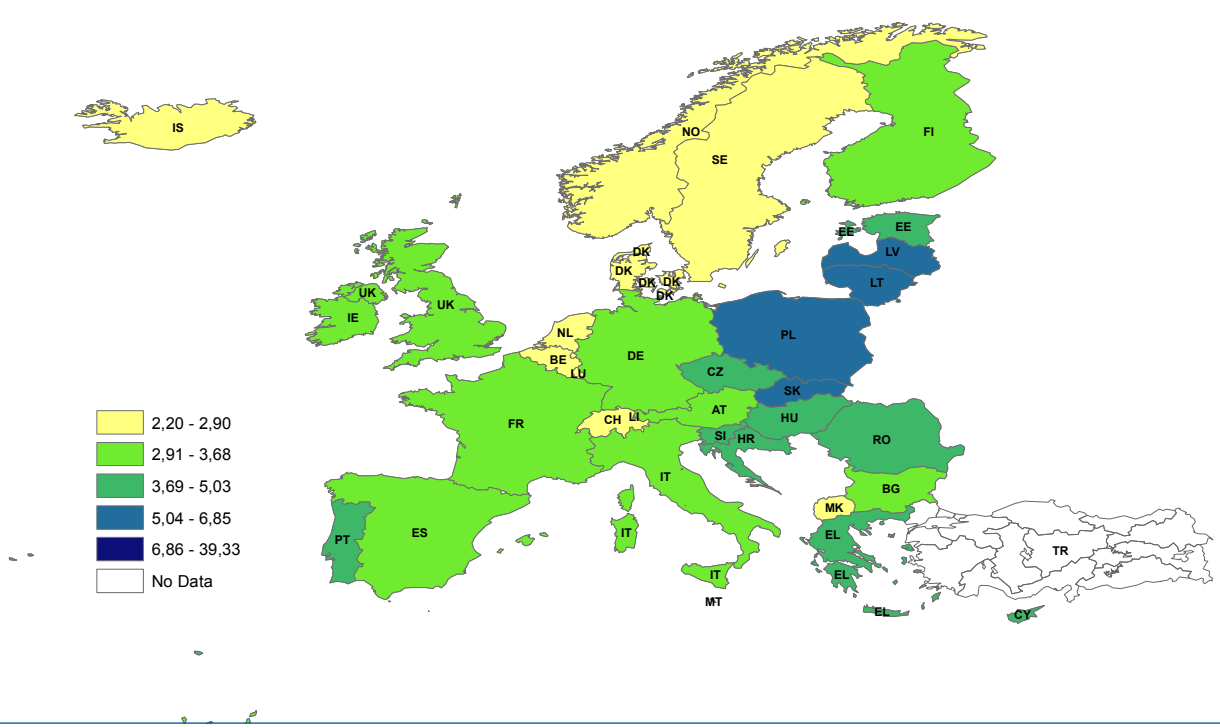


**Age specific mortality rates due to Suicide and intentional self harm, male, for selected countries, latest year**

*Source: Eurostat hlth_cd_acdr*




**Map Male:female ratio of intentional self harm**



At all ages, men commit suicide at higher rates than women. Among men, a regular increase of risk is seen after the age of 15, with suicide rates varying considerably across the EU27.

Compared to 15-24 years-old, the risk of suicide death among the elderly (aged 65+ years) is three times higher. The number of suicides rises significantly with age among men, but not among women. Men aged 70+ years die by suicide up to five times more often than women in the same age group. This is thought to be due to a range of factors including men's retirement, being single, widowed or ill-health[196]. The social and economic impact on men is thus a significant factor in age differences in suicide. These sex differences also suggest that a large number of older men have untreated depression[197].

Some of the reasons for the higher rate of suicide in men lie in the methods that men and women use to take their own lives: hanging is the most common male method while overdose is the most common female method. There are also sex differences in fulfilled suicides and attempted suicides: women have many more attempted suicides than men. An attempted suicide builds upon a belief that there is still hope that things might improve with involvement from others ('a cry for help'). On the other hand, it seems that male suicides are grounded in the conviction that nobody can help and that there are no alternatives other than to die. This is also seen as consistent with how men typically cope with emotional pain and anguish, namely: withdrawal from close relationships rather than seeking help and comfort; quickly getting away from pain, emotional conflicts and feelings of being weak; and tendencies to act out and become angry. Male suicides might often be seen as grounded in one or more of these mental responses.

## Summary

Mental ill-health in European men is under-diagnosed and under-treated. Many men seem to find it challenging to seek help when it comes to mental or emotional health problems. It may be difficult for health professionals themselves as well as individual men to identify changes in health behaviour as signs of mental disturbances. There is a lack of adequate assessment tools suitable to diagnose men's symptoms, and a lack of suitable ways of referral for gender specific treatment.

Mental and behavioural disorders due to the misuse of alcohol are one of the most disturbing problems of men's mental health. The deaths of men and women as a result of mental & behavioural disorders due to alcohol show a significant gender difference with three to four times more men dying than women.

There has been a 15% increase in the number of suicides in the last decade. Eight Member States are amongst the fifteen countries with the highest male suicide rates in the world, with large differences seen between the highest and lowest countries.

In order to address mental health issues more effectively in men, there is a need to address gendered patterns in the upbringing of boys, and to improve our understanding of gendered dimensions to mental health disorders, mental health service delivery and in the behaviours of men themselves.

One very important change that has emerged is in relation to more contemporary approaches to fatherhood. Greater numbers of men attending the births of their children and participating in caring may enhance men's awareness of their own and their family's mental and emotional well being. This may also sensitise men to be more aware of their own mental health and to seek help more promptly (Madsen, 2010).

# Headline recommendations for actions:

- **At both an EU and member state level, develop the techniques to detect the 50% of male depression that remains undiagnosed and to treat it in the places where men are (eg the workplace)**
- Research into the symptoms of male depression in men leading to screening instruments for men especially those in vulnerable groups such as older or single men

# Detailed recommendations:

1 Europe / the European countries must detect the men who have depression, which implies detecting nearly twice as many men as are detected today. This must be done by:
   a Giving men appropriate information that they actually see and hear and can use
   b Developing screening instruments that include the symptoms more often seen in men
   c Offering the men treatment where they are – especially via working places

2 Europe / the European countries must develop instruments for referral and treatment models better suited for men.

3 Europe / the European countries must prevent much more men's suicides – especially older men's suicides. This must be done by:
   a Detecting men's depressions earlier and to a much greater extent (see 1.)
   b Developing programs for identifying (especially) single men and older men with mental problems, not least by educating GPs and health professionals in home and institution services for older people.

# Problems of the male reproductive system

# 10

- There is a lack of patient focused research into men's experiences of reproductive health problems.
- There appears to be a gap between men's needs for treatment or advice in relation to sexual health and the capacity of health services to meet these needs. This gap is a result of men's under-use of health services and an apparent reluctance of many health care professionals to address men's sexual health.
- Erectile dysfunction is a common condition that can cause great distress to sufferers, but it is also an important early warning sign of Cardio-Vascular Disease and other health problems.
- Lower Urinary Tract Symptoms (LUTS) cause significant problems for a large proportion of the older generation of men across Europe.
- Late onset hypogonadism has been found to have a biological basis for about 2% of men.

Reproductive health has been defined by the WHO[198] as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. When this definition is applied to men, it can be seen that problems in the way the system works (i.e. at the anatomical / physiological level), the way it is used (i.e. relational), and the associated psychological/emotional issues make this a serious men's health concern.

In a study[199] exploring sexual difficulties in Austria, Belgium, France, Germany, Italy, Spain, Sweden and the UK, 27% of men reported experiencing at least one sexual difficulty lasting at least 2 months in the last year. This was significantly lower than the 32% prevalence among women. There was significant variation between men in different countries, ranging from 13% in Austria to 32% in Spain and the UK.

Early ejaculation was the most common difficulty, reported by 11% overall (ranging from 3% in Austria to 20% in Spain). There was less clear variation in less frequently reported difficulties: erectile problems (8% overall), lack of interest in sex (6%), inability to orgasm (5%), and not finding sex pleasurable (4%). Many people who experienced sexual problems did not take any action such as consulting a doctor or talking to their sexual partner, and men were less likely than women to have taken any action[200]. Approximately half of the men (45% in Northern Europe, 49% in Southern Europe) thought that doctors should routinely ask about sexual health, and men were more likely than women to express this belief. The finding that only 7% of men reported that their doctor had asked about their sexual health in the last 3 years clearly indicates an unmet need.

## Erectile dysfunction

Erectile dysfunction (ED) is 'an inability of the male to achieve an erect penis as part of the overall multifaceted process of male sexual function'[201]. The impact of ED on men can be severe. Men with ED report lower levels of satisfaction with a range of aspects of quality of life[202]. The effects of ED can include depressive symptoms such as loss of self esteem and feelings of inadequacy, leading to negative effects on men's interactions with others, potentially causing relationship problems[203].

There are a number of factors associated with both the diagnosis and treatment of ED that have an effect beyond the psycho-sexual. ED often acts as an indicator of actual or impending serious health problems, including CVD and diabetes. The earlier a man presents for treatment, and the more rigorous the diagnostic process, the sooner both the emotional and physical factors associated with this condition can be managed.

## Causes and implications of ED

Emotional wellbeing and the ability to be aroused have to be coupled with an intact nervous and cardiovascular system to achieve and maintain an erection. Evidence indicates that most ED is multifactorial in origin, with organic factors and psychogenic factors contributing to the development of the condition[204]. However, organic factors are the most common reasons for the development of ED. Around 80% of cases are believed to have a physical grounding, with diabetes, neurological problems, urological surgical and many prescription and recreational drugs implicated[205]. The diseases most frequently associated with ED are prostate cancer, diabetes mellitus and myocardial infarction. A causal link to the metabolic syndrome is now felt to be assured[206]. It has been estimated that 50% to 70% of ED can be attributed to endothelial changes seen in vascular disease. Because the penile arteries are smaller than the coronary arteries, the development of vascular problems is often picked up first through ED, making ED a very effective early warning system for coronary artery disease[207].

Side- effects from treatment of prostate cancer are a major contributor to ED[208]. Although the importance of intact sexual function decreases with increasing age, it is found to have large impact on quality of life for a large proportion of men in all age groups[209].

## Prevalence of Erectile Dysfunction

Although there is little consensus over the actual numbers of men with ED, it has been shown to be closely associated with age and with incidence rates increasing within older populations[210,211]. The most severe forms of erectile dysfunction are reported by 5% to 16% of the male population: This equates to between 14 million and 46 million men across the 34 countries covered by this report. Less severe forms are estimated to occur in 60% of men, giving a total affected population of 173 million men.

Determining the actual numbers of ED sufferers is difficult considering that some men are reluctant to discuss sexual health problems. Assuming these are underestimates, a worrying issue is the number of men who fail to seek medical assistance or who turn to the internet for medication. This both removes the possibility of diagnosis of the underlying problem, and also exposes men to the risk of potentially dangerous counterfeit drugs. Until the professional and lay population recognise the importance of determining the proper diagnosis of the underlying causes of ED, its potential to act as a warning system for cardio-vascular and other serious health problems will continue to be overlooked. ED also leaves men unable to engage in satisfactory sexual activity, with all that that entails for themselves and their partners.

## Lower Urinary Tract Symptoms (LUTS)

In the past, there was a tendency to see the prostate as the root of all the urological problems men experience. It is now recognised that this is not the case, so it is preferable to use the term lower urinary tract symptoms (LUTS). These comprise storage symptoms (i.e., daytime urinary frequency, nocturia, urgency, urinary incontinence), voiding symptoms (i.e., slow stream, splitting or spraying, intermittency, hesitancy, straining, terminal dribble), and post micturition symptoms (i.e., sensation of incomplete emptying, post-micturition dribble)[212].

Though it is recognised that many women have problems with urinary incontinence as a result of childbirth, it is not so widely acknowledged that men also have significant problems with urinary flow and incontinence: 90% of men aged 50-80 years are affected. Despite the prevalence and severity of some of the symptoms of LUTS in men, they are often un-reported by older men[213].

It is beyond the scope of this Report to cover all the causes associated with LUTS, so the focus will be on two main problems: benign prostatic enlargement and prostatitis. This is neither to diminish the other conditions nor to overlook the need to have active research programmes in place to determine best preventative and management programmes.

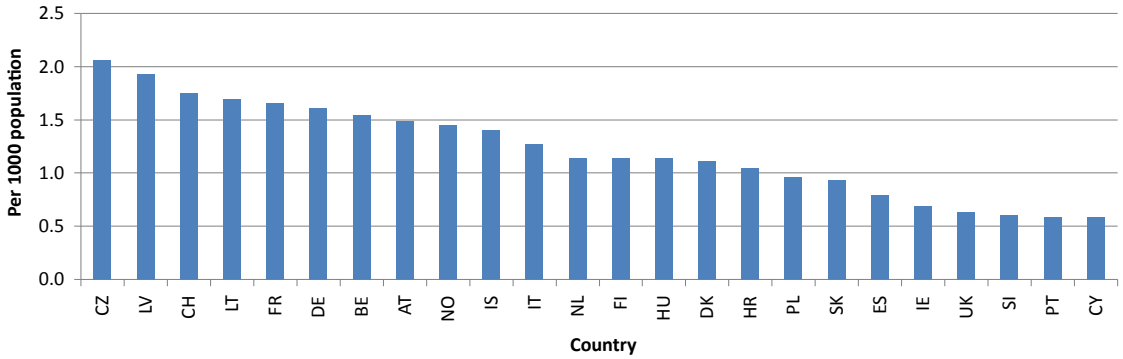
## Benign prostatic hyperplasia (BPH or BPE[214])

With advancing age, the prostate usually increases in size. This enlargement puts pressure on the urethra, which affects the flow of urine and increases the activity of the main muscle surrounding the bladder, this detrusor muscle has to work harder to expel urine and to manage a distended bladder due to incomplete voiding (bladder outflow obstruction (BOO)).

A large scale cohort study in the Netherlands comprising some 80,774 men identified an overall incidence rate of LUTS/BPH at 15 per 1000 man-years, with a linear increase with age from 3 cases per 1000 man-years at the age of 45–49 years to a maximum of 38 cases per 1000 man-years at the age of 75–79 years. The overall prevalence of LUTS/BPH was 10% (ranging from 3% among men aged 45–49 years to 24% for men aged 80 years[215]. A study of the impact of prostate problems on work and society was conducted in 2002 in seven EU countries (Denmark, Hungary,

**Age-standardized admission rate for hyperplasia of Prostate per 1,000 population, by country, latest year[1]**

*Source:HMDB. [1] 2007 except HR, DK, IS, IT (2006). NL, PT, ES (2005)*




Ireland, Netherlands, Slovenia, Spain, United Kingdom)[216]. The report noted that "Although there is much research that looks at the clinical aspects of non-malignant prostatic disease, and in particular the effectiveness of different treatments, there is very little patient-focused, qualitative research that looks at the morbidity of non-malignant prostatic disease and the impact of the disease on men' s lives and the lives of their family members". Though there has been some improvement with this regard there is still a paucity of work in this area.

Differences are seen across countries with regard to age-standardised rates of admission to hospital and treatment choices (in-patient vs outpatient management). With the male population increasing at its current rate the need to find effective ways of managing this problem will become more pressing.

# Prostatitis

Prostatitis is one of the most common and debilitating urological conditions in men, yet it receives very little recognition. There are different forms of the disease but all are associated with often intense debilitating pain (genitourinary and/ or pelvic), variable voiding, and sexual dysfunction leaving many men living with a high degree of chronic pain and disrupted lives[217].

Prostatitis has been associated with cigarette smoking, a high caloric diet with low fruit and vegetable consumption, constipation, meteorism (gaseous distension of the stomach or intestine), slow digestion, multiple sexual partners, decreased sexual desire, erectile dysfunction and premature ejaculation[218]. Chronic pelvic pain symptoms are the most common presentation[219].

It has a significant negative impact on quality of life[220]. A Finnish study found that in one district the overall lifetime prevalence of prostatitis was 14%, with an age-related increase in the risk of having the disease [221]. In a larger study conducted in Italy the prevalence of the syndrome was 13.8%, while the estimated incidence was 4.5%[222].

The causes of prostatitis are often bacterial in the first instance, but it can occur or re-occur without an associated infection, sometimes through trauma (both acute or accumulative i.e. bicycle riding). For many men the causes are not clear. There is a current debate as to the effect of Chlamydia trachomatis infection in the development of prostatitis in younger men and the subsequent decrease in semen quality and reduced fertility[223].

Treatment of prostatitis usually involves lengthy antibiotic therapy due to the difficulty of getting penetration into the prostate, but in many cases there is no current adequate therapy and the focus is on symptom control.

## Late onset hypogonadism

There is an association between levels of testosterone and male behaviour. Late-onset hypogonadism, has been defined as "a clinical and biochemical syndrome associated with advancing age and characterised by typical symptoms and a deficiency in serum testosterone levels. It can significantly reduce quality of life and can adversely affect the function of multiple organ systems."[224]

A recent study in eight European countries (Belgium, Estonia, Finland, Hungary, Italy, Poland, Spain, Sweden and the UK) found evidence of a set of definite symptoms associated with late-onset hypogonadism but that these were relatively rare and affected only about 2% of the ageing male population[225]. It found weak overall associations between symptoms and testosterone levels, however three sexual symptoms - poor morning erection, low levels of sexual desire and erectile dysfunction were linked to low testosterone levels. Other non-sexual symptoms were identified: an inability to engage in vigorous activity, inability to walk more than 1km, and an inability to bend, kneel or stoop; and three psychological symptoms were identified: loss of energy, sadness, and fatigue. However, these non-sexual symptoms were only weakly related to low testosterone.

There has been a marked increase in the use of testosterone replacement therapy in the USA, but this pattern has not been seen elsewhere. There is now concern over the use of such treatment, with anxiety that it does not improve many symptoms of late-onset hypogonadism and may have detrimental effects on men with existing prostate disease, raised haematocrit, or those at risk of sleep apnoea due to obesity[226].

## Infertility

Infertility has been defined as by the WHO as the inability to conceive after two years of intercourse without the use of contraception[227]. According to the European Society of Human Reproduction and Embryology, infertility affects one in six couples in Europe. It has been estimated that male factor infertility plays a role in up to 50% of couples who are unable to conceive. Both the quality and quantity of sperm appear to be in decline. Sperm DNA can be damaged by lifestyle factors including smoking, alcohol, drugs and obesity. Other factors believed to increase sperm DNA fragmentation are being over 50 years old, exposure to air pollution or environmental toxins, prolonged sexual abstinence or exposure of the testicles to greater warmth than normal, as seen in obese men due to excess fat in the genital area[228].

Other causes of infertility in men include[229]:

- possible genetic causes
- systemic illnesses (diabetes, cancer, history of sexually transmitted diseases)
- pelvic trauma, prior hernia repair, and bladder, prostate, or scrotal surgery
- childhood history of cryptorchidism, orchidopexy, torsion, and timing of puberty,
- medication
- occupational exposures
- incomplete virilization
- disorders of the penis and anatomical defects such as vasal agenesis, clinically significant varicocele, or problems with the epididymis
- infection, obstruction, or a neurological disorder.

## Congenital problems of the male reproductive system

There are a number of congenital problems associated with the male reproductive system including those related to the formation of the penis (i.e. hypospadias), the ducts (i.e. congenital absence of the vas deferens), the testis (e.g. missing or undescended), and those related to chromosomal disorders (i.e. Kleinfelter's syndrome). It is beyond the scope of this report to fully explore all these conditions, but it is worth noting that hypospadias is generally estimated to occur in about 1 out of every 200-300 live births, but the numbers affected may be increasing[230]. This may be a consequence of better reporting, but nevertheless this should be monitored. The causes are not fully understood, but the consequences in terms of fertility, risk of testicular cancer and the psycholgical impact are very apparent.

## Summary

The problems encountered by men with regard to the male reproductive system are often wrongly associated with the ageing process. Early diagnosis of the causes of erectile dysfunction can uncover serious health concerns as well as allowing restoration of a normal sex life. The lower urinary tract symptoms (LUTS) are associated with a number of conditions, such as Benign Prostatic Hyperplasia and Prostatitis, which cause significant discomfort for the affected individual. Though these are significant illnesses for the older man there remain few treatment options available. Over 40% of cases of infertility are due to male problems.

## Headline recommendation for action:

- **Improved communication with men on the signs and symptoms of male reproductive disorders including understanding of ED as a symptom of other conditions as well as a problem in its own right.**

# Communicable Diseases

# 11

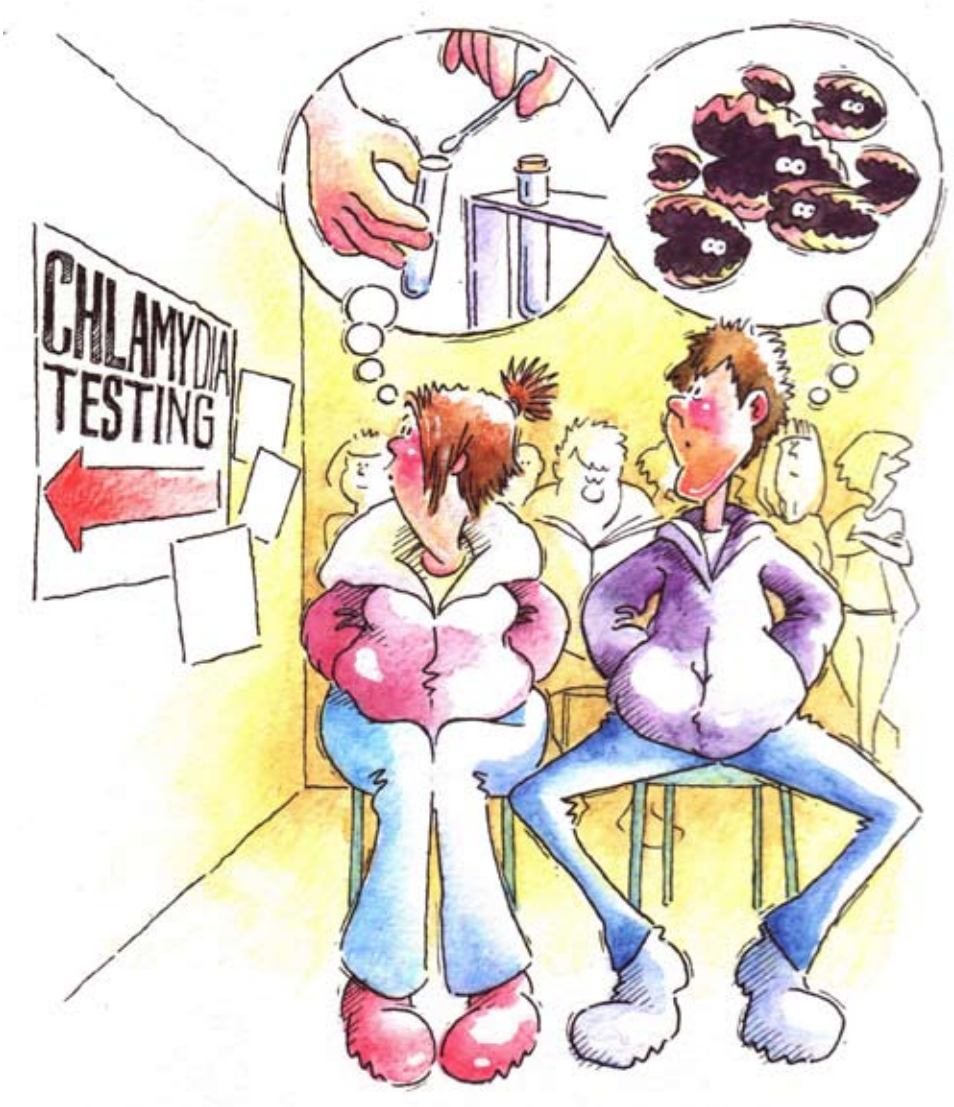
- Men have a higher risk of dying prematurely from the major infections as a result of reduced immunity and their greater likelihood being exposed to a lifestyle or social circumstances that makes them more susceptible.

- Pneumonia kills more men than women across the lifespan up until age 80 years. Its strong association with alcohol abuse, smoking, pre-existing lung disease and HIV/AIDS makes men more likely to develop and die from this disease.

- Tuberculosis was in decline, but it is increasing in sub-populations of men. Drug-resistant hamper the management (and containment) of this disease.

- Across Europe there are about 2 HIV cases in men for every 1 case in women, and 3 AIDS cases in men for every 1 case in women. Differing patterns of incidence are found across Europe.

- Viral Hepatitis affects more men than women by a ratio of about 4:1.



Within countries undergoing major social upheaval, communicable diseases are an important cause of premature death. The risks to men in all member states with regard to pneumonia, tuberculosis, sexually transmitted diseases and HIV continues to be a challenge.

# Pneumonia

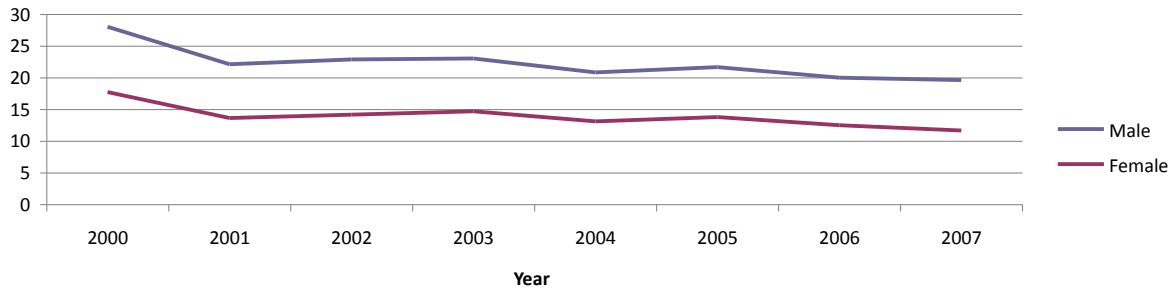
Pneumonia is the biggest cause of death from a communicable cause. In 2007, it accounted for some 59,414 deaths in men across the EU27 (66,197 deaths in women). Pneumonia is responsible for some 2.5% of male deaths across the EU27 (2.8% female deaths). Despite the higher absolute number of deaths among women, men have a higher standardised death rate: more deaths in women occur among those over age 80 years (77% compared to 55% for men).

The causes of pneumonia include a number of different infecting agents. It can result from external causes which have specific importance to men's increased vulnerability. The risk of developing pneumonia is greater in people with general ill-health or with pre-existing lung disease. It is also greater in smokers, users of immunosuppressant drugs, and users of intravenous drugs. A further significant factor is alcohol abuse, which results in a diminished immune response and increases the risk of developing the disease and of its severity[231]. The most common AIDS associated disease in 2008 was Pneumocystis pneumonia (22%).

There has been an overall steady decline in the age-standardised death rate for pneumonia, with the rate of decline similar for both men and women.

**Time trends of Pneumonia mortality, by sex, all ages, EU27, 2000-2007**

*Source: Eurostat hlth_cd_asdr*




# Tuberculosis

In the majority of the populations across the countries covered by this report, the number of cases of Tuberculosis (TB) is declining almost to the point of eradication. However, this trend is not true for all countries or for all groups within individual countries: TB is now seen as an increasing public health risk.

TB thrives in populations which have difficulty in accessing public health services such as the homeless, or the Roma community. Prison conditions within some of the Eastern European countries have resulted in 'breeding grounds for TB'[232], with cases in prisons representing 10% of all TB cases reported in Eastern Europe. The main causes implicated are the very high incarceration levels in Eastern Europe coupled with poor prison conditions and the presence of other contributory factors such as poor health and poor health behaviour[233]. The European Region has the highest number of drug resistant cases in the world. Across 30 of the 34 countries covered by this report for which data are currently available, there were 53,424 new cases of TB in men and 29,108 cases in women in 2008[234]. Although

the median number of cases is relatively small in relation to total population in the majority of countries, some States that have far higher numbers: Romania had 17,293 male cases in 2008 (a considerably reduction from the 21,331 cases seen in 2004), and Poland, Spain and the UK all had over 4,000 cases.

# Sexually Transmitted Infections

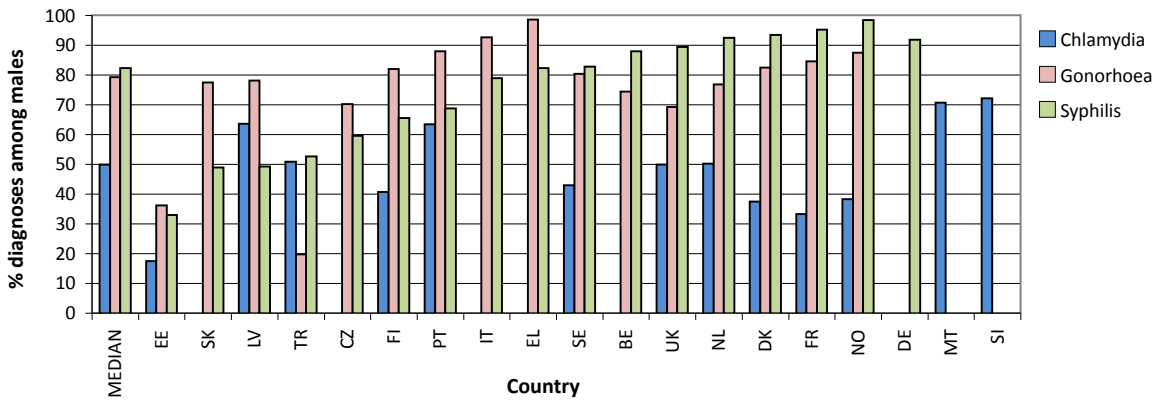
Sexually transmitted infection (STI) rates are affected by a range of factors: decreases in the age of first sexual experiences, higher rates of change of sexual partners, more diverse sexual networks, and inconsistent patterns of condom use. In the absence of vaccines or effective cures for man STIs, safer sexual behaviour is an important aspect of epidemiological control. It is also important to monitor risk behaviour. Although surveys of representative samples have been conducted in many European countries, it is often difficult to make comparisons because of variations in sampling, data collection and measurement. Comparisons of STI rates between EU nations are hampered by substantial differences in national systems of STI surveillance and behavioural monitoring[235]

European STI surveillance data[236] reveal important sex differences in STIs. Although less than half (45%) of all diagnoses of Chlamydia occur in men, in four of the 13 countries with valid data men comprise the majority of Chlamydia diagnoses. Furthermore, the age distribution among men is different to than for women, with a greater proportion of diagnoses in men occurring in those aged over 25 than is the case for women.

The sex distribution of gonorrhoea and syphilis is markedly different to that for Chlamydia. Across the 18 countries with valid comparable data, 71% of all diagnoses of gonorrhoea infection occurred in men. Although direct comparisons are confounded by differences in definitions, men are also more likely than women to have been diagnosed with syphilis: in 14 of the 18 countries, the majority of syphilis diagnoses occurred in men, and in 8 countries over 80% of diagnoses occurred in men. Male:female ratios do not appear to be affected by the stage of infection used in different countries' surveillance data. Homosexually active men are at particular risk for STIs (ibid). Among men, the proportion of diagnoses of gonorrhoea and syphilis are markedly higher than the population proportions of homosexually active men. The proportion of gonorrhoea attributed to homosexual transmission ranged from 19% to 69%, and in 7 of the 10 countries with data on presumed transmission mode, the majority of infections among men were attributed to homosexual activity.

**Proportion of sexually transmitted diseases, male, by country, 2008**

*Source: ESSTI Annual Report 2008*



# HIV/AIDS

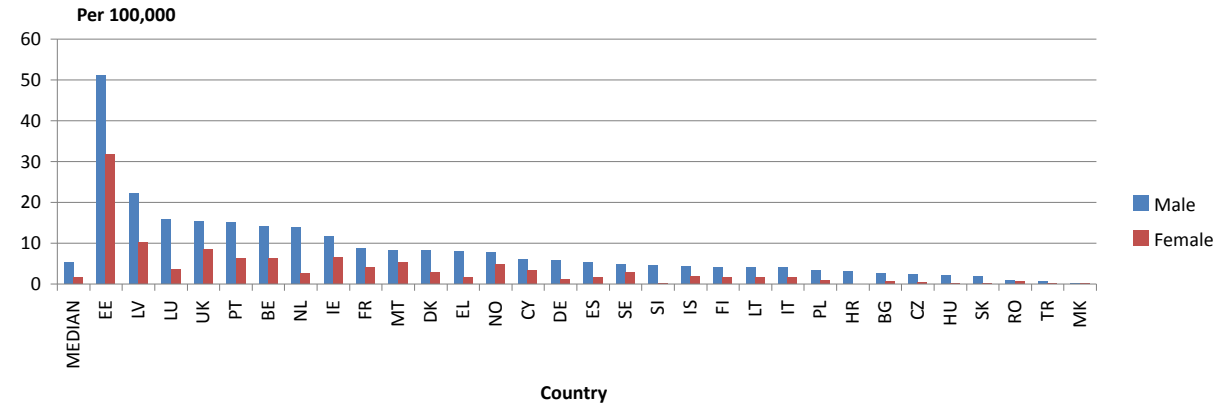
Within Europe, there are more men than women infected with HIV, and men continue to be more likely than women to become infected with HIV. Across Europe there is wide variation in the rate of new HIV diagnoses among men, with Estonia standing out as carrying a particularly high burden of the disease.

A review of HIV epidemiology in Eastern and central Europe indicated that men are more likely than women to become infected because of the high proportion of transmission attributable to sex between men and injecting drug use (which is more likely among men)[237]. However, there is wide variation across Europe in the proportion of new HIV infections attributable to sex between men - ranging from a low of 0% in several countries, to the majority of new infections in the Czech Republic (56%) and Croatia (53%) - and to heterosexual contact - ranging from a low of 8% in Poland to a high of 84% in Albania.

The data show that in all but 4 of the 26 countries there was an overall increase in the rate of new cases of HIV in men over the last decade[238]. In the Netherlands and several Central and Eastern European countries (Slovenia, Turkey, Slovakia, Bulgaria, Hungary, Czech Republic, Croatia), there was at least a doubling in the rate of new HIV diagnoses in men over the last decade. Only Portugal, Romania, and Latvia observed declines in HIV cases among men. The largest change is in small countries reporting small numbers at the start of the AIDS epidemic. All other negative changes

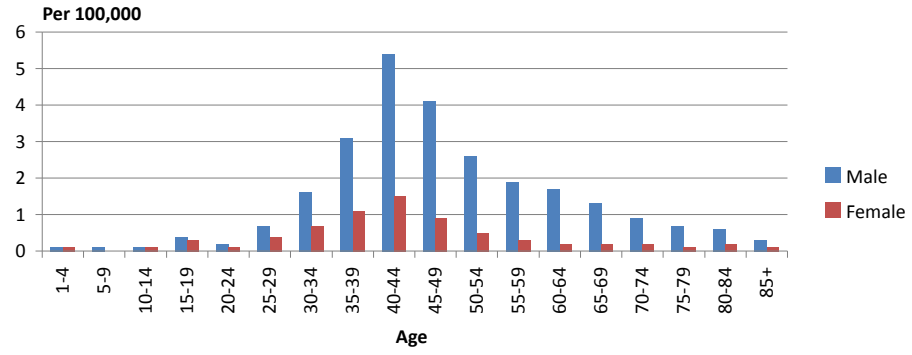
**Rate of new HIV cases, by sex and country, latest year[1]**

*Source:calculated from ECDC. [1] 2008 except IT, DK, TR (2007)*




**Age specific death rates for HIV, by sex, EU27, 2007**

*Source: Eurostat hlth_cd_acdr*



are due to anti-retroviral (ARV) drugs, underreporting and under diagnosis. The overall increase in HIV cases over the last decade was greater among men than women. In 17 of the 26 countries, changes in HIV cases were less positive among men than among women. HIV infections have increased in most countries despite substantial health promotion activities in many countries. For several countries, changes in surveillance system may have contributed to variations. For several other countries there was a peak of the HIV epidemic in 2000-2002, therefore it is most likely in subsequent years the change would be less pronounced (Lithuania, Estonia) or even negative (Latvia). Usually some countries have important reporting delays (Portugal).

Romania stands out as the only country with a large proportion of AIDS cases diagnosed among people aged 0-19 years.

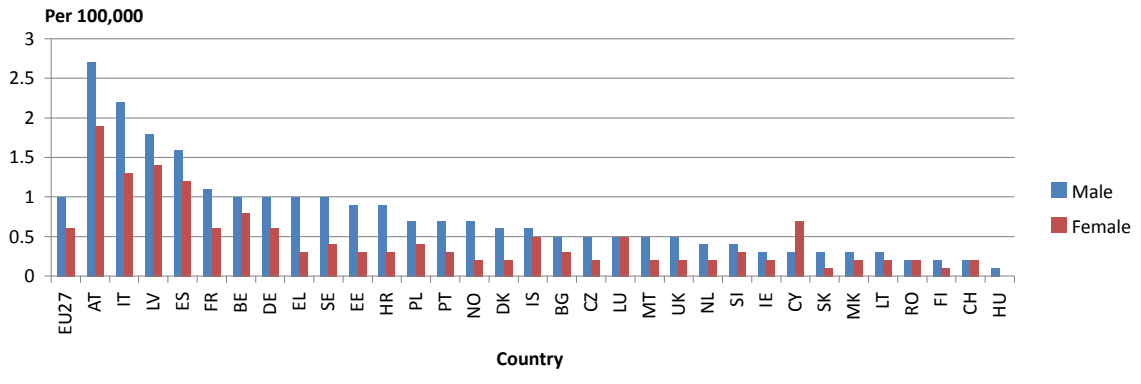
Comparison of the data highlights the importance of not relying too heavily on simple AIDS diagnosis figures when making between-country comparisons. It is important to consider the size of the population in which the incident cases are found, and the link between diagnosis and deaths. For example, in terms of simple numbers, the UK has the fourth highest number of AIDS diagnoses each year, but only the 18th highest AIDS death rate. There are clear age trends with men in their forties seeing the highest death rates for HIV.

## Viral Hepatitis

There are a number of forms of hepatitis, namely those as a result of liver damage due to alcohol abuse, autoimmune diseases, as a result of damage caused by drug overdose or through bacterial or viral infection. These diseases cause inflammation of the liver and have varying degrees of impact on the health of the individual, from acute to chronic and from mild to life threatening. Hepatitis A is transmitted through infected stools or contaminated food, Hepatitis B is transmitted through contact with an infected individual's blood or through direct contact with an infectious person and is common in migrants from countries where the condition is more commonplace (such as Asia and South East Asia), men who have sex with men, and drug users. Hepatitis C is spread by contact with contaminated blood and is most common in injecting drug users (IDUs).

**Standardised death rates for viral hepatitis, by sex and country, all ages, latest year[1]**

*Source: Eurostat hlth_cd_asdr. [1] 2008 except BG, CH, CY, EU27, FR, IS, IT, MT, PL, RO, SE, UK (2007). DK, PT (2006). LU (2005). BE (2004).*



## Summary

Communicable diseases have significantly been reduced in Europe over the last two decades for both men and women, but the gender differences in morbidity and mortality between countries and within the EU are still very significant. The accession countries, particularly those of Eastern Europe and the former soviet block are struggling with higher rates of communicable diseases particularly among men. Across the lifespan deaths from Pneumonia are higher in men and boys until the over 80 age bracket, which accounts for 77% of female deaths and 55.4% male deaths. Tuberculosis continues to be a public health risk with 18 European States in the WHO 'high-priority' category. Mortality from HIV and AIDS has seen a general decrease across EU27 with a larger decrease in Males but there are still 3 new AIDS cases in men to every one in women.

## Headline recommendation for action:

- **Improved reporting of communicable disease states including standardisation of data collection and of age/sex breakdown and the routine inclusion of men in, for example, health promotion and screening for chlamydia, HPV and other sexually transmitted infections.**

# Dental and oral health

# 12

- Dental and oral ill-health problems cause many systemic diseases as well as being the source of marked discomfort to the individual.
- Dental caries and missing teeth are a bigger problem for women than men.
- Periodontal disease affects a significant proportion of the population and has a greater prevalence in men
- Older generations are most at risk, but obese young men are emerging as another at risk group.
- Strong links are evident between periodontal disease and cardio-vascular disease.

Oral disease is the fourth most expensive disease to treat in the industrialised world[239]. Men are more at risk of cancer of the lip, oral cavity and pharynx (C00-C14), and in addition there are some conditions that can both occur in the mouth and aggravate or be caused by other serious health conditions in men. The WHO identify the most important risk factors for oral health problems as tobacco use, excessive alcohol consumption, stress, and diabetes mellitus[240]. Many of these aggravating factors are more prevalent in men. Careful and regular oral hygiene can make significant differences in oral health and consequent systemic health, but evidence suggests that men are less effective in this regard than women and are less likely to use preventative dental services.

## Dental Caries

Within the WHO Oral Health Country / Area Profile Programme database[241] it is evident that dental caries are more prevalent in women than in men[242]. This appears to be a multifactoral issue with no one definitive answer but it is possible that different salivary composition and flow rate, hormonal fluctuations, dietary habits, genetic variations, and particular social roles among families are associated with the increased risk for women[243]. Due to this increased risk women are more likely to wear a removable denture and to have lost more natural teeth[244].

## Periodontal disease

Periodontal disease is a broad term encompassing several different conditions that can affect the mouth, but are separate from conditions affecting the teeth themselves. Most often oral diseases are related to infections with many factors influencing their ability to take hold and progress to advanced chronic conditions. These risk factors include both the local environment within the mouth and any disease which compromises the immune system, repair system (e.g., poor diet), or alters the mouth environment (e.g. diabetes) can have significant impact on oral health. In addition there are a number of other important associated conditions that also have relevance to the higher prevalence this disease has in men.

Periodontal disease tends to be more prevalent in men than women[245]. The recent fourth German Dental Health Survey identified a high prevalence of periodontal disease in adults aged 35–44 years and 65–74 years[246]. Men and those from East Germany had significantly higher prevalence.

A study exploring the relationship between socioeconomic disadvantage and periodontal disease found lower income and lower educational attainment to be related to worse periodontal disease[247]. Age is an important factor, with older men having more oral health problems than younger men. However, younger men and boys having more signs of poor oral hygiene than girls[248]. There is also an increasing number of younger people affected due to obesity[249].

## Health implications of periodontal disease

Periodontal disease has been implicated in the development of atherosclerosis[250]. A study in Sweden found that increasing periodontal disease was also significantly associated with hypertension and in the middle aged with myocardial infarction[251]. It has been suggested that the identification of periodontal disease may be used as a marker of the metabolic syndrome, and that improved oral health care in those with the metabolic syndrome may help to reduce the incidence of various systemic diseases[252].

A number of oral conditions are linked to HIV/AIDS. A study in Spain found that oral candidosis was highly predictive of immune failure in those

receiving highly active antiretroviral therapy (91% for men who have sex with men, 96% for heterosexuals, and 96% for intravenous drug users)[253]. It may also be an important sign of non-adherence to therapy[254]. However, studies are not yet available to show if this is more prevalent in male patients.

# Oral health care

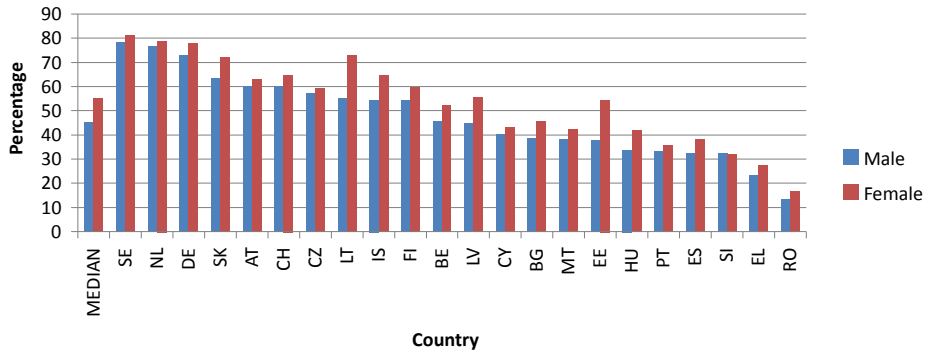
In a Swedish study on oral health girls scored more favourably on behavioural measures, showed more interest in *oral health,* and perceived their own *oral health* to be better than did boys[255]. Studies of the Danish and German adult populations found that women were more likely to clean their teeth, use toothpicks, and have regular dental check-ups and take better care of dentures[256,257].

The strongest predictor of poor oral health behaviour is being male[258]. Women tend to see good oral health as having a greater impact on their quality of life, mood, appearance, and general well-being[259]. Women are more likely than men to visit a dentist. The median proportion of men who had made a consultation with a dentist in the previous year was 45% as compared to 55% for women. There are marked differences between countries with only 13% of Romanian men having had a visit to the dentist as compared to 78% of men in Sweden.

The association between education and consultation with a dentist varies markedly between countries. For example, only 27% of the most educated men (33% of women) in Romania access dental services[260]. For men who have only the most basic education this level drops to 4% of men and 5% of women. The main reason given for not visiting the dentist was cost, but this was not the case in all the countries, with some countries such as the UK, the Czech Republic, Austria and Luxembourg having this as a minority issue. Fear of treatment is an issue in a number of countries as, is does having no time to attend for consultation. When the data are broken down by age, across all the income groups expense and a feeling of lack of time predominate in the younger age band (18-44 years). In the older age bracket cost is still one of the main problems, with lack of time becoming a less relevant reason for delayed use of services. Comparisons between the highest and lowest income quartiles for having unmet dental needs suggest that in some countries there are no barriers to services. In others a more marked inequality exists, with Bulgaria having a 20% difference between the rich and the poor.

**Consultation with a dentist during the previous 12 months, by sex and country, 2004**

*Source: Eurostat hlth_co_dente*



## Summary

Dental and oral ill-health are a major cost to both the individual and the state. Women tend to have more problems with regards to dentition but men have the greatest need with regard to poor periodontal health, which, apart from being a cause of considerable pain and discomfort, is associated with cardiovascular disease and increasingly with metabolic syndrome in men. It is ironic that although men are less likely to use preventative dental services women have a higher incidence of dental caries.

The causes of periodontal disease are closely associated with risky male health behaviour but though this was once seen mainly as a problem of the older man it is now being increasingly seen in the young, especially those who are obese.

Whilst there are variations across the EU with regards to consultation with a dentist by educational level, periodontal disease can be prevented through changes in lifestyle behaviours. Improved oral care is a precursor to reducing the incidence of systemic diseases across the world and early health promoting strategies aimed at men would seem to hold great worth.

## Headline recommendation for action:

- **Improved surveillance of men's oral health problems (including gender specific information in oral health reports) and men's access to dental services**

# Other health conditions affecting men

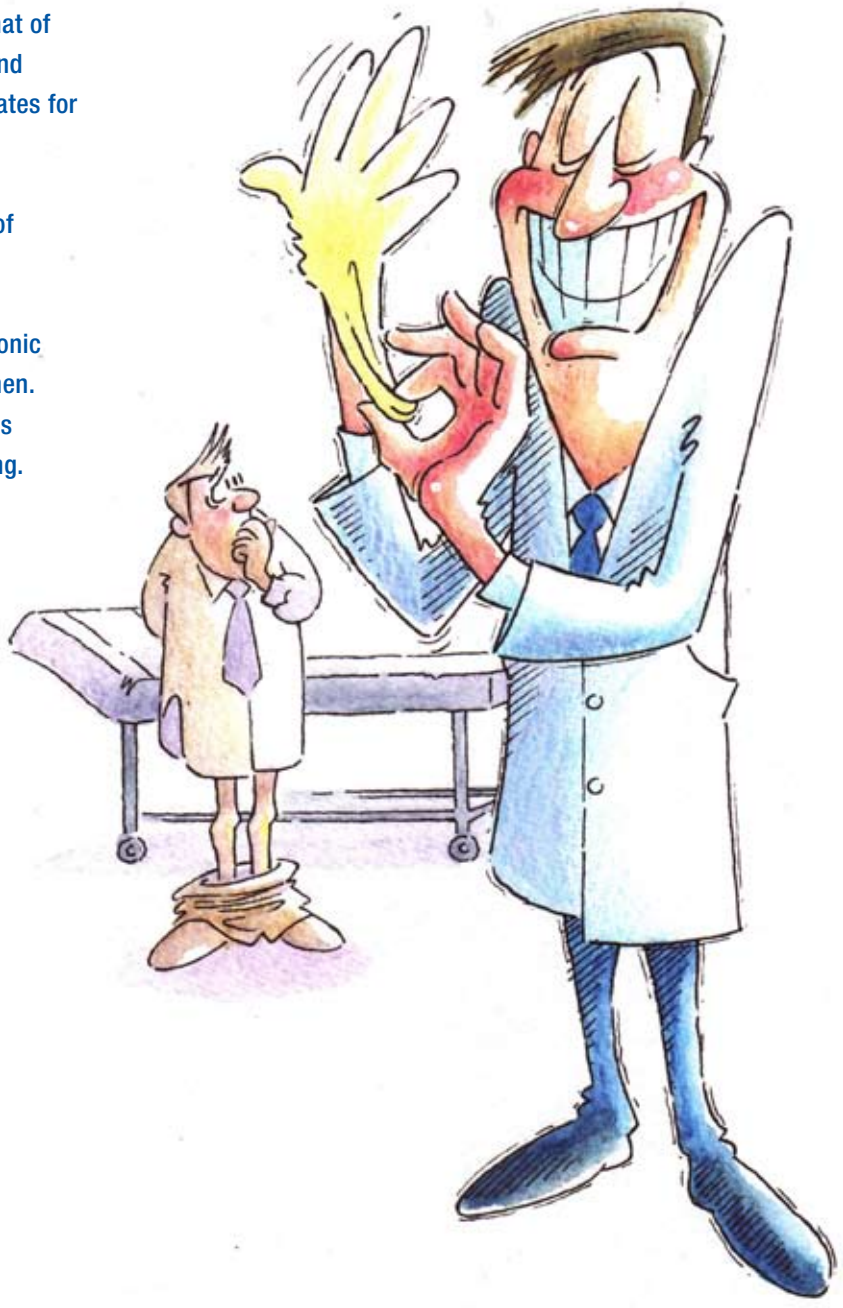
# 13

- Type 2 diabetes is increasing in men as a result of obesity. The death rate in men is twice that of women in those under the age of 65years, and across Europe men have higher admission rates for diabetes

- Obese diabetics have a 40-60% higher risk of cardiovascular mortality

- Across Europe there are higher levels of chronic lower respiratory diseases in men than women. Around 4% of all male deaths result from this condition, which is mainly caused by smoking.

- Osteoporosis is traditionally seen as a problem of older women. There are however problems of low bone density in young male athletes, men with specific health problems and hereditary factors. A growing number of men develop the condition as a result of hormone ablation therapy for prostate cancer.



A number of health conditions can be seen to have a gendered component, through men being more liable to die prematurely (e.g., diabetes), lifestyle factors making men more likely to contract the disease (e.g., chronic lower respiratory disease), or conditions that are often thought to specifically affect one sex despite while having a marked effect on the other (e.g., osteoporosis). Within this section a sample of these conditions will be considered, with the implication being that there will be other health conditions that may also be influenced by the sex and gender of the individual and that we should include an analysis of any potential sex or gender effects.

# Diabetes Mellitus Type II

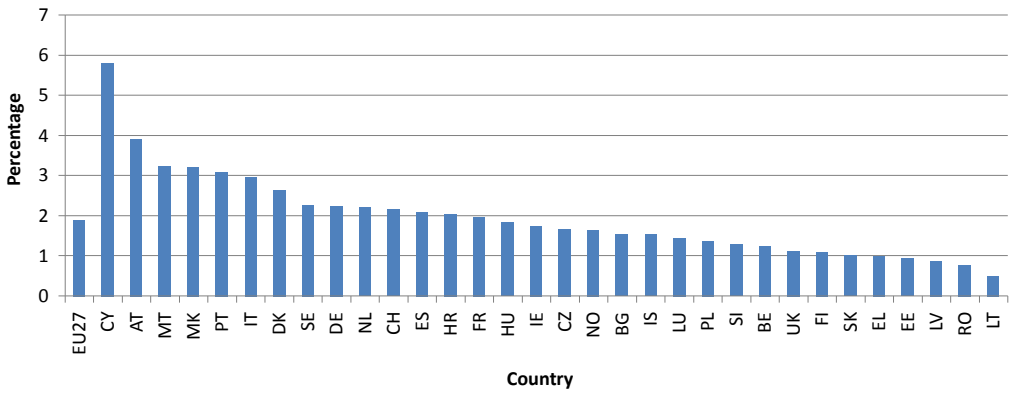
Diabetes Mellitus Type II is associated with an inability to keep up with the body's demands for insulin. Although there is a genetic link associated with diabetes, the majority of cases are due to amendable/ avoidable causes, the most important of which is central (or visceral) obesity and development of the metabolic syndrome. This complex condition has insulin resistance as a principle component. In those with obesity, the incidence of diabetes rises alongside the risk of developing the metabolic syndrome. This then significantly increases the risk of cardiovascular mortality.

Estimates of the prevalence of diabetes are complicated by a significant number of people (estimated at over 50%) being unaware that they have the condition[261]. The current estimate by the International Diabetes Federation (http://www.idf.org/) is that there 285 million people worldwide have diabetes, with a projected rise to 438 million cases within 20 years. Current prevalence estimates for the EU are 9% of the population, with a 10% increase expected over the next 20 yrs (ibid). There is a suggestion that men are more likely to remain undiagnosed for longer as a result of less frequent access of health services (see section on health service usage)[262].

Although there are marked and important impacts of diabetes on women's health[263], men have a higher rate of mortality from this condition. There has been little change in the overall rate of death from diabetes since 2000, with men consistently at about 15 deaths per 100,000 population and women at about 11-12 deaths per 100,000 population.

**Proportion of total male deaths as a result of Diabetes mellitus, by country, latest year[1].**

*Eurostat database: hlth_cd_anr. [1] 2008 except BG, CH, EU27, FR, IT, MT, PL, RO, SE (2007). DK, LU, PT (2006). BE (2004)*



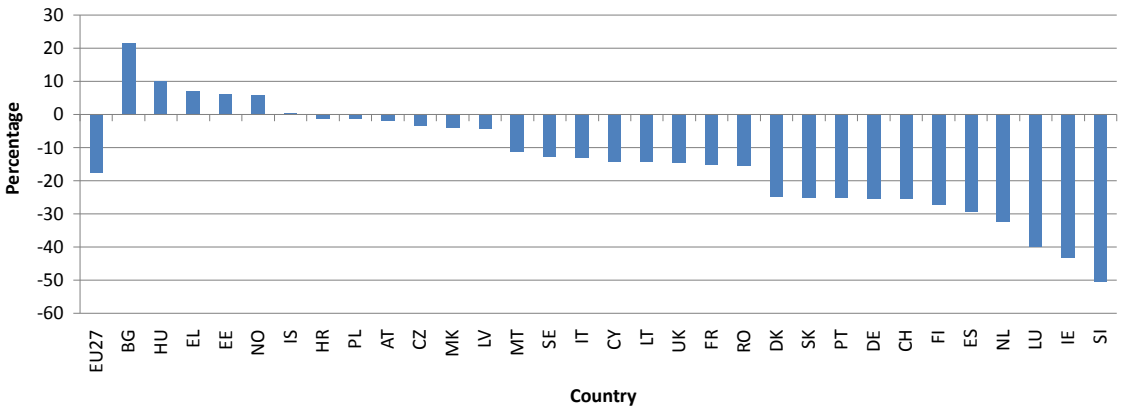
# Chronic lower respiratory diseases

The broad category chronic lower respiratory diseases (CLRD) - consisting of: bronchitis, emphysema, asthma, bronchiectasis, and other chronic obstructive pulmonary diseases - accounts for a significant degree of morbidity and mortality across Europe. Currently this condition causes more deaths in men than women, but it is likely that there will be increases in morbidity and premature mortality among women due to the increasing number of women smoking.

CLRD death rates are there are just over 29 per 100,000 for men and 12 per 100,000 for women. There has been a small but steady decline in the death rate from CLRD since 2000 across the EU27 as a whole (17% for men), but this decrease is not seen in all countries. Slovakia stands out as having

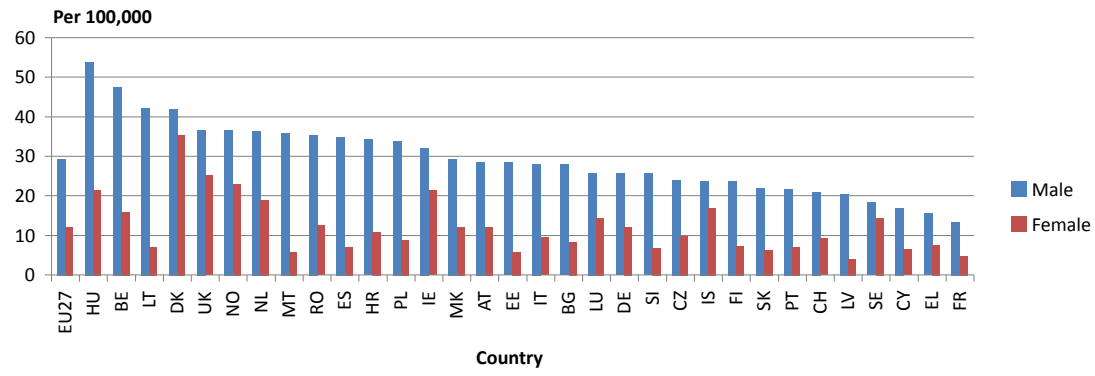
**Percentage change in age standardised death rates for Chronic lower respiratory diseases, 2000[1] to latest year[2]**

*Source: Eurostat hlth_cd_asdr. [1] Except France, 2001 [2] 2008 except BG, CH, EU27, FR, IT, MT, PL, RO, SE, UK (2007). DK, LU, PT (2006). BE (2004).*




**Age standardised death rates for Chronic lower respiratory diseases, by sex and country, all ages, latest year[1]**

*Source: Eurostat hlth_cd_asdr. [1] 2008 except BG, CH, EU27, FR, IT, MT, PL, RO, SE, UK (2007). DK, LU, PT (2006). BE (2004).*



a greater than 50% reduction in the rate of CLRD deaths, while Bulgaria saw a decrease from 2000-2004, but a subsequent 20% increase on their 2000-2004 rate.

The highest rates of death are found in Hungary (age standardised mortality of 55 per 100,000) and Belgium (48 per 100,000). These are a long way above the EU27 average of 29 per 100,000 and the 13 per 100,000 found in France.

Overall CLRD accounts for just under 4% of all male deaths across the EU27, with a high of just over 6% of all male deaths in Belgium. It is noticeable that the Eastern European countries have a lower percentage of their total deaths as a result of CLRD than many of the Western European countries despite their higher levels of smoking. This may be due to their higher levels of cardio-vascular deaths.

## Osteoporosis

Some conditions are more associated with a particular sex than others. osteoporosis has commonly been seen as a problem of post-menopausal women and rarely thought of as an issue for men. It is now acknowledged that men have a significant risk of developing osteoporosis, with some 20% of men over the age of 50 suffering fractures and disability as a result of this disease. Maximum bone density has to be attained by the age of 40 years and this is influenced both by sex and gender. The age of puberty is known to occur earlier in girls than in boys, such that the rate of bone deposition is higher in females, who reach peak bone mass faster than males.

Young men's increased bone density is partly explained by the extent of their participation in manual labour. However this may be affected by current demographic trends in which men are now more likely to be in similar jobs to women and have more sedentary lives.

Men's heavier bone structure puts them an advantage with regard to bone loss as a result of ageing, such that they tend to develop osteoporotic fractures some 10 years later than women. At this point, however, their clinical condition has usually also deteriorated, such that the morbidity and mortality associated with fractures and their (surgical) treatment is considerably greater than in women. The one year mortality rate for men following hip fracture is twice that of women . Following a first fracture, the risk of having a second is the same in men as it is in women. Even though more older women than men experience falls, men have a higher mortality as a result of falls.

The most significant predictors of risk in men developing osteoporosis are increasing age and low body mass[264] . The role of androgen deficiency (hypogonadism) and androgen ablation therapy for the treatment of prostate cancer (which affects oestrogen levels in men) are also major contributors to developing this condition [265,266,267]. There are a number of other factors associated with the development of the disease in men, including heredity[268], low body mass, weight loss, smoking, physical inactivity and chronic alcoholism [269].

A further important factor is that with women having increased screening opportunities, they more frequently come into contact with health professionals who can pick up emerging problems at an earlier stage. Health literature, and indeed general health messages about bone health, are often focused onto women, and may contribute to men's lack of awareness of the problem.

## Summary

This section was not meant to be totally inclusive of all those conditions that can be seen to have a sex difference or gendered component to them but rather it highlights than many health issues require interrogation as targeted health interventions to men would reduce chronic illness, disability and premature mortality. The mortality data for diabetes masks the true extent of its influence on the overall health of the population as it is the fourth leading cause of death in the EU.

Type II diabetes, once only seen in adults, is being diagnosed in younger populations and is associated with obesity. With the link between male form of central obesity and the metabolic syndrome and other health conditions this is a major cause of premature death as a result of cardiovascular disease. With chronic lower respiratory diseases it is noticeable that the Eastern European countries have a lower percentage of total deaths despite having higher levels of smoking than Western Europe. This may be explained by higher mortality levels of cardiovascular disease in Eastern Europe. Osteoporosis once seen as a problem for post menopausal women is also prevalent in men.

## Headline recommendations for actions:

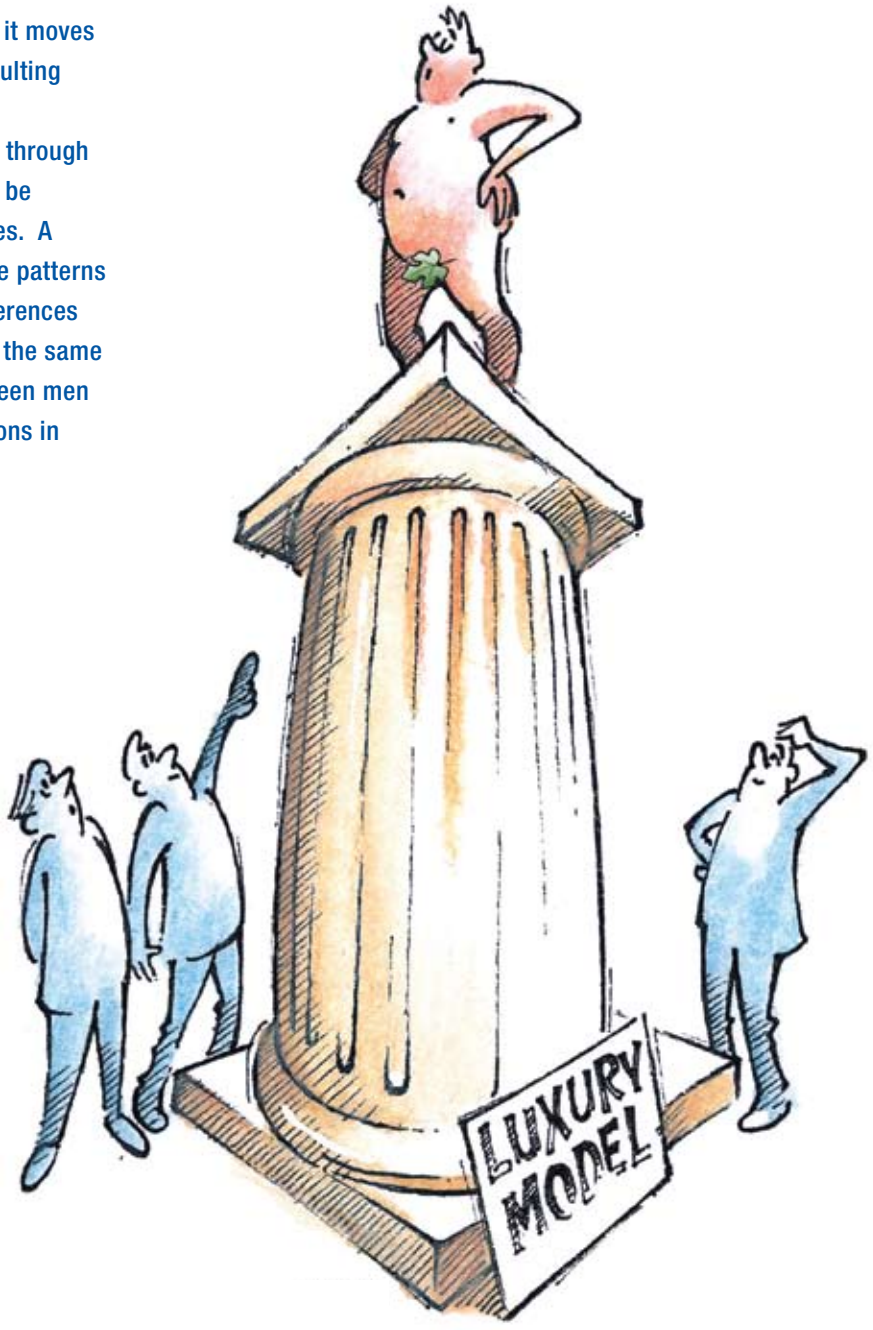
- **All health conditions to be assessed for gender differences**
- Routine checking of men to identify undiagnosed disease including diabetes, chronic lower respiratory disease, osteoporosis

# Epilogue

# 14

Men's health is complex and multifaceted, and it moves well beyond those male specific conditions resulting from men's differing biology with women.

Looking at the mortality and morbidity data through a 'gendered lens' has allowed fresh insights to be gained on key physical and mental health issues. A major observation from the report relates to the patterns emerging from the data that show marked differences between the health of men and women, and at the same time large disparities in health outcomes between men in different countries and within male populations in each Member State.



The extent and depth of the problem of premature mortality is one of the most striking and worrying findings, especially as it involves nearly the whole spectrum of health conditions. Men's greater risk of developing and dying from nearly all the cancers that, biologically, should affect men and women equally; the high rate of premature deaths from cardio-vascular disease; the increased risk from the major communicable diseases; the vulnerability of men to accidents, both in the workplace and at leisure; and men's high levels of suicide are but some of the life-limiting factors impacting on men which lead to such a high number of early deaths.

The marked rise in the number of overweight and obese men, especially when linked to the reduced physical activity levels seen in most men's lives, are also creating significant increases in life-limiting disease. Other lifestyle related factors such as a high alcohol intake, dietary deficiencies, and various forms of risk-taking continue to increase the likelihood of premature death and disability.

The report also demonstrates, however, that men's health encompasses much more than simply disease related mortality; there are significant issues relating to men's overall health and well-being that have emerged through the analysis. As we move from an industrial base to a post industrial society, it would seem that many men are struggling to cope with problems relating to their mental and emotional well-being as well as their physical health. Many of the indicators relating to social exclusion can be seen to be an issue for men i.e. there are worsening opportunities for men with regard to work and full time employment, men are less likely to have post secondary level education, are more likely to lose contact with families and to end up homeless or in prison.

Whilst the vast majority of both victims and perpetrators of violence are male, females are much more likely to be the victims of intimate partner violence (IPV) and the outcomes of IPV in terms of physical and psychological injuries tend to be considerably more negative for female victims than for male victims.

An increasingly aged population is also starting to create new challenges for men with regard to their physical and mental health; with more chronic problems emerging and older men committing suicide five times more often than women. Problems of the male reproductive system are both extremely unpleasant for the sufferer and also costly in terms of their management, though much uncertainty still exists as to how many of these problems should be addressed due to lack of research.

# Academic development of men's health

The literature search for the completion of this report has highlighted that there is only a relatively recent focus on men and their health, with a short time frame of activity to really develop a good understanding of men and their relationship to their physical and mental health and wellbeing. There are many unanswered questions, for instance, how does 'masculinity' and the heritage of male socialisation processes over the generations influence men's health behaviour?, and how are men's changing roles in a post industrial society influencing their health patterns? These are tied in closely with the question of how the social determinants of health impact on men and whether these differ from their effect on women.

It would appear from the scope and complexity of the data covered in this report that a field of practice and academic endeavour around the emerging field of men's health is warranted, in a similar way to that seen around the field of 'women's health'. There would also seem to be scope for much more deconstruction of men's physical and mental health before we can fully begin to understand what is happening.

# Research

This academic development is closely tied to our observations relating to the relative lack of a research base for men's health. Many of the key research studies that we hoped to be able to use for this report were found to be redundant as they lacked a breakdown by sex of their data. The Eurobarometer reports are a case in point, where some give good sex specific breakdown of their data, but others do not fully explore gendered patterns underpinning their findings or to link them to this most fundamental of issues. We also see in reports that children are grouped into one category, rather than exploring the differing influences of the biological and social development of boys and girls.

There is still much data that is not disaggregated according to sex differences within the main databases. Where there is data broken down by sex there is also a tendency for the data to be presented as age standardised and, judging from much of the findings within this report, there is a need for a much clearer focus on age specific analysis as the large differences that exist between the physical and mental health of men and women is most obvious in the early years of life.

There have been calls for more research into men's personal experiences of health and ill-health so that we can learn from their own perspective what influences their lives.

# Policy

Successes are being seen, with the most significant being smoking legislation, which is starting to bring down the tobacco related health conditions. Other key legislation relates to health and safety in the workplace, and transport related legislation which is seeing major improvements in those countries where it is more strictly enforced.

The policy documents explored through this report were notable in their lack of comment on the male specific issues. It would appear from our analysis that, although individual countries have developed health policies and strategies aimed at improving their population's health a 'one size fits all' approach is evident, which would seem to be to the detriment of both men and women.

A strong impression gained from the reports studied is that the term 'Gender' would still seem to be very closely aligned to women and that gender mainstreaming activity is focused onto the needs of women rather than being inclusive of men. A similar observation is made on the work around gender equality and gender equity.

## Practice

There appeared to be little work that was directly focused onto the needs of men, either in a form that men would use or in places that men would more easily access. Most of the targeted activity appears to be small local initiatives, with the larger scale opportunities being the result of external funding rather than driven by Member States' health plans. Ironically, while is that it is acknowledged that male socialisation tends not to lead men to be as aware of health and wellbeing issues as women, men are seldom the focus of specific or targeted health education or health promotion initiatives.

It would seem that current configuration of health services makes it difficult for many men to utilise them as effectively as they should do. This moves beyond direct access to family practitioners, as it also extends into weight loss groups, counselling services and health promoting activities. Where a male focused approach has been adopted there have been marked improvements in up-take and success of health initiatives.

Though it was not part of the analysis undertaken for this report, there would seem to be an absence of men's physical and mental health as part of either initial or post qualifying training for health professionals. This absence of men's issues from educational curriculum does not help practitioners to understand either the health challenges facing men or how they may be addressed.

## Concluding comments

This report highlights that:

- The lives of both men and women can be severely affected by the health challenges men face and how they respond to them.
- Consensus is starting to emerge on what constitutes a 'men's health' issue.
- We are now recognising that the health of men is a particular issue and one that needs specific management and a more targeted approach.
- Men are dying from heavy impact diseases that are strongly related to their biology, their lifestyle and other social determinants of health. This would suggest a more aggressive approach to targeted activity is warranted.
- Key health policies are in-directly affecting men's health in a positive way, such as smoking bans, road safety legislation, health and safety in the workplace, but the lack of gender specific policy limits the potential for legislative influence on the health of men.
- Gender equality initiatives will have a positive impact on the way men's needs are taken into account within government health strategies and at the more local practitioner level.

This report's findings make it abundantly clear that taking a more focused and targeted approach to the physical and mental health of men is not some sort of 'luxury' that is undertaken for academic interest; it is an essential action that is required for the economic and social wellbeing of the European Union.

This report provides the foundation for a wealth of activity in and around the emerging field of 'men's health'.

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# 15


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