‘It is widely known that there are differences between men and women in the incidence and prevalence of most health conditions. Sometimes there are clear biological reasons for these differences – but often there are not.’ (Mens Health Forum – www.menshealthforum.org.uk)

Although men are starting to realise that their health outcomes could be much better with a bit of effort, they continue to die on average, years earlier than women, and for just about every disease common to both sexes, men still come off worse. It’s only in the last few years that we have started to ask ourselves why is this?

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Obesity and Men
Improving services

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n the United Kingdom (UK) the average life expectancy of a female born in 2004 was 81.07 years, compared with 76.82 years for males, almost 5 years difference. Although this has improved over the last decade there remains the opportunity for improvement as these figures do not reflect the true picture around the country; in some parts of the United Kingdom the gap is much higher. In London for example, a man in Queen’s Gate, in the borough of Kensington and Chelsea, lives to the average age of 88.3 but in Lewisham Central, South East London, life expectancy is only 70.8, a gap of 17 years. Given these statistics, the government recognised that men and women have very different healthcare needs and if these are not understood or met, service users are likely to experience unfair and unequal outcomes. Accordingly, the document ‘Gender Equality Duty’, aimed at key public bodies, including the NHS, to pro-actively promote gender equality was launched.

The Royal College of Nursing (RCN) believes that community nurses are well placed to ensure that local clinical governance frameworks incorporate user involvement. Community nurses also work with all members of the community and have a responsibility to the public, as health educators, to educate people for the purpose of promoting, maintaining and improving individual, family and community health. However, the responsibility placed on community nurses seems endless, especially as the elderly population is on the rise, more services are moving into primary care and district nurse numbers are on the decline. Yet another responsibility is to be added to the list; men.

It’s interesting that over the past decade, the interest in health promotion initiatives has grown both in the health profession and the general public, yet the middle-aged male rarely comes into contact with preventative services. Are you aware of the health status of men in your area and how this might compare to the rest of the UK? I have to confess that as a community nurse working as a Health Visitor, Practice Nurse and Public Health Nurse, it was many years before I reflected on my own practice and realised

that I was involved in few services that were directly aimed at men. They often had little contact with health services until they were ill making it quite difficult to give out health messages until it was almost too late. For example, there is an average delay of 14 weeks between a young man finding a lump on his testicle and going to see his GP despite early detection and intervention being crucial to positive outcomes.

Health services specific for boys and men

Men are half as likely as women to visit their doctor, particularly to discuss male specific illnesses. For this reason, health services should be designed to meet the specific needs of men, otherwise engagement and improvement of men’s health is unlikely to take place. Community nurses are ideally placed to support and develop the personal skills necessary for men to exercise more control over their own health and well-being, but what skills might nurses themselves need to develop?

Right now you might be reassuring yourself that you already provide a service that is equal for all, but is this true? When did you last talk to the man of a household you are visiting about a male health issue? Do you know enough about prostate problems, erectile dysfunction, testicular awareness and depression to start the conversation? Can you explain why fewer men develop melanoma yet more men die from the disease and why despite more men than women in the UK being overweight or obese, few obesity services are geared towards men?

Obesity and men

Since the early 1990s, obesity has increased year-on-year for the whole population. However, male obesity has grown at a quicker rate than female obesity and if current trends continue it has been predicted that by 2025, 47% of men and 36% of women could be obese with men also more likely to be overweight (Figure 1).

Obesity is closely associated with premature death and increased morbidity; around 14,000 male deaths each year in England are attributed directly to obesity. It also increases the...
risk of a variety of chronic diseases (box 1) and it has recently been suggested that obesity may be as hazardous to health as a life time of smoking. The government’s White Paper, Choosing Health: Making Healthy Choices Easier encourages primary care teams to play a greater role in the public health agenda. It states that traditional methods of improving health are outdated and new approaches and new actions are needed to secure progress, such as developing innovative practice, working with communities and agencies and having a much greater focus on public health.

Engaging men to lose weight

In 2005, I undertook a poll of more than 100 male truck drivers, only 13 per cent said they would consider going to the GP for help with their weight. This may partly be attributed to the fact that many do not see obesity as a problem; in this poll, only 10 men put themselves in the obese bracket despite 78 per cent having a body mass index (BMI) over 30 (normal range: 18.5 - 24.9), or waist measurements over 40 inches. These statistics are reflected in other evidence; for example, the Australian Gut Buster Programme (one of the world’s most successful male weight loss services) found that ‘denial’ was common place among men, and a Canadian study found that half the overweight men considered themselves normal weight.

An ideal opportunity to discuss weight with ‘men’ is in their own environment. For example, you could consider these points:

• If a male member of a family you are visiting (regardless if they are ‘your patient’ or not) looks overweight or obese, why not broach the subject?
• Get him to weigh himself if there are reminders such as those outlined above, can often be the trigger a man needs to get him to start taking his weight seriously.

Conclusion

While none of this is rocket science, we must remember that public health is part of our duty of care to society. Simple reminders such as those outlined above, can often be the trigger a man needs to get him to start taking his weight seriously.

References

2. Source: WHO 2009 Life expectancy at birth (years) data http://apps.who.int/ghodata/ ?vid=7109

Box 1: Risks associated with obesity

• Hypertension
• Cardiovascular disease
• Type 2 diabetes
• Strokes
• Osteoarthritis
• Some forms of cancer including prostate, oesophageal, colon and rectum, kidney, pancreatic, gallbladder
• Reduction in life expectancy up to 13 years8,9

Figure 1: Obesity prevalence among adults in England, by gender

<table>
<thead>
<tr>
<th>Year</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-1995</td>
<td>18.5%</td>
<td>24.9%</td>
</tr>
<tr>
<td>2000-2001</td>
<td>21.0%</td>
<td>27.2%</td>
</tr>
<tr>
<td>2006-2008</td>
<td>23.7%</td>
<td>29.5%</td>
</tr>
</tbody>
</table>

Note: The proportion of people who are obese steadily increased between 1993 and 2010.