Int J Public Health 52 (2007) 267–268
1661-8556/07/050267-2
DOI 10.1007/s00038-007-0223-4

Men as a target group for disease prevention and health promotion

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The data emerging from comparative gender health studies are clear. For instance, the life expectancy of Swiss men (78 years) is considerably lower than that of Swiss women (83 years). This reduced life expectancy for men is primarily due to premature mortality from specific causes. More men than women die before the age of 70 from heart attacks, lung cancer, cirrhosis of the liver, accidents and suicides – all causes that are at least partly connected with health risk behaviour. Men drink more alcohol, smoke more (still!), take more risks when driving and during their leisure time, eat less healthy food and are less likely to make use of medical screening. These findings point to the conclusion that, especially in the male population, there are health improvement potentials that have not yet been exploited and there should be a stronger emphasis on men as a target group for disease prevention and health promotion.

A plea for a stronger focus on the disease prevention potentials of men, particularly when it comes from a woman, may seem to be "betraying" the women's health movement. In view of the fact that resources are becoming increasingly tight, the call to focus more strongly on the health potentials of men may in fact pose the risk that less will be invested in women's health projects. The current recognition of gender as a key aspect that significantly affects health and disease is down to the activities of the women's health movement and research into women's health. For more than 30 years committed feminists have consistently argued that women receive worse health care in a supposedly gender-neutral health system. This statement still holds true and requires the systematic reduction of the health inequalities suffered by women. But neither does a gender-neutral health system meet the health needs of men.

For some years the concept of "gender mainstreaming" has been found in the health system and other areas as a key strategy for increasing equality of opportunity between the genders. In its Madrid statement "Gender Equity in Health" the WHO clearly defined the importance of gender for health and disease and required its member states to implement gender mainstreaming: "To achieve the highest standard of health, health policies have to recognize that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities" (WHO Euro 2001).

Gender mainstreaming means identifying the health needs and requirements of women and men and meeting them by means of specific measures, e. g. through programmes to prevent alcohol-related road accidents, enhance physical activity in older women or measures to prevent violence against women. It goes without saying that gender mainstreaming initiatives should not be funded from the same budget that was previously available for women's health projects. Gender equity in health cannot be achieved free of charge and both women and men need specifically targeted programmes.

Gender mainstreaming also means checking all measures to see whether they are suited to the life-worlds of women and men and whether the access pathways and methods are appropriate for reaching men and women. A brief look at the range of preventive programmes shows that this is not currently the case. Health promotion in settings, e. g. at work, generally do not take into consideration the importance of the gender dimension at all. For instance, questions regarding the compatibility of work and family life are disregarded. Behaviour-related programmes in the areas of exercise, nutrition, relaxation and addition are designed without sensitivity to gender differences. The programmes offered by providers are full of courses that implicitly take a female orientation to the body. The fact that men do not feel that these "fluffy" courses are aimed at them is shown by take-up rates of 4:1 in favour of women (German Central Organisation of Health Insurance Funds 2007). But such courses could be organised differently

and the number of models of good practice is on the increase. Some recent initiatives to stop smoking among young people have taken into account that boys and girls have different reasons for starting or continuing to smoke. One of the main reasons for girls is the use of cigarettes as a means of losing weight. More gender-sensitive anti-smoking measures take account of this difference by developing different methods for weight regulation. Accident prevention programmes can also be designed in a more gender-sensitive way. Whereas young men need to be made to realise that they drive less safely than they think when they have alcohol in their bloodstream, young women must be encouraged to take the car keys away from their drunken companions (for further examples, see Kolip & Altgeld, 2006).

Gender mainstreaming can lead to an increase in quality because it raises the precision of the programmes on offer and more clearly specifies the target group. Gender mainstreaming can contribute to increased sensitivity to social diversity if providers consider the dimensions of social differentiation that they need to take into account when planning and implementing their interventions. Women and men are not homogenous groups and health promotion will need to be more strongly differentiated in future in order to use the available resources appropriately.

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