Masculinity, however, is not uniform: some forms of masculinity are more highly valued, whilst different forms of masculinity are accessible to different men and this helps explain variations in health risk between men. Structural factors such as poverty will impact directly on health through lack of resources, but may also lead to an increase in risky behaviour - particularly amongst younger men - because of values placed on particular forms of ‘manhood’ available to these men. Similarly differences between men in relation to ethnicity, class and socio-economic group will interact with, and help shape, gendered influences on health, masculinity and health risk. Differences in health care treatment and access to health care which partly reflect socio-economic factors are also relevant.

Explanations of men’s health - and of the ‘crisis’ in men’s health - thus need to reflect not only biological or sex-linked factors, but also gender. In evaluating the role of gender, it is important to consider not only men’s behaviour but also how behaviour and differences between men can be explained - drawing on ideas of the social construction of masculinity and the ways in which masculinity is variously located in social and cultural structures which affect health impact. The social and institutional structuring of health care, affecting access to resources including treatment, are also important. And finally, we need to recognise the relational aspects of gendered influences on health, and that whilst ‘masculinity’ affects men’s health, there are implications too for the health of women associated with particular aspects of male behaviour.

Sarah Payne
Senior Lecturer in Social Policy
University of Bristol

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Smoking, drinking and drug use: a privilege and a burden

In many societies, access to recreational drugs has been forbidden or restricted for women. Drug use has been a male privilege, often an integral part of men’s public, economic and political roles as well as their friendship networks and private activities. But privilege has been at a cost. Although in some countries women have been catching up with men in their use of alcohol, tobacco and illicit drugs, worldwide, men are still the heaviest users of these substances and more likely than women to experience physical and mental health problems and social difficulties associated with substance use.1 This is
especially true in the case of alcohol, ‘our favourite drug’, which, according to estimates from the World Health Organization, accounts for around 5.6% of male deaths every year. In the UK, this figure has been rising steadily over the past decade from six deaths per 1,000,000 to 13 deaths per 100,000.2

ALCOHOL CONSUMPTION AND HARM
Prevalence data show that in England nearly a third of adult men drink above the recommended guidelines of 21 units* a week and around 22% of men drink on five or more days in the week. In the youngest age group (16-24 years), where alcohol consumption is heaviest, 14% of males drink more than 50 units a week, much of it concentrated into a few days of weekend ‘binge’ drinking which accounts for 40% of all drinking occasions by men.3 Although alcohol misuse does not automatically result in harm, it does increase the risks. Both the amount of alcohol consumed and the pattern of consumption are important and can contribute to the development of chronic physical conditions such as gastrointestinal problems, liver disease, stroke, cancer and sexual dysfunction; alcohol consumption is associated with problems at work, in relationships and with the law, as well as with acute problems such as alcoholic poisoning, accidents, assaults and self-inflicted injuries. Health consequences are compounded by the fact that many heavy drinkers also smoke and many illicit drug users also misuse alcohol.

A ‘LIFESPAN’ PERSPECTIVE IS NEEDED
Current concern has tended to highlight the problem of substance use by young people and it has been suggested that adolescent recreational drug use has become ‘normal’ behaviour.4 With the exception of smoking, where girls are as likely as boys to be smokers,5 young men remain at the forefront of public and professional attention. For instance, the links between alcohol and public disorder, anti-social behaviour and violence typically involve young men (16-29 years) who are single and unemployed, drinking frequently (3-4 times a week) and heavily (over 10 units on a typical drinking day) in urban or inner city areas.6 In one study, 37% of males under 25 reported either sustaining or causing injury because of drinking; other research from hospital samples has found considerable numbers of alcohol-related injuries including facial cuts from ‘glassing’.8

However, patterns of drinking and the associated problems change over the lifespan and in relation to many factors in an individual’s personal and environmental situation. While many young men move out of harmful drinking, others develop long-term drinking problems and dependancy or move in and out of harmful drinking patterns, and some men become problem drinkers at a later age. Knowledge of the triggers of shifting patterns of harmful substance use over the life course is sparse. Older men, for instance, have been a largely neglected group. Based on data from the General Household Survey, one study reported a relationship between smoking, alcohol consumption and self-reported health according to marital status among men over 55; married men were less likely to report poor health and less likely to smoke or drink above recommended limits than previously, or never married men.9

Although the emphasis on youthful drinking is important, a ‘lifespan’ perspective is needed to gain a clearer picture of how and why alcohol use may become ‘misuse’ at different stages in men’s lives. Gender issues, an influence on lifestyle from the cradle to the grave, deserve particular attention in seeking explanations.

GENDER ISSUES IN SUBSTANCE MISUSE
Explanations for substance misuse tend to focus on factors associated with risk behaviours or on circumstances which trap individuals within high-risk groups. But perhaps it is time to take stock of lessons learned from research on women’s substance use and look more closely at gender as a key issue in understanding why men - at all stages of life - are the dominant risk takers in their use of both legal and illegal drugs. At the same time, we cannot assume that men, themselves, regard their use of substances as ‘risk behaviours’; for the majority, perhaps, it may be just part of life and for some, it may simply be part of ‘being a man’.

Substance use continues to be a central part of images linked to notions of masculinity. These may change with age from the youthful ‘macho’, rebel images to the stressed ‘family breadwinner’ to the ‘stoic’ older man, influencing the role of substance use in constructing or sustaining male identities and in providing a coping mechanism or an escape route in difficult times.

The precise ways in which substance use interacts with individual and social factors, including gender, varies between different groups of men over the lifespan; but research indicates that the risks are greater for men in the lower socio-economic groups and for those living in disadvantaged communities. Structural disadvantage and social exclusion may underpin a move from youthful experimentation towards continuing drug use by providing an alternative route to carving out a masculine identity and achieving success within the peer group,10 or sustaining status as the family breadwinner and protector11 or addressing the loss of traditional forms of power in relationships with women.12 When help is needed, men are often reluctant to ask for it. Seeking help signifies a sign of weakness and loss of control. A ‘real’ man is able to control his drinking or drug taking and should be able to deal with his problems without outside intervention.1, 9

It is important for prevention and intervention strategies to recognise the influence of gender factors on attitudes and behaviours across the lifespan. The drive to provide more gender sensitive prevention approaches and services for women has led to considerable changes in the structure and content of drug and alcohol interventions. The significance of notions of ‘masculinity’ and of ‘appropriate’ male roles in men’s substance use and in their responses to associated harm deserves equal attention.

Betsy Thom
Reader in Drug and Alcohol Studies, Middlesex University, and Honorary Professor (Public Health and Policy), London School of Hygiene and Tropical Medicine Email: b.thom@mdx.ac.uk

*The alcohol content of a given beverage is calculated from its percentage alcohol content by volume (%ABV). A ‘unit’ of alcohol is the amount contained in half a pint (284ml) of beer, a single glass (125ml) of table wine, a single glass (50ml) of fortified wine, for example sherry, or a single measure (25ml) of spirits. A ‘unit’ approximates to 10ml or 8g of absolute alcohol.

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Male central obesity

Obesity is widely perceived to be a uniquely female concern. Thirty years ago leading feminist campaigner Susie Orbach pointed out that “Fat is a feminist issue.” Weight problems, diets, supermodels becoming too skinny; the public face of obesity and weight is devoted to women and their curves. Author Robert Kemp wrote “Women care a great deal, very few men care at all.” Men need to start caring about their health, and particularly their waistlines.

The World Health Organization describes obesity as “one of today’s most blantly visible - yet most neglected - public health problems” which “threatens to overwhelm both developing and developed countries.”

In the UK we currently have an epidemic of obesity. We are not the worst in the world: certain Pacific Islanders and American Indians hold that position; and we are not even the worst in Europe, but here in the UK we are climbing the obesity premier league table faster than anyone else.

Not all sections of the population are affected the same way by obesity; the problem is worse in deprived areas, and much more significant amongst many ethnic minority populations, e.g. South East Asians, who succumb to type II diabetes at a much lower Body Mass Index (BMI) than their non-Asian counterparts. Another main subsection of the population to have their own unique risks and predisposing factors to obesity-related comorbidities, are men.

The risk of carrying excess weight for men is so great that they even have a form of obesity named after them: ‘android’ obesity. Overweight and obese individuals are referred to as either ‘apples’ or ‘pears’. Pear-shaped people, generally women, carry their excess weight around their thighs and buttocks, hence ‘gynoid’ obesity. Apples are usually men, who carry their fat abdominally: android obesity. Unfortunately for men, the android form is dangerous. Abdominal obesity refers not to subcutaneous fat beneath the skin of the abdomen, but to visceral fat, which surrounds the omentum of the bowel. The amount of visceral fat inside the abdomen is directly proportional to the waist circumference, implying that waist circumference is a more accurate measure of the dangers of obesity than BMI, which can be erroneously elevated to ‘obese’ levels in super-fit athletes. The relevance of visceral fat is that it acts, not as an inert lump of fat, but as an active endocrine organ, secreting neuroendocrine factors and cytokines into the blood stream; absorbing hormones which undergo peripheral conversion and re-enter the blood in a changed state, along with the products of lipolysis from adipose cells which enter directly into the portal circulation. These adipose cells, along with smooth muscle cells and liver cells are resistant to the effects of insulin, which is the basic underlying phenomenon of the metabolic syndrome.

The metabolic syndrome is not something that the average man knows about, even though up to a quarter of the population suffer from the condition, and amongst the male, pub-going population, the percentage is considerably higher. It is incredibly easy to attain the qualifications to be diagnosed as metabolic syndrome: waist >102cm, blood pressure >135/85, and fasting blood sugar >6.1 is enough. But the ramifications of the condition are staggering. The 15-fold increase risk of type II diabetes is well known, as is the quadruple risk of heart disease, and the danger of blood pressure, high cholesterol and stroke. There is also the risk of around 20 different sorts of cancer, including colon, prostate and testicular; the increased likelihood of arthritis, not just in the weight-bearing joints, but even in the wrists and elbows; the danger of sleep apnoea which leads to daytime somnolence and vastly increased number of fatal road traffic accidents; and the risk of liver failure; obesity has the same effect on the liver as excess alcohol. And worst of all premature death. A young obese black male from a deprived inner city area will lose up to 20 years of life because of obesity.

Overweight and obesity can be treated. It is not always easy and not always successful, but a combination of nutrition and lifestyle advice, with modern excellent anti-obesity pharmacotherapy, and in extreme cases surgery, can very often produce a successful outcome, and prevent

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