WHERE ARE THE MEN?

Chief Medical Health Officer's Report on the Health & Wellbeing of Men and Boys in Northern BC

November 2011

northern health
the northern way of caring

TABLE OF CONTENTS

ACKNOWLEDGMENTS

Many people have contributed to this Report, but I would like to particularly acknowledge several people whose work and interest in Men's Health made the Report possible:

Julie Kerr who kept track of the material and ongoing development of the Report

Theresa Healy whose work with focus groups brought the voices of Northern men into the Report

MaryAnne Arcand whose work with RoadHealth demonstrated that working with men can make a difference

Bernard Denner whose work and leadership in Men's Health Promotion in Australia has inspired us

Roxane Griffith who helped to format the Report

James Haggerstone who dug up most of the data and who has waited patiently for this Report for many years

WELCOME TO THE REPORT ON MEN'S HEALTH IN NORTHERN BC

This report was produced by the Population Health department of Northern Health, under my direction.

We have called it "Where Are the Men?" because, in many important ways, men appear to be missing. Where are the men who rarely, if ever, use preventive health services? Where are men if we compare their health to the health of women? Where do men live and work and where should services designed for men be located if we want to improve the health of Northern men? Where are the men who will stand up as role models for healthy fathers, brothers, uncles and sons in our communities?

We hope this report will be of interest and use to a broad audience, because we know that men's health outcomes affect all of us. When men are unhealthy, we pay for it through economic hardship, family stress, crime, unemployment, domestic violence and direct health care costs. We believe that healthier men will help to build healthier families and communities in northern BC.

Many factors determine whether people are healthy: living conditions, income, employment, education, housing, food, sex and gender, the environment, personal choices and behaviors and, of course, the ability to access quality health services. For generations, men seem to have had these so-called "determinants of health" weighted in their favour. This might lead to the assumption that men would also enjoy good health and longevity. However, the opposite is true. Men's health is surprisingly poor.

The same observation can be made in almost all developed countries. It is clear that the issues are deeply entrenched, but there are good examples from around the world of approaches that work. The challenge for us will be how we can begin to work to support improvements in the health of the men who live and work in our Region.

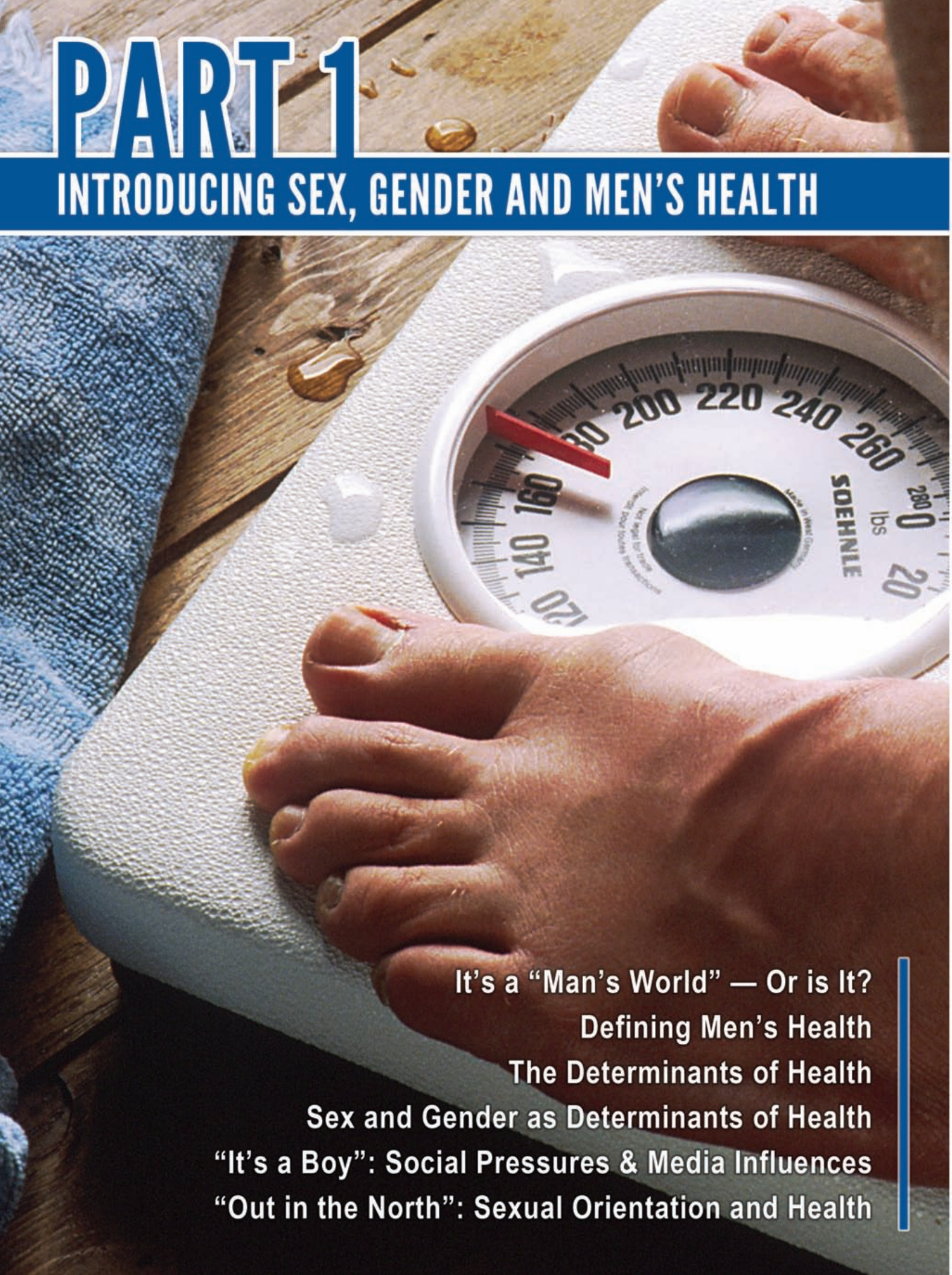
This report is intended as a first step on a challenging and, we hope, rewarding journey. It will outline the context within which northern men live, discuss the health status of northern men and identify some of the initiatives being undertaken here and abroad to improve men's health.

We have supplemented the Report with ideas, experiences and insights provided by northern men through email, telephone conversations, face to face interviews, and focus groups. These men have expressed a strong desire to improve their own health and that of their families and their honesty and courage have inspired us. We look forward to continued conversations with them and with you as we begin to take a serious look at Men's Health in Northern BC.

Dr. David Bowering,
Chief Medical Health Officer, Northern Health

PART 1

INTRODUCING SEX, GENDER AND MEN'S HEALTH



It's a "Man's World" — Or is It?
Defining Men's Health
The Determinants of Health
Sex and Gender as Determinants of Health
"It's a Boy": Social Pressures & Media Influences
"Out in the North": Sexual Orientation and Health

"IT'S A MAN'S WORLD" – OR IS IT?

The focus of this report is the health and wellbeing of men in northern BC. The premise is that the health and wellbeing of men and boys is important and that healthier men will lead to healthier and more prosperous northern communities. We believe that healthier men will be better partners, fathers, providers, and role models. Women and children will be healthier in prosperous communities where men are less violent, more involved as fathers, and more socially responsible.

The statistics in northern BC reaffirm the global observation that men's health, in general, lags behind that of women, despite the apparent social, political and economic advantages that men enjoy. Men are more likely to be injured or killed through workplace incidents, suicides, diseases, unintentional injuries and intentional violence. This differential begins in childhood and persists throughout the lifespan.

Men often grow up relatively unaware of their bodies and ignore symptoms of trouble. Embarrassment at discussing intimate physical issues with service providers (who are often women) may mean that the warning flags of serious underlying disease go unmentioned for years.

The assigned male role as protector of women and children, combined with societal expectations of men to be stoic and uncomplaining of pain or other physical symptoms, is communicated to boys from an early age. As primary income earners and financial providers in families, men may fear the loss of pay resulting from taking time off work for sickness or medical exploration. The ideal of men as strong providers means many men define themselves by their work, and this can result in poor work-life balance and high levels of stress.

Throughout the life course, men tend to access health care services less frequently than women. Often, by the time they do seek medical attention, their conditions have progressed and are more complex. For example, a typical man with unrecognized hypertension, diabetes, and elevated cholesterol may finally come into contact with medical professionals via a fatal or near fatal heart attack. This pattern can result in poorer outcomes and greater burdens on the health system, families, communities and the economy.

Men die earlier than women of virtually all causes. Life expectancy for males is, on average, about 5 years shorter than that of females. Further, men living in northern BC do not live as long as their male counterparts in the lower mainland.

Image source: http://the17thman.typepad.com/my_weblog/2008/05/mens-health-mark-wahlberg.html

"Health is something you don't think about until you don't have it."

From senior men's focus group, Nov. 2010

DEFINING MEN'S HEALTH

Understanding men's health requires an approach that recognizes the differences as well as the similarities among men and male groupings. One approach is to look at the life course of men in terms of their ages and the roles and activities associated with each stage of life.

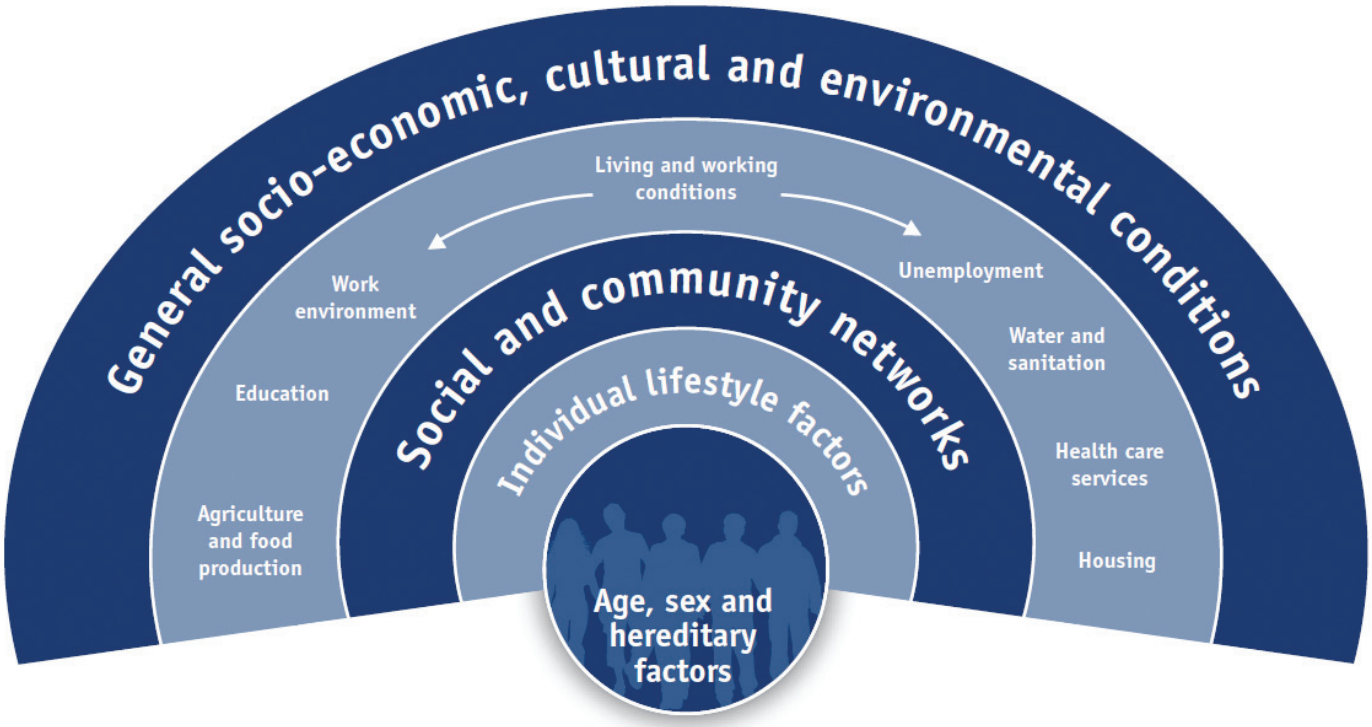
Examining groups of men by occupation or ethnic heritage helps to isolate specific challenges and needs. Clearly, a 16 year old runaway requires very different approaches and services than a 50 year old married father of 3 or a respected Aboriginal Elder of 70.

A settings-based approach is also required if we are to understand the contexts within which men live, work, play and learn. Home, school, work environments and recreational and leisure settings shape men's behaviour and make it easier or harder for them to be healthy.

Another approach is to consider the determinants of health, those broad contextual factors that affect us all but that interact with gender in important ways.

THE DETERMINANTS OF HEALTH

Many factors determine whether people are healthy: living conditions, income, employment, education, housing, food, sex and gender, the environment, personal skills, capacities, choices, behaviours and, of course, the ability to access high quality integrated health care services. We often refer to these health influencing factors, collectively, as the determinants of health.



Factors that influence our health, as found in The Report on the State of Public Health In Canada, 2008. Dahlgreen & Whitehead, European strategies for tackling social inequities in health: Levelling up. Part 2, WHO, 2006

While there have been multiple reports and programs focused on the health of women, Aboriginal peoples, children and other groups, there has been very little consideration of the equally significant health issues faced by men or the striking differences in life expectancy, morbidity and mortality, and the underlying determinants of health which give rise to these differences.

First, what do we mean by Sex and Gender?

Sex is commonly understood to refer to biological characteristics that vary and yield distinctly male or female persons. Using sex as a variable allows us to investigate the potential differences associated with biological differences between men and women.

Gender refers to the array of socially and culturally determined roles, personality traits, attitudes, behaviors, values and amount of power and influence that society applies to the two sexes. A gender based analysis may help us to determine the potential differential impacts of policies and programs on women and men.[1]

Over age 45 the leading causes of death for both men and women are chronic diseases. Men die of heart disease in equal numbers but at a younger age than do women. With increasing age the number of deaths for women creeps upward to equal that of men.

Male gender roles as manifest by risky behaviour around drinking, driving, and sex, account for virtually all excess male mortality below age 45, and approximately 50% of the excess below age 60. This data suggest that gender is a central, although not the sole cause of the shorter life expectancy of men in western society.

How much of this gendered behaviour actually arises from a male, historic, biological imperative to dominate other males and thereby win a mate to procreate is unknown. Therefore, a sex difference in longevity appears to result, in part, from a gender difference in behaviour, which may, in turn, arise from the biology of sex.

Defining which aspects of female advantage in life expectancy arise purely from the fixed biological attributes of sex and which are due to gender and amenable to change is challenging.

Susan Phillips Defining and measuring gender: A social determinant of health whose time has come. Int J Equity Health, V. 4 2005

"God gave man a penis and a brain but not enough blood to supply both at the same time."

Robin Williams' joke reflects a common stereotyping of men as motivated only by their sex drive. Such caricatures can serve to undermine the reality of the male experience and the assets and contributions that men can make to society. The "penis brain" stereotype is frequently and vigorously reinforced in the media.

"The other barriers [to men's health] are in the media. And this is happening to all men. There is pressure, an image of what a man should be, to measure up to. And it is a pretty boy image, he shaves everything every few days, has a ripped six pack."

"Girls get all the rituals of puberty; they get taught about their bodies; they get a supported passage into womanhood. Boys get nothing like that and, in fact, men are taught not to talk to other men about their bodies."

Focus Group #3, August 2010

Examples of advertising and media targeted to men

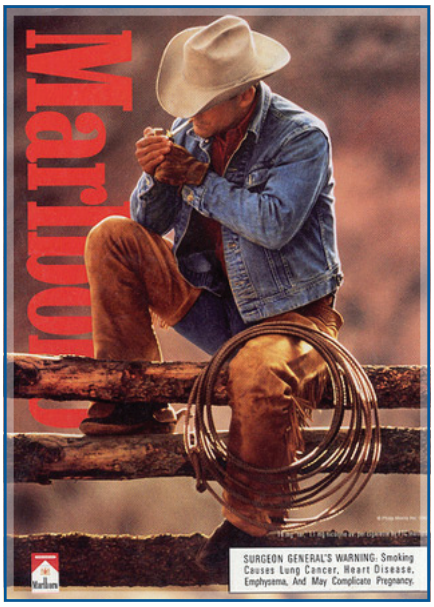


Image Sources :

Jose Cuervo Ad
http://blog.lib.umn.edu/raim0007/gwss1001/assignment_posts/weekly_assignments/8_adbusting/

Men's Health Cover
http://kseniyalive.com/?attachment_id=30

Marlboro Ad
http://www.asianmalerevolutions.com/remember/ii-the-appropriation-of-multiculturalism/

Scruffs Safety Footwear Ad
http://feministphilosophers.wordpress.com/2007/07/

Old Spice Ad
http://latimesblogs.latimes.com/gossip/2010/02/isaiah-mustafa-old-spice-commercial.html

"OUT IN THE NORTH": SEXUAL ORIENTATION & HEALTH

Men who have sex with men (MSM), gay men, bisexual, transgendered, queer and questioning men face unique stresses within our communities in the North. Homophobia, whether perceived or real, creates barriers of silence and shame. While they make up a comparatively small portion of the population, these men have health needs that, if overlooked or unmet, take a large toll on them, their social networks and society at large.

We held a focus group in preparation for this report that provided fresh insight into the unique realities of life as a northern gay man. The full transcript is available upon request. Here is a sample of the issues raised:

> *"You know, I am not even sure my own doctor knows I am gay. I want the fear of telling him to go away… I like my doctor. He's smart, he takes good care of me. I have no reason to believe he would treat me any different if he knew I was gay, but I don't know. I am doing these complicated mental calculations about whether it is safe to come out or not."*
>
> ***Focus group # 3, August 2010.***

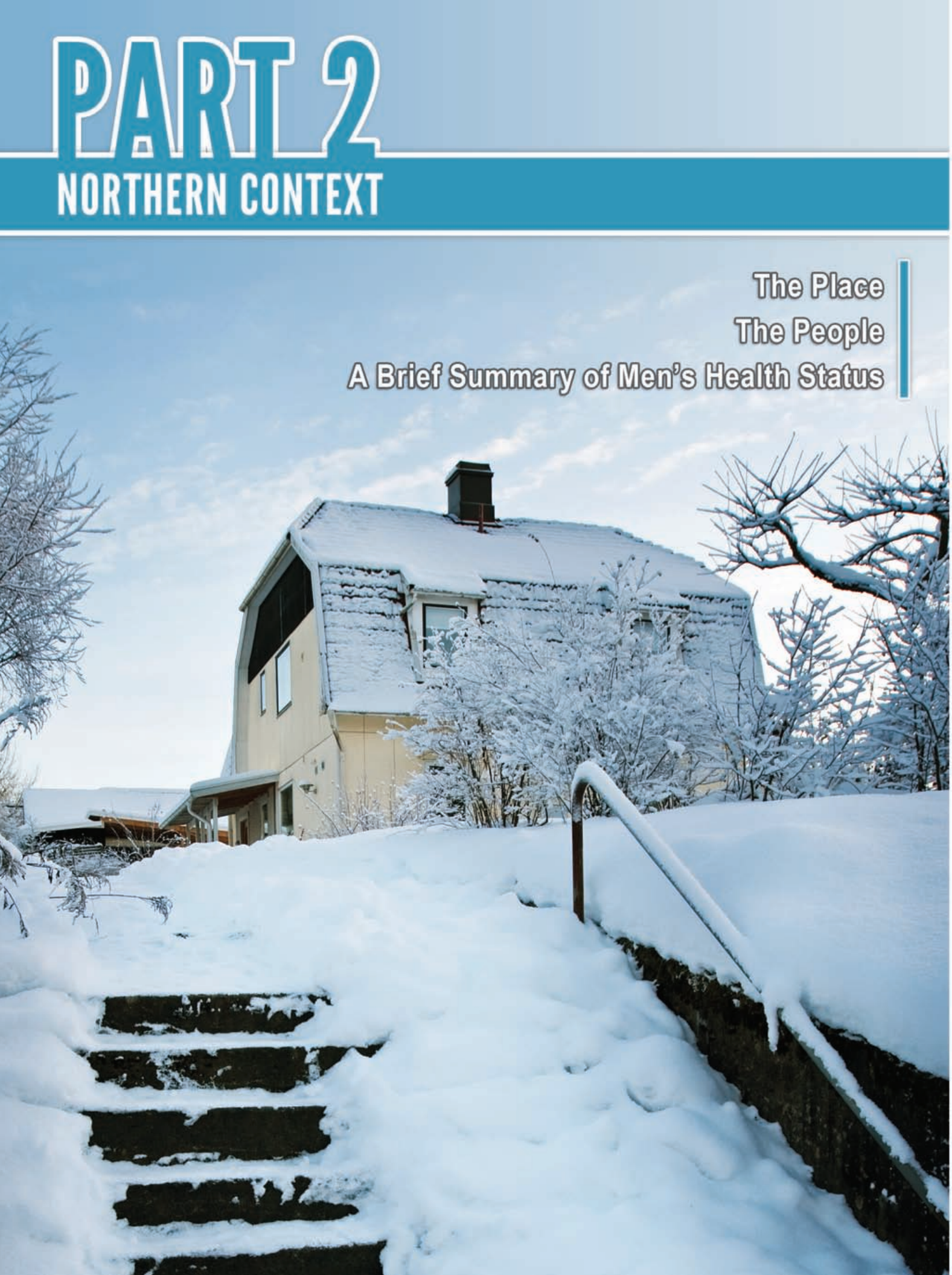
The fears we heard men express are reflective of a growing body of literature, media reports and research that demonstrate how sexual orientation can further confound and be confounded by other key determinants of health.

> *Transphobia, the fear of gender variance in society, impacts all parts of life. Children who do not gender-conform are often met with physical, verbal and sexual cruelty and are sometimes forced to drop out of school, while youth are frequently disowned by their families and lose economic support systems. Transgender adults face significant obstacles to accessing employment, healthcare, police protection and other essential services. Today, gender variant communities live in relative poverty habitually alienated from social services, spiritual care or support. And, as in the case with anyone experiencing multiple oppressions, transpeople who are also people of color, poor or working-class, disabled, etc. are exponentially affected and they have less access to resources (such as money) that can alleviate the effects of living in a transphobic society."* [2]

The death of Faye Paquette in Prince George in 2002 exemplifies this risk. She was brutally beaten to death after the john she picked up discovered she was a transsexual.[3]

PART 2
NORTHERN CONTEXT

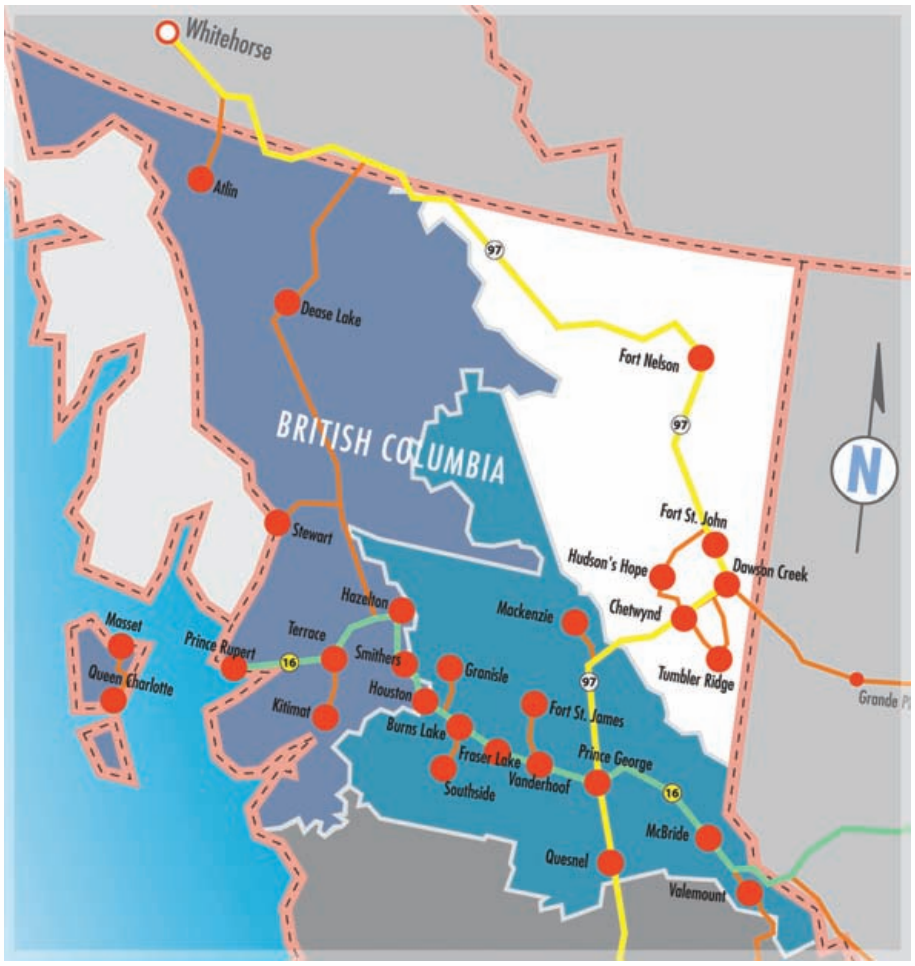
The Place
The People
A Brief Summary of Men's Health Status



THE PLACE

The region served by Northern Health is vast.

It covers nearly 600,000 sq. km, or two thirds of the province. It is the size of France, yet only 285,493 people (7 % of the BC population) call this area “home.”



People choose to live in the North for a variety of reasons. For many Aboriginal peoples, northern BC has been home for, literally, thousands of years. Because of BC’s resource based economy, many men and their families have moved here for the work. More and more Northerners are choosing to stay in the North because of the exceptional beauty of the land and the affordable lifestyle.

The small population and vast geography of this region present unique challenges to the delivery of effective and efficient health services, further compounding the issues that typically prevent men from seeking help when they need it.

“I wore out a pick up truck driving to Vancouver for the tests and surgeries.”

“Well now they have that bus and it is only forty dollars.”

“What guy is going to take the bus? Really, I don’t know the guy driving it, I don’t trust him. I want to do the driving.”

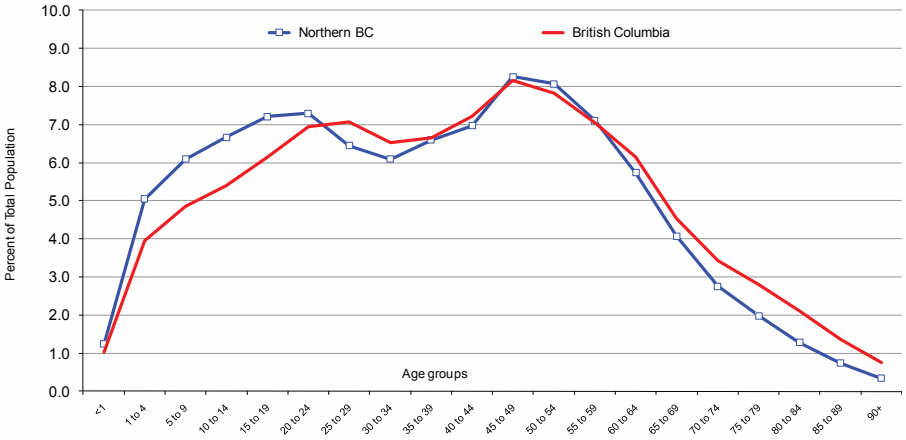
From senior men’s focus group, Nov 2010.

The Population in 2010

This graph compares the northern BC population to that of BC overall.

The baby boomers are clearly visible. So too is the relatively large number of younger people.

Source: PEOPLE 35, BC Stats.



The Sexes:
Men outnumber women in northern BC by a small margin. Approximately 51.3 % of the population is male; 48.7 % is female.

Children & Youth Ages 0 – 17:
This demographic comprises 24 % of the Northern Health population, whereas the proportion for BC is 19 %.[4] Certain segments of this young age-group are "at risk." The Northwest and Northern Interior HSDAs have the highest percentages of children living in families receiving Income Assistance. Child abuse rates are high and many children entering kindergarten are assessed as developmentally vulnerable. The academic success of northern youth falls behind that of youth in the more metropolitan areas. [5] [6] [7] [8]

Adults Ages 18 - 64:
These are the principle income earners that lubricate the local economies, support the young and contribute to the welfare of older persons. Our reliance on this age group is often expressed in terms of child and senior dependency ratios.[9] In the past decade, the Northwest and Northern Interior health areas have seen large outflows of this important age group, whereas the Northeast has seen net inflows.[10]

Seniors:
The northern seniors' population (about 10 % of the overall population) is expected to grow quickly over the next 15 years. The 65+ and 75+ populations are expected to grow by 93 % and 97 % respectively. These are the highest anticipated growth rates of all the health authorities in BC and represents a predicted doubling of the seniors' population by 2025.[11]

Aboriginal Peoples:
At least 17.5 % of the population in northern BC is Aboriginal, the highest of any BC health authority.[12] This Aboriginal population is young; 32.5 % of persons are under age 15. This compares to 17.7% for BC overall.[13]

Visible (and not-so-visible) Minorities:
Only 4.2% of northern BC's population is made up of non-Aboriginal visible minorities, compared to 24.5% in BC overall. While their numbers are relatively small, northern BC is home to a wide range of ethnic minority groups.

How do we meet the needs of the men and families from minority populations?

The challenges facing men that have immigrated to Canada, or those of First Nations ancestry, are compounded by cultural expectations that may be in conflict with mainstream Canadian society.

Northern BC is unique in the nature of its cultural diversity. There are proportionately more Aboriginal people residing in northern BC than elsewhere in the province and, except for places such as Prince Rupert, Kitimat, Terrace and Prince George, there are far fewer persons who fit the Census definition of "visible minority."

Visible minority: Refers to the visible minority group to which the respondent belongs. The Employment Equity Act defines visible minorities as persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in color.[14]

Local Health Area	Percent of Local Population	
	Visible Minorities	Aboriginal Persons
LHA 050 - Haida Gwaii	1.9	39.2
LHA 051 - Snow Country	not published	not published
LHA 052 - Prince Rupert	9.9	38.9
LHA 053 - Upper Skeena	1.0	69.2
LHA 054 - Smithers	3.6	11.5
LHA 080 - Kitimat	6.0	18.1
LHA 088 - Terrace	5.1	23.6
LHA 028 - Quesnel	4.6	11.6
LHA 055 - Burns Lake	0.9	27.7
LHA 056 - Nechako	3.5	22.1
LHA 057 - Prince George	5.1	10.9
LHA 059 - Peace River South	2.0	13.8
LHA 060 - Peace River North	2.2	9.5
LHA 081 - Fort Nelson	5.0	20.8
LHA 087/094 - Stikine Telegraph	not published	not published
LHA 092 – Nisga'a	0.5	92.7
Northwest HSDA	5.1	30.0
Northern Interior HSDA	4.6	13.1
Northeast HSDA	2.4	12.4
Northern BC Overall	4.2	17.5
BC Overall	24.8	4.8

Source: BC Stats. Regional Socio-economic Profiles and Indices
http://www.bcstats.gov.bc.ca/data/sep/index.asp

"If I kept kosher, I'd starve to death."

Tongue-in-cheek observation of a Jewish man who recently relocated to northern BC from eastern Canada.

"Residential school grew me up to be a hitter. I had no problem shooting, stabbing. I didn't care about life, mine or anyone else's. I was the scariest guy you wouldn't want to meet. Being a man today is tough because you have to fight that expectation."

Focus group #1, Warrior Caregivers Story Telling Circle, August 2010.

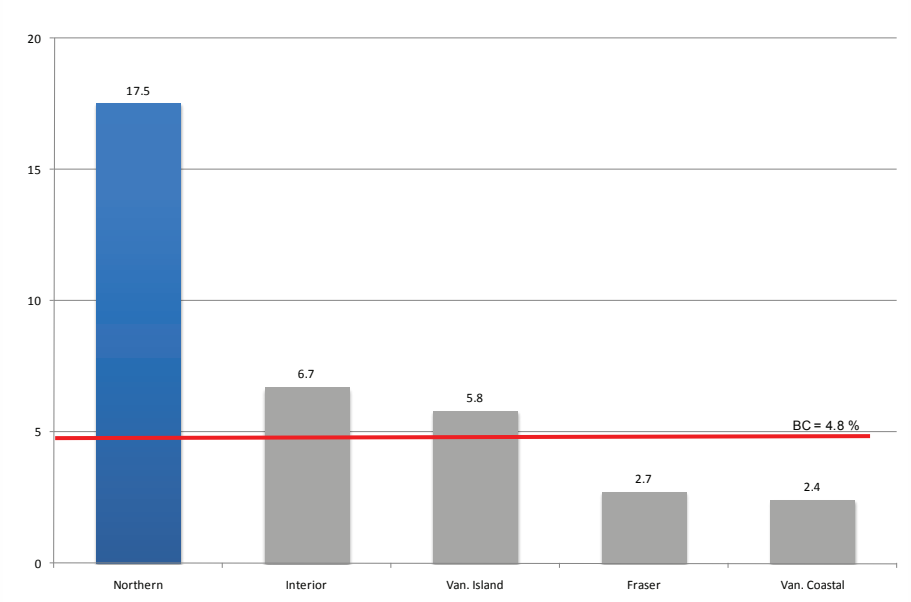
"The challenges to be a good man are hard. I was doing the laundry and these roofers working on the house next door started harassing me, came up to me and started smelling me, saying, "Oh you smell good, you must use, like, 'Gain'." As if men aren't supposed to do laundry and there must be something wrong with you if you do. This is a new place for me, that to be a man is about NOT reacting, not just reacting violently, to let it go. And anyway, I use 'Bounce'. [Everyone laughs]

Focus group #1, Warrior Caregivers Story Telling Circle, August 2010

For First Nations men, colonization is widely understood to have disrupted traditional parenting, caused cultural dislocation, introduced violence and substance abuse, and given root to criminal behaviors. These all have had profound negative impacts on the health and wellbeing of the men, their families and their northern communities.

Aboriginal men face significant challenges. Throughout this report there are references to interviews and focus groups with Aboriginal men. Their voices are of great value and will help inform our understanding and our service planning.

Aboriginal persons as percent of Health Region populations [15]



The general Aboriginal population of Canada is only 2.7% of the Canadian adult population.

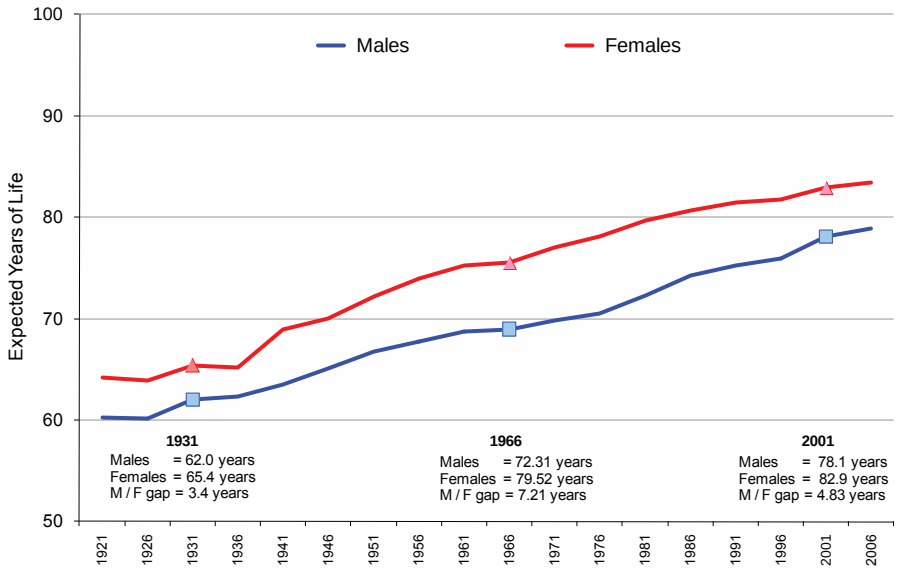
At the end of March 2007, Aboriginal people comprised 17.0% of federally sentenced offenders.

Source: Correctional Service of Canada, www.csc-scc.gc.ca/text/prgrm/abinit/who-eng.shtml

A BRIEF SUMMARY OF MEN'S HEALTH STATUS

Life expectancy at birth is used around the world as a basic health indicator. It reflects the extent to which people are able to live a long life, that a population is healthy, has adequate food and access to health care, and is protected from disease and other threats that would shorten the life span.[16] The most significant increase in life expectancy over the past 60 years has been the result of improvements in infant and childhood survival. This is a direct result of cleaner water, sanitation, and the effective control of infectious diseases such as polio, tuberculosis, diphtheria, and others.[17 18 19]

Life expectancy at birth



The chart above shows the gains in life expectancy from 1921 to 2006 in BC. Both sexes have seen their overall life expectancy steadily increase, but there is a consistent gap between them ranging from 3.4 years in 1931 to 7.21 years in 1966 and 4.83 years in 2001.

Men are twice as likely as women to die from unintentional injuries.

www.Aboutmen.ca

Men are 50% more likely to die from diabetes than women.

www.Aboutmen.ca

"You've come a long way, baby!"

Men surpass women in almost all types of cancer except lung cancer, which has become an "equal opportunity" disease.

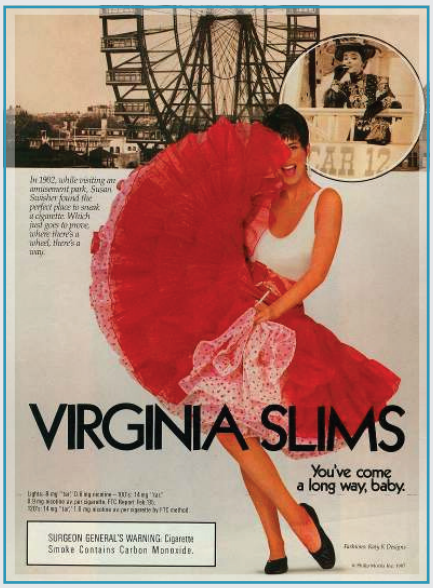


Image source: http://www.pettipond.com/v_slims.jpg

Men and boys in northern BC consistently have death rates higher than their female counterparts. Men not only die sooner, but the mortality rates show they also die more frequently, from all causes of death *(see table below)*, with the exception of lung cancer, which has become an "equal opportunity" disease as a result of the upsurge in women's smoking following the two World Wars.

Deaths	Northern Health		
	Total	Male	Female
Infant mortality rate	4.9	3.8	5.9
Life expectancy at birth	77.7	75.3	80.2
Life expectancy at age 65	18.0	16.2	19.7
Total, all causes of death	707.1	863.4	564.8
All cancers	177.2	230.8	137.6
Colorectal cancer	21.7	26.3	17.9
Lung cancer	42.3	43.4	42.0
Prostate cancer	...	29.1	...
Circulatory diseases	227.9	270.3	184.3
Ischaemic heart diseases	97.7	125.9	67.1
Cerebrovascular diseases	79.4	89.7	71.1
All other circulatory diseases	50.8	54.7	46.1
Respiratory diseases	76.5	91.7	63.3
All other respiratory diseases	49.4	67.5	35.5
Unintentional injuries	54.5	79.3	28.7
Suicides and self-inflicted injuries	13.7	20.1	6.5
Deaths attributable to alcohol	67	49	18
Deaths attributable to tobacco	281	181	100

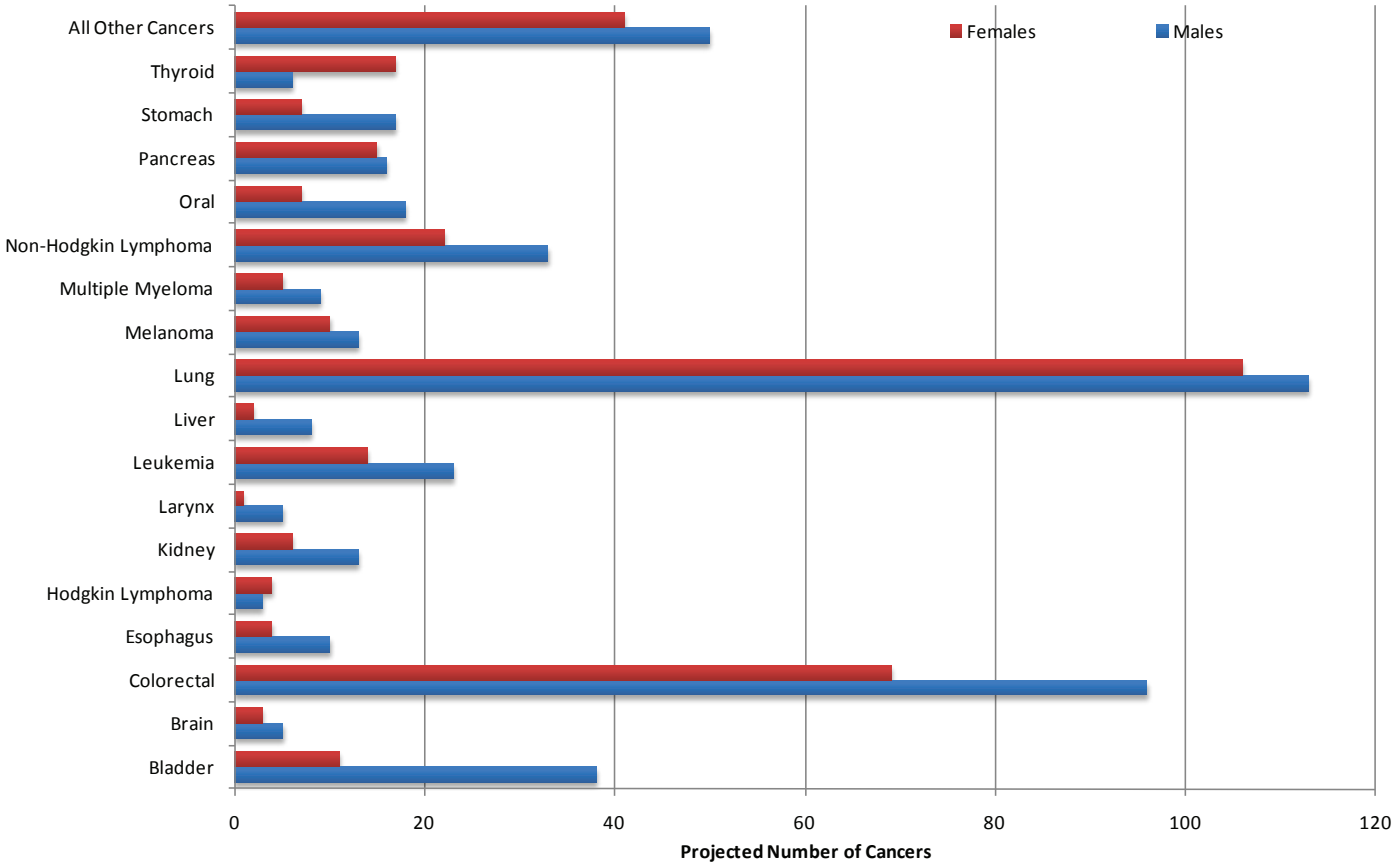
Note: Mortality rates are the Age Standardized Rates for Deaths per 100, 000 population

Death rates and causes, men and women, Northern Health 2009

MEN AND CANCER

The causes of most cancers are uncertain, in that they cannot be attributed to any single factor. But as a whole, lifestyle (tobacco, diet and exercise) appears to greatly influence individual risk. The primary factors affecting the number of cancer cases in a population are its size and age distribution. Most – but not all – cancers are more common among older people. For cancers that affect both men and women, the disease is usually more common among men.[20]

Estimated New Cancer Diagnoses: Northern BC, 2011 [21]



Evidence such as the relative number of roadside suspensions, alcohol and tobacco related hospitalizations, alcohol and tobacco related mortality, and levels of obesity, suggest strongly that life-style choices play a significant role in increasing the risk of cancer for northern men.[22 23 24 25 26 27]

In the graph above we have omitted cancers that are unique to either men or women. These cancers are summarized below.

Cancer Type	Males	Females	Total
Body of Uterus	0	27	27
Breast	0	166	166
Cervix	0	9	9
Prostate	204	0	204
Testis	7	0	7

PART 3
A STRONG START

Early Development Index

Youth at Risk

Foundation Skills Assessment: Grade 7 Students

"Boys Will Be Boys": Bullying

As Dr. Perry Kendall, Provincial Health Officer, points out in his recent report, An Ounce of Prevention,

"...the knowledge, attitudes and behaviours established in childhood ***and youth have significant implications, beneficial or otherwise,*** *for behaviours and circumstances in later adult life. These outcomes are experienced by individuals, by communities and by society at large."*

Research clearly demonstrates that the investment in prevention and health promotion has the best return when made in the early developmental years—before age five—and that personality, preferences and behaviours are largely established by the age of four. We need to pay attention to the environments our young boys are being raised in, to the skills of their parents and childcare providers and the supports they are provided, their exposure to abuse and violence, and the modelling of safety practices and substance use.

While all-day kindergarten and junior kindergarten are widely viewed as worthwhile investments in the future health and well-being of our youngsters, the evidence is mounting that our education system is failing to adequately engage and meet the developmental needs of our future men. A recent CBC report focused on this issue:

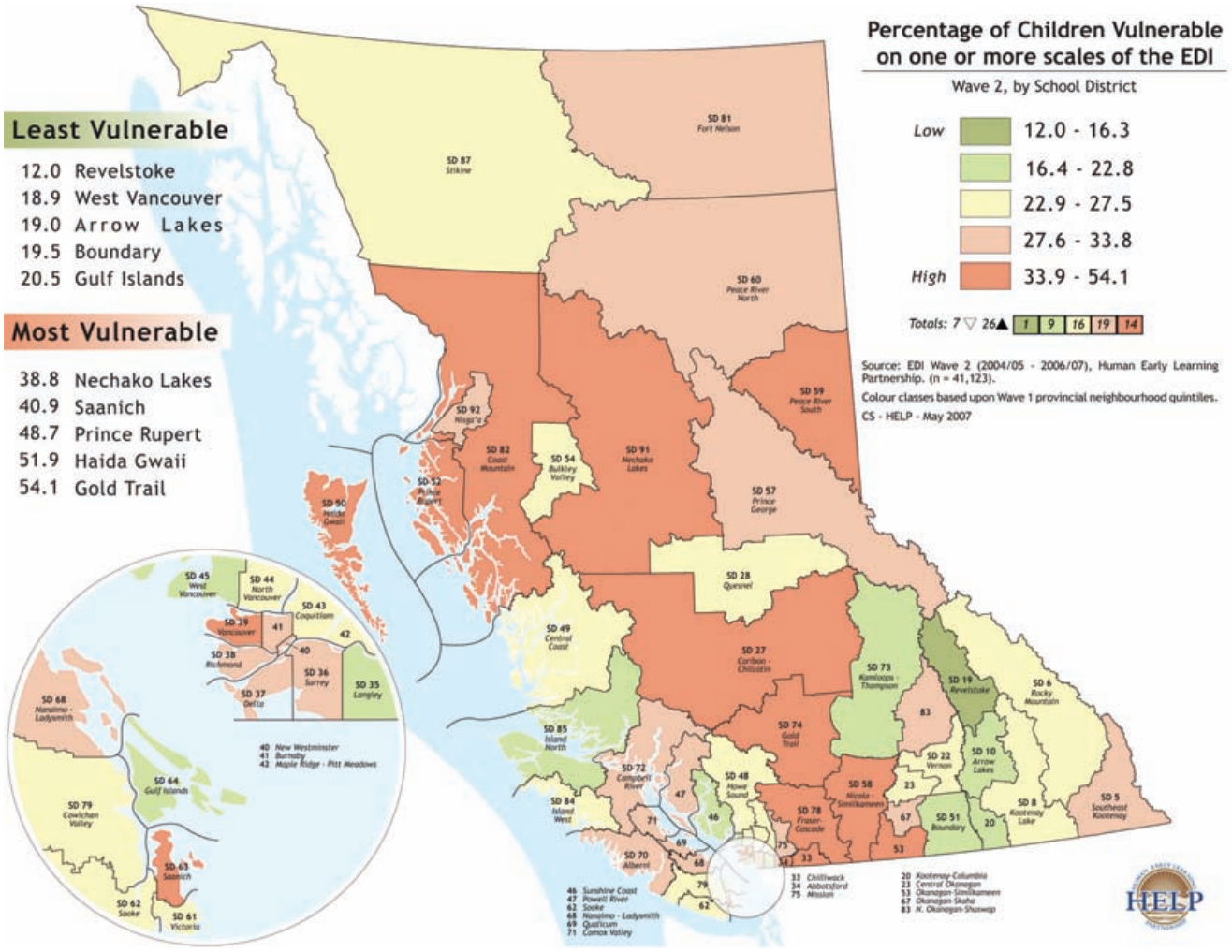
> *"Classrooms keep getting set up more and more around the verbal and less around the kinesthetic and active," says Michael Gurian author of Boys and Girls Learn Differently. "They are increasingly becoming environments that favour the girls' brain." And as enticing as the notion may be to some radical feminists, we simply cannot re-engineer the male brain. From a teacher's perspective, at least, boys and girls are simply different. As Gurian says, "You can't treat boys as defective, they are not defective, they are really good learners. But they are not going to learn well in the environments that we are putting in front of them." Apart from being hands-on learners, boys tend to have a preference for informational text as opposed to narrative, according to some research. In fiction, they like text that is funny and they like material with action and description. They also seem to like to solve problems. So why do we not treat this male brain as a springboard from which we can set the groundwork for a new generation of male scientists, engineers, teachers, journalists and businessmen, as a change from our current one-size-fits-all approach?*

Source: Robert Smol, Why Our Schools are Failing Boys. CBC News. Available at: http://www.cbc.ca/canada/story/2010/01/08/f-vp-smol.html

THE EARLY DEVELOPMENT INDEX

The early years of life play a crucial role far beyond childhood. Research shows that many challenges in adult life: mental health problems, obesity, heart disease, criminality, competence in literacy and numeracy, as well as billions of dollars in health care costs, have their roots in early childhood.[28] [29]

The Human Early Learning partnership (HELP) developed the Early Development Index (EDI) as a checklist that kindergarten teachers can complete for each child in their class.

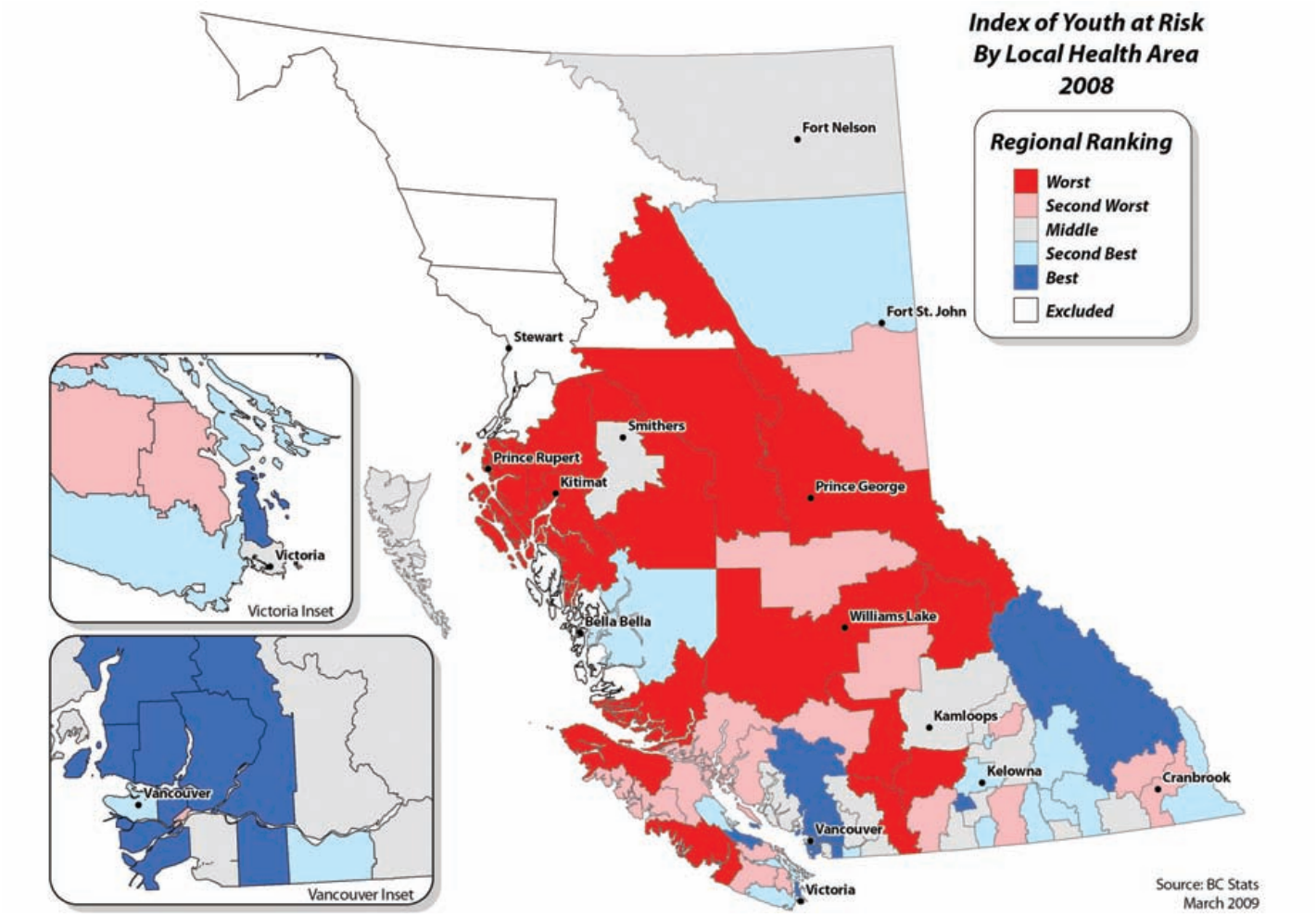


The EDI measures children's development / vulnerability along five scales:

- Physical health and well-being
- Emotional maturity
- Communication skills and general knowledge
- Social competence
- Language and cognitive development

Children, and for the purposes of this report, boys, in Prince Rupert, Haida Gwaii and Nechako Lakes School Districts are some of the most developmentally vulnerable in British Columbia. These school districts are shown as dark coloured areas on the above map.

For more Information on the EDI:
http://www.earlylearning.ubc.ca/research/initiatives/early-development-instrument/



The Youth at Risk Index shown above is composed of the following indicators:

- The percent of youth ages 19 – 24 on Income Assistance;
- The percent of 18 year olds who did not graduate from high-school;
- Serious criminal offences per 1,000 youth.

While this index is not sorted by sex, we know that boys in Northern BC have a lower school completion rate than girls, and that the vast majority of youth involved in the criminal justice system are boys.

For more information on the Youth at Risk Index:
http://www.bcstats.gov.bc.ca/data/sep/index.asp

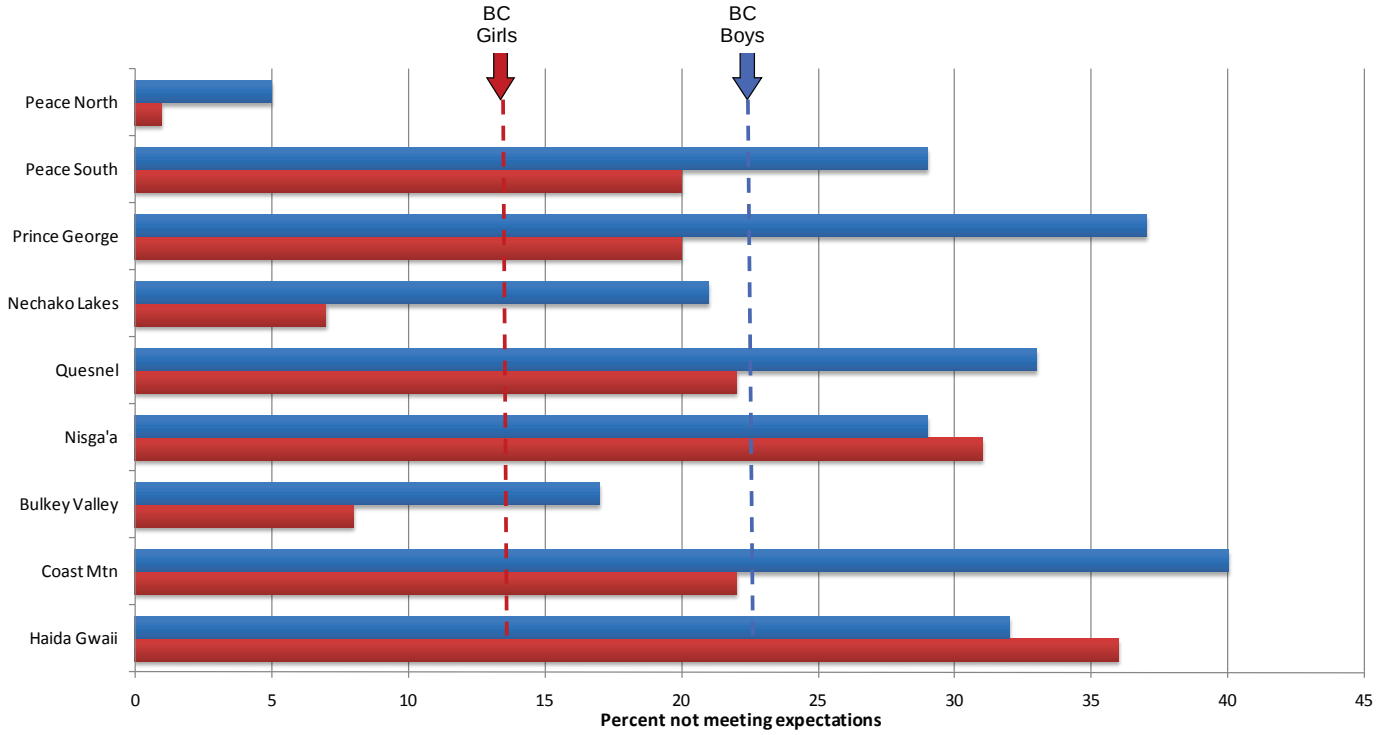
FOUNDATION SKILLS ASSESSMENT: GRADE 7 STUDENTS

The Foundation Skills Assessment (FSA) is a set of tests in reading, writing and numeracy. These are considered essential skills in the provincial curriculum. The FSA measures skills students have gained in several school years, not just in a single year.

FSA provides a "snapshot" of how well BC students are doing on foundation skills. It helps answer important questions such as: "Are students learning vital skills they will need later?"; "Is student achievement improving over time?"; "Are there any trends in student performance at the school, district or provincial levels?"; and "How are specific groups of students doing?". [31]

As the following data illustrate, these concerns hold true and are magnified in northern BC. If we hope to improve the health and wellbeing of our men in this region, we need to rethink our approach to raising and educating our boys.

Foundation Skills Assessment: Grade 7 Students: Writing Skills February 2010.[32]



The graph above summarizes the percentage of Grade 7 students, by northern BC school district and gender, who were **not** meeting the expected standard for writing skills at the grade 7 level. Also shown on this graph is the percentage of students in BC overall who are **not** meeting the standard. It is noteworthy that, on average in BC, about 10% more boys than girls fail to meet expectations and that, in many parts of the North, the situation is significantly worse.

Scores shown above are as of February 2010. The number of students engaged in the FSA varies across districts. The number of students whose performance level is unknown is generally between 5 - 15% except for two districts, where the proportion of students with unknown performance is between 25 % and 29% . Results for Fort Nelson have not been show due to small numbers.

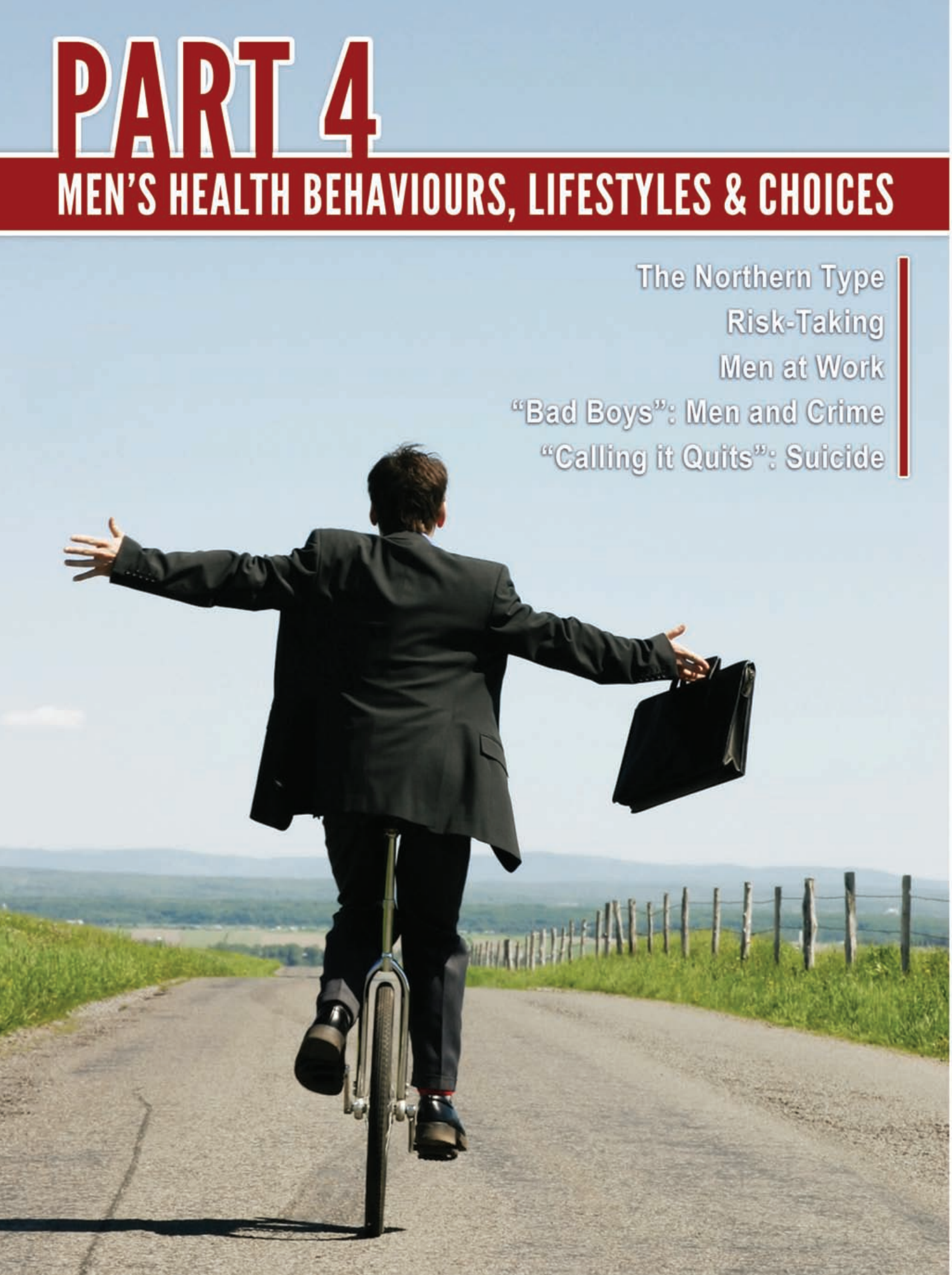
"BOYS WILL BE BOYS": BULLYING

A serious issue that impacts male development and occurs in schools, as well as in a variety of other settings, is bullying. Beyond the rough and tumble physicality of boys' interactive styles is a sinister culture of older, bigger, stronger boys targeting younger, less powerful peers, causing physical injury, humiliation and isolation. Research has shown that boys who bully are four times more likely than their non-bullying peers to be incarcerated by the age of 24, and we have been seeing increased media reporting of victims of bullying and the negative impacts, including youth suicide.

> *"When I was a young boy, the bully called me names, stole my bicycle, forced me off the playground. He made fun of me in front of other children, forced me to turn over my lunch money each day, threatened to* ***give me a black eye if I told adult authority figures.*** *At different times I was subject to a wide range of degradation and abuse -- de-pantsing, spit in my face, forced to eat the playground dirt....To this day, their handprints, like a slap on the face, remain stark and* ***defined on my soul."***
>
> ***Eric E. Rofes --***
> ***Making our Schools Safe for Sissies***

PART 4

MEN'S HEALTH BEHAVIOURS, LIFESTYLES & CHOICES



THE NORTHERN TYPE

While there is clearly no such thing as a "typical Northern man", there are characteristics of northern men as a group that set them apart from their southern counterparts. For example, per capita alcohol and tobacco consumption is higher in northern men, road traffic injuries, and per capita occupational deaths and injuries are higher in the North, and high school completion rates are lower. The choice to live and work in the North may, in itself, demonstrate a degree of tolerance for risk and a willingness to live on the edge. The proportion of men with Aboriginal ancestry is higher in Northern BC, and this also brings with it a unique set of issues. The story below is an extreme example, but illustrates that risk factors and circumstances for men in the North can align in ways that would be unlikely in more urban settings.

NHL player, Brian Spencer, grew up in Northern BC. His father, Roy, was a hopeless alcoholic, a stern man who instilled the attitude and drive that would serve Brian in the NHL. On the other hand, he also most likely taught him anger and a weakness for alcohol.

One of the proudest days of his father's life was when Brian was drafted. As it turned out, Roy was perhaps a bit too proud. Brian was drafted by the Toronto Maple Leafs in '69, and made the roster as a fulltime player for the '70-71 season. On December 12, 1970, the Leafs-Boston Bruins game was aired nationally on Hockey Night in Canada. Mr. Roy Spence however, was deprived of seeing his son play when the local CBC station decided to broadcast the Vancouver-Oakland Seals game instead.

Roy Spencer was displeased, to say the least. And, as he was drunk at the time, his decision-making skills were not at their highest. The irate Spencer drove 70 miles to the nearest CBC broadcast station in Prince George, British Columbia (that the nearest station was 70 miles away should give you a good idea of how remote Ft. St. James is). Once there, he entered the station with his shotgun and demanded that they air his son's hockey game.

The station actually complied with his order. However, the RCMP encountered Spencer and a shoot-out ensued. While Brian Spencer's Maple Leafs were defeating the Chicago Blackhawks halfway across the country, his father was shot dead by the police.

Excerpted from: http://sportsbybrooks.com/found-worlds-most-depressing-sports-life-story-28449; also recounted in the book, Gross Misconduct and a CBC movie by the same name.

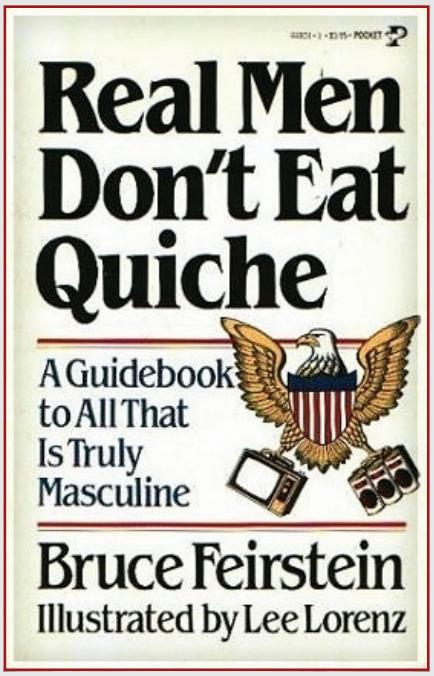


Image source: http://www.goodreads.com/book/show/968474.Real_Men_Don_t_Eat_Quiche

Real men don't eat quiche

Published in 1982 & on the New York Times best sellers list for 55 weeks, satirized the assumptions and expectations of masculinity.

Such negative stereotypes as "real men don't cook" keep men locked into unhealthy choices, such as eating burgers and fast foods that lead to increased risks for heart attack and stroke.

Societal expectations often mean some men order in fast food on the nights "mother" isn't home to cook, a fallacy reinforced by fast food commercials on television.

RISK-TAKING: A HALLMARK OF MALE CULTURE

Many injuries, hospitalizations and deaths are due to risk-taking behaviour, which is often romanticized and portrayed as “manly.” One example among the many we could highlight, is “high marking,” the practice of a rider taking a snowmobile to the highest point that can be reached on a mountain or hillside. High marking, combined with hazardous terrain and competitive instincts, has recently cost several lives in BC.

During one week in the spring of 2010, a 30 year old Calgary man was killed by an avalanche in Eagle Pass, just west of Revelstoke. This avalanche and death was followed by another avalanche in the same general area. The second slide, started by a high-marker, swept over 200 snowmobilers and left another 2 people dead. Both of these events occurred while both areas were under extreme avalanche warnings.

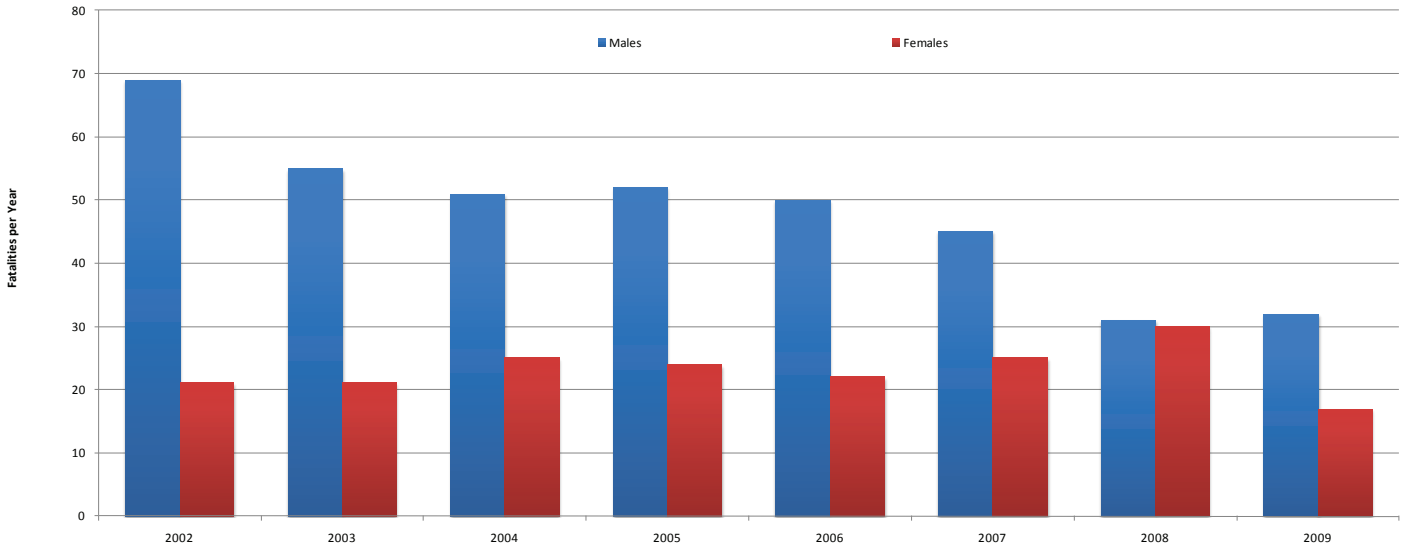
(See “Highmarking Addictive Thrill”, Vancouver Sun, March 2010.)

The choice to take such risks is not made in a vacuum, but within a specific male cultural context. Testosterone driven male behaviours, applied thoughtfully, are strengths and assets and are needed as such within society. However, media glorification and heedless encouragement to take these risks thoughtlessly puts men in peril.

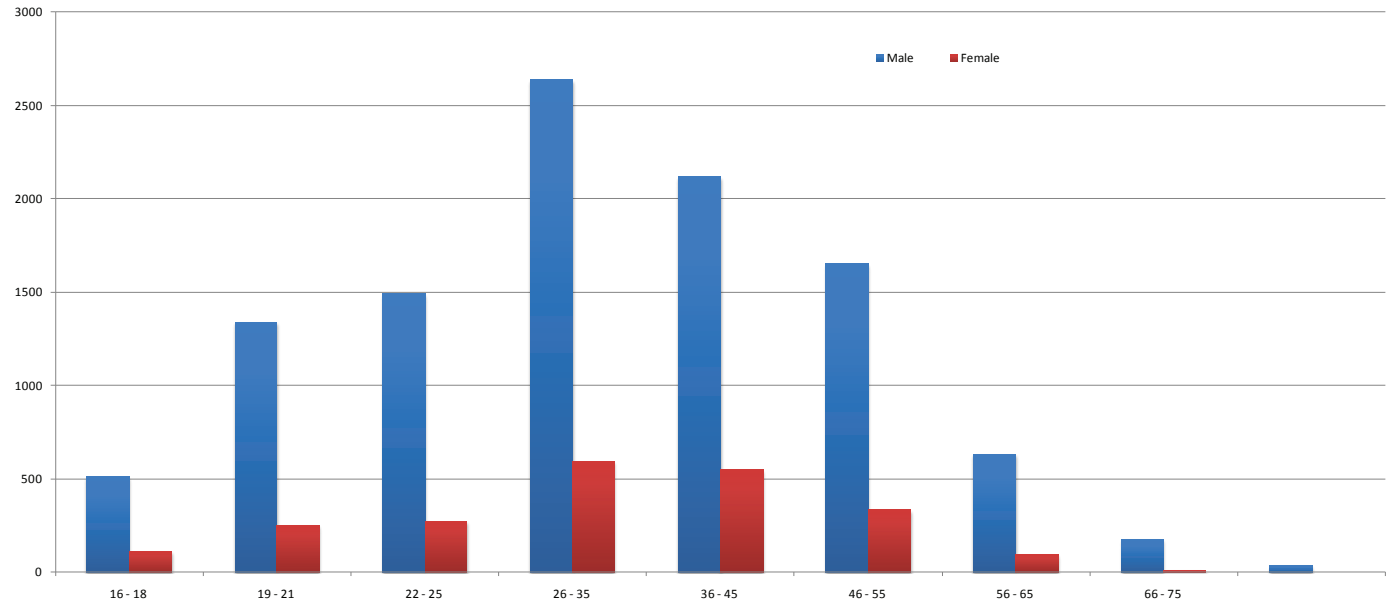
MOTOR VEHICLE FATALITIES / SUBSTANCE USE WHILE DRIVING

The RoadHealth Coalition was formed over 5 years ago in response to the need to reduce the deaths and injuries on our northern roads. The coalition that includes the RCMP, ICBC, WorkSafe BC, Ministry of Transportation, Northern Health, BC Coroners Service and others has been successful in reducing the number of deaths on northern BC roads. Interestingly, much of the RoadHealth work has been with men such as truckers who work on northern roads, and men have accounted for almost all of the reductions in mortality that have been associated with the initiative. This is encouraging with respect to the prospects for making a difference in men's health. However, the data shows that high risk behaviour, notably impaired driving, remains a problem for males in northern BC.

Annual Number of Motor Vehicle Fatalities in North Central BC: 2002 – 2009 [33]



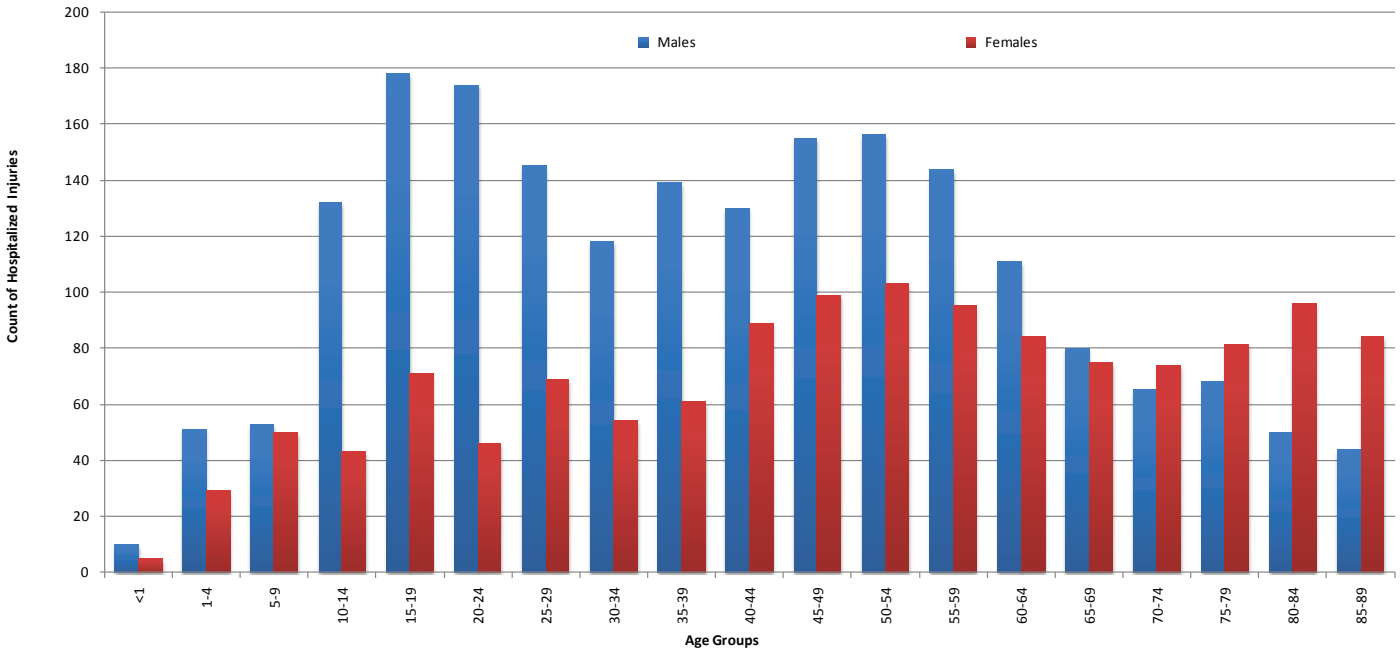
24 Hour Roadside Suspensions in North Central BC; 2002 – 2009 [34]



HOSPITALIZATIONS AND COSTS FOR INJURIES

The graph below shows that males comprise most of the injuries requiring hospitalization. Somewhere between 60 and 70 years of age, there is a shift and women begin taking the lead on hospitalized injuries as the men die off.

Count of Hospitalizations by Age Group and Sex: 2008 – 2009 [36]

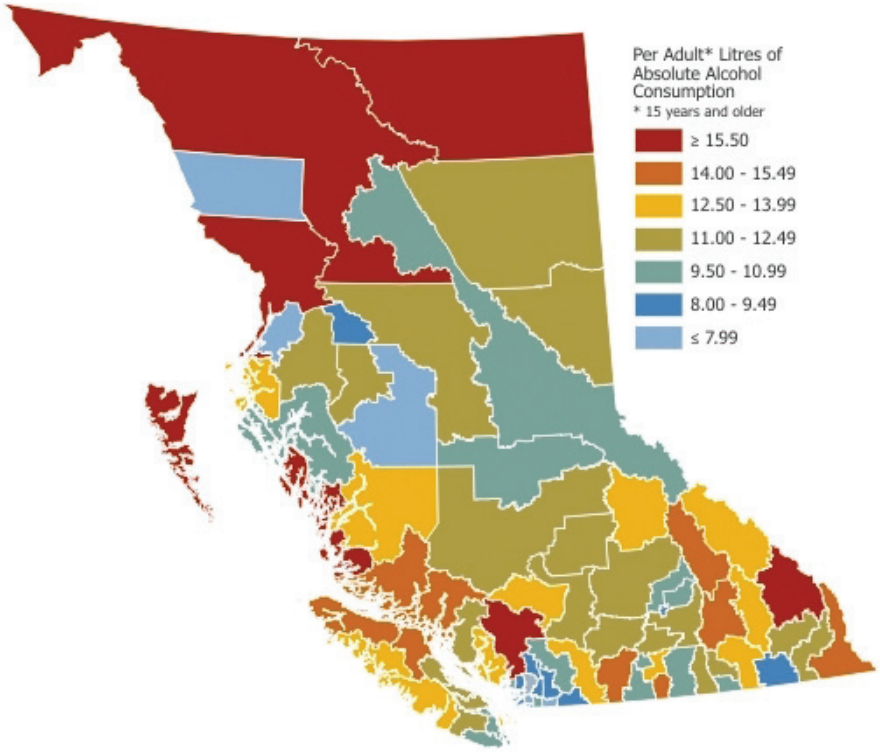


Age Group	Injuries		Hospital Days		Direct Care Costs for One Year (2008-09)[35]		
	M	F	M	F	Males	Females	Total
<1	10	5	42	18	91,881	14,244	106,125
1 - 4	51	29	43	36	97,196	85,961	183,158
5 - 9	53	50	114	45	196,130	130,760	326,889
10 - 14	132	43	144	40	305,047	86,395	391,442
15 - 19	178	71	797	170	1,207,772	258,078	1,465,850
20 - 24	174	46	442	84	676,854	140,052	816,906
25 - 29	145	69	561	161	678,930	267,454	946,384
30 - 34	118	54	342	145	504,960	220,727	725,686
35 - 39	139	61	380	180	643,011	248,386	890,387
40 - 44	130	89	324	223	482,308	282,750	765,058
45 - 49	155	99	589	1,074	806,439	882,117	1,688,556
50 - 54	156	103	566	549	749,088	690,767	1,439,854
55 - 59	144	95	791	385	895,951	437,726	1,333,677
60 - 64	111	84	472	501	507,411	437,487	944,898
65 - 69	80	75	758	610	695,879	552,603	1,248,482
70 - 74	65	74	704	933	645,264	779,478	1,424,743
75 - 79	68	81	784	829	717,912	669,079	1,386,991
80 - 84	50	96	972	1,102	793,990	851,9991	1,645,981
85 - 89	44	84	1,090	1,917	736,414	1,393,743	2,130,157
Total	**1,998**	**1,303**	**9,915**	**9,002**	**11,432,436**	**8,428,789**	**19,861,225**

ALCOHOL AS RECREATION

Rates for alcohol consumption in the North are higher than in the rest of the province, and alcohol related health conditions are most often found in men.[37] The map below shows alcohol use as litres of alcohol consumed per person in 2008.

Per adult absolute alcohol consumption in BC Local Health Areas in 2008



Source: Liquor Distribution Branch. Data analysed by the Centre for Addictions Research of BC for the BC AOD Monitoring Project. This data also includes U brew sources. CARBC, AOD Monitoring Project: http://carbc.ca/

According to Statistics Canada data, BC alcohol consumption has been increasing at a faster rate than the rest of Canada (by 16 per cent versus 9 per cent since 1998). The AOD has found that increased alcohol consumption is reflected in a 17 per cent increase in the rate of people hospitalized because of their drinking.

Rates of alcohol and tobacco consumption and related harms tend to be higher in the north and the interior of the province, though there are more individual cases of such harm in the lower mainland where the bulk of the population resides.

Centre for Addictions Research in BC, Dec 2009

Men are twice as likely to die from liver disease as women.

www.Aboutmen.ca

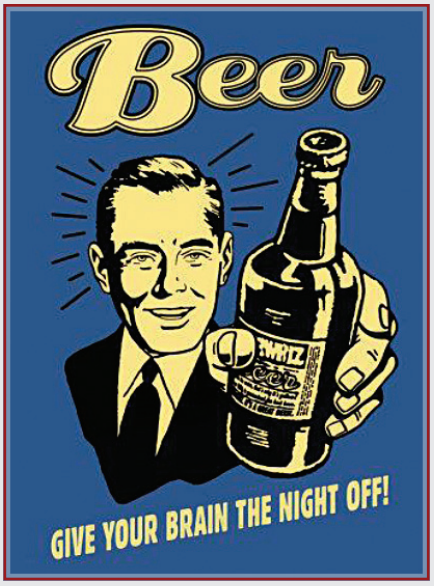
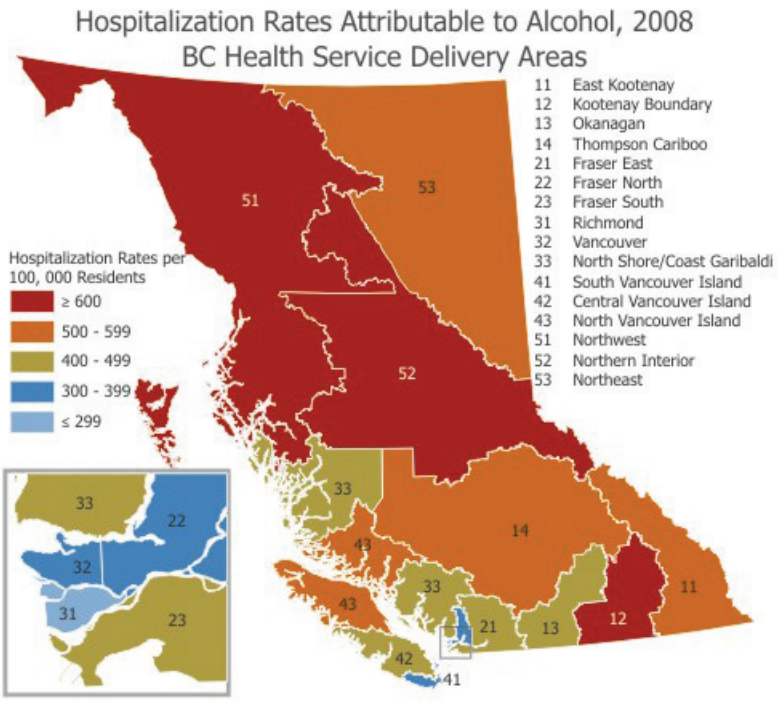


Image source: http://www.cool-chaser.com/graphics/510051

HOSPITALIZATIONS ATTRIBUTABLE TO ALCOHOL USE

During 2008, Northern residents had the highest rates of hospitalization in BC, for conditions related to the use of Alcohol (674.1 hospitalizations per 100,000 residents).[38]

As shown in the table below, there is a real difference between the two genders in terms of hospitalizations.



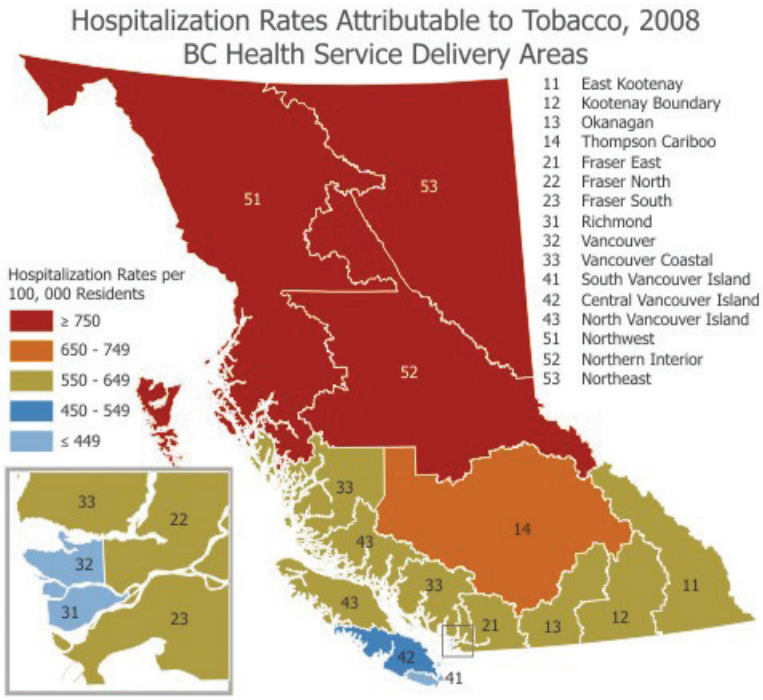
2008 Health Service Delivery Area	Alcohol Hospitalizations / 100,000 persons [39]		
	Males	Females	Average
(11) East Kootenay	636.8	402.2	519.5
(12) Kootenay Boundary	743.0	457.7	600.0
(13) Okanagan	616.6	340.8	477.6
(14) Thompson Cariboo	642.9	398.5	520.5
(21) Fraser East	646.5	308.4	475.7
(22) Fraser North	460.4	279.8	369.2
(23) Fraser South	530.2	287.2	406.5
(31) Richmond	358.6	208.5	282.2
(32) Vancouver	405.4	230.8	316.6
(33) North Shore/Coast Garibaldi	539.9	308.1	422.7
(41) South Vancouver Island	506.8	277.3	390.1
(42) Central Vancouver Island	581.6	350.0	464.6
(43) North Vancouver Island	689.6	364.7	524.0
(51) Northwest	1139.9	593.6	862.0
(52) Northern Interior	748.9	480.5	614.2
(53) Northeast	736.2	451.8	593.2
Northern BC Overall	848.9	502.6	674.1
British Columbia Overall	557.7	311.2	433.0

Source: Hospitalization Rates Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities 2002-2008 Per 100,000 Residents. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring Project: March 2010. Rates shown are age and sex standardized.

HOSPITALIZATIONS ATTRIBUTABLE TO TOBACCO USE

During 2008, Northern residents had the highest rates of hospitalization in BC for conditions related to the use of tobacco (791.1 hospitalizations per 100,000 residents).[40]

As shown in the table below, there is a real difference between the two genders in terms of hospitalizations.



2008 Health Service Delivery Area	Tobacco Hospitalizations / 100,000 persons [41]		
	Males	Females	Average
(11) East Kootenay	800.9	445.9	611.5
(12) Kootenay Boundary	782.1	494.6	634.2
(13) Okanagan	818.1	491.7	644.6
(14) Thompson Cariboo	831.2	533.5	675.2
(21) Fraser East	809.0	440.1	617.1
(22) Fraser North	703.7	418.8	554.0
(23) Fraser South	777.0	425.5	592.5
(31) Richmond	514.4	300.1	402.5
(32) Vancouver	580.8	309.4	437.8
(33) North Shore/Coast Garibaldi	658.7	362.7	504.7
(41) South Vancouver Island	546.4	308.2	420.5
(42) Central Vancouver Island	710.8	392.9	545.6
(43) North Vancouver Island	837.7	433.1	629.8
(51) Northwest	1067.1	603.2	833.0
(52) Northern Interior	896.2	646.7	767.6
(53) Northeast	879.7	698.6	795.3
Northern BC Overall	940.3	644.9	791.1
British Columbia Overall	720.9	411.9	559.1

Source: Hospitalization Rates Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities 2002-2008 Per 100,000 Residents. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring Project: March 2010. Rates shown are age and sex standardized.

DEATHS ATTRIBUTABLE TO ALCOHOL & TOBACCO IN NORTHERN BC

"Some of them will do stupid stuff and drink themselves to death, but hey, that's just how it goes. Not everyone gets to survive, you know. Just because one or two people kill themselves due to sheer stupidity doesn't mean we need to go making some kind of policy about it."

Comment posted to CBC "Binge Drinking a red flag "

http://www.cbc.ca/canada story/2008/11/19/f-student-drinking.html#ixzz0w9mOTI7O

Image source: http://farbror-sid.se/home/2009/03/camel-pleasure-to-burn/

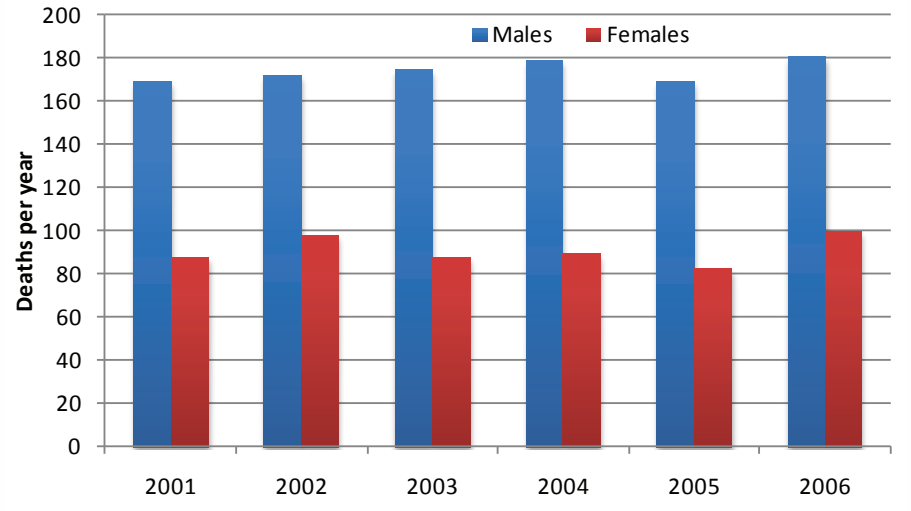
In spite of a decreasing trend, northern BC residents had the highest rate of alcohol-related deaths in BC and the highest mortality due to alcohol-related mental illness.

Deaths attributable to Alcohol by Year and Sex [42]

Males	53	60	53	55	51	49
Females	24	16	19	20	13	18

Northern BC residents continue to have the highest tobacco related mortality rates and the largest proportion of cancers related to tobacco use for all BC health areas.

Deaths attributable to Tobacco by Year and Sex [43]

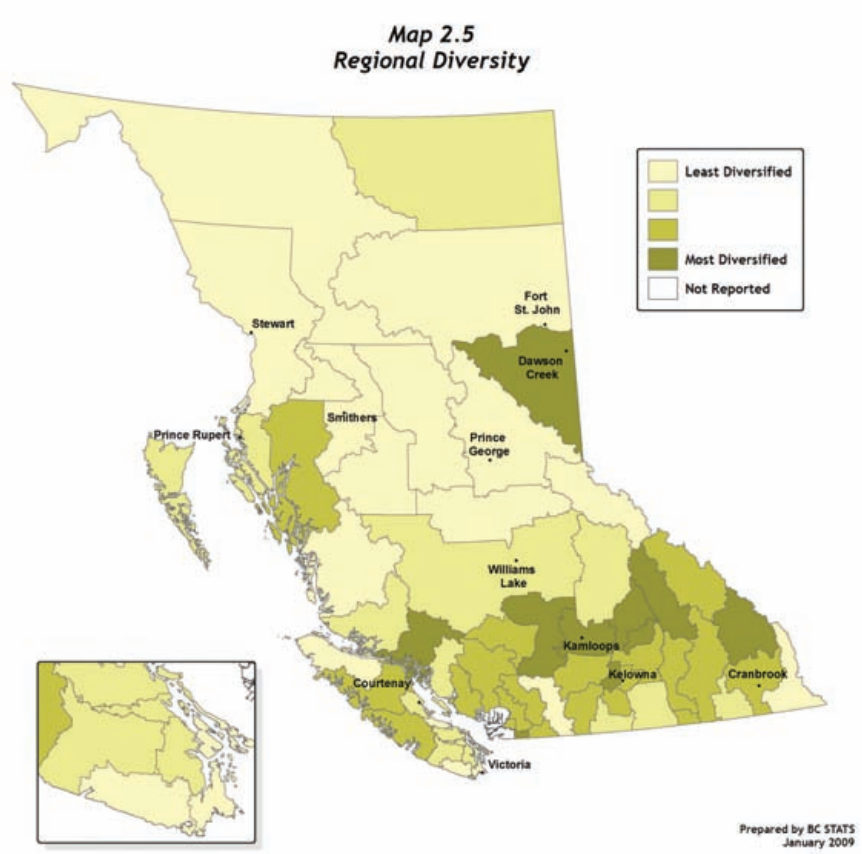


Males	169	172	175	179	169	181
Females	88	98	88	89	82	100

The employment and economic opportunities that exist for men and their families in northern BC have been greatly determined by the relative prosperity (boom or bust) of the resources sector. While resource sector jobs provide good benefits when things are "booming," many northern communities have experienced the downside or "bust."

In this context, most analysts believe that greater local economic diversity can increase the capacity of northern communities to weather economic downturns.

In 2009, BC Stats published a series of analyses that looked at the economic diversity and industry dependencies of rural areas in BC. The analysis showed that one of the most diversified local economies, and many of the least diversified ones, are in northern BC. In the table below: the higher the index value, the greater the economic diversity; the lower the index value, the smaller the local area economic diversity.



Source: British Columbia Local Area Economic Dependencies 2006. BC Stats: 2009.

Most Diversified Economies [44]	Diversity	Least Diversified Economies	Diversity
Invermere	79	Vanderhoof	59
Ashcroft	77	Fernie	59
Dawson Creek	76	Hazelton	57
Bute Inlet	75	Quesnel	56
Peachland	75	Stikine	54
Spallumcheen	75	Central Coast	52
Salmon Arm	75	Stewart	51

Our natural environment and the activities related to resource extraction are an integral part of the fabric of northern communities. The dominant income sources in most communities reflect this connection. In the Northeast, there are thriving oil, gas and coal industries, and a well developed agricultural base. In the Northern Interior and Northwest there is a recovering forest sector, as well as several operating mines and several more in various stages of development.

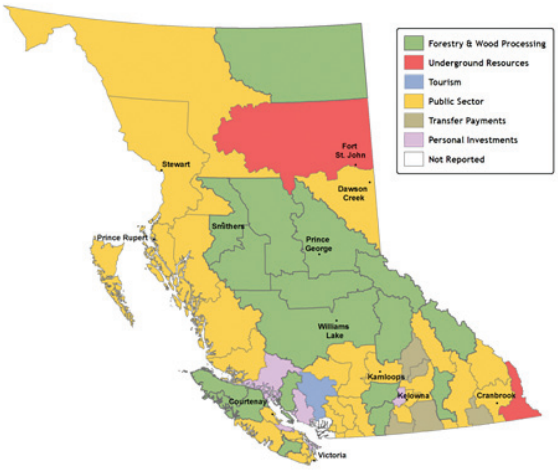
Photo Source: http://sun.men-loschool.org/~sportman/ethics/project/topics/heimbuck/

From 2005 to 2010, there were 83 accidental workplace deaths in the Northern region. These deaths account for 21.3% of all the work-place fatalities in BC despite this region having only just under 7% of the BC population.

Males accounted for 81 / 83 deaths or 97.6% of these deaths. The average age of the decedents was 46.6 years.

Workers in forestry, mining and the commercial transport sectors were responsible for 54 / 83 deaths or about 65% of the total.

Source: Northern Region: Accidental Workplace Deaths 2005 – 2010 YTD. BC Coroners Service; Ministry of Public Safety and Solictor General. Special request for Northern Health . November 16, 2010.



Life in Northern B.C. is resource based and steady work can be boom and bust. As a result, the type of lifestyle is hectic. Men make up a high percentage of the workforce and are most exposed to long work hours, few vacations, and stresses from living apart from their families for long periods of time, poor diets, financial stresses and the likelihood of substance abuse. This is a deadly mix that will inevitably lead to health issues over time for the men and their families. This hectic lifestyle results in men ignoring health issues and avoiding regular medical check-ups.

I have seen lots of guys who have suffered from illnesses that could have been prevented. But if they don't work, they don't get paid. They don't have the kind of jobs where they still get paid if off sick, or they aren't working for a company with extended health benefits. When you work for the government you have extended benefits, but many companies up here do not. So, the guys put things off because they are working while they can.

The insecurity is you have to work while you have it. Stress is a big thing too. I've heard so many stories because of this workload/job insecurity issue. Families split up, and the problems go on and on. They live through it and say it won't happen again, and it does.

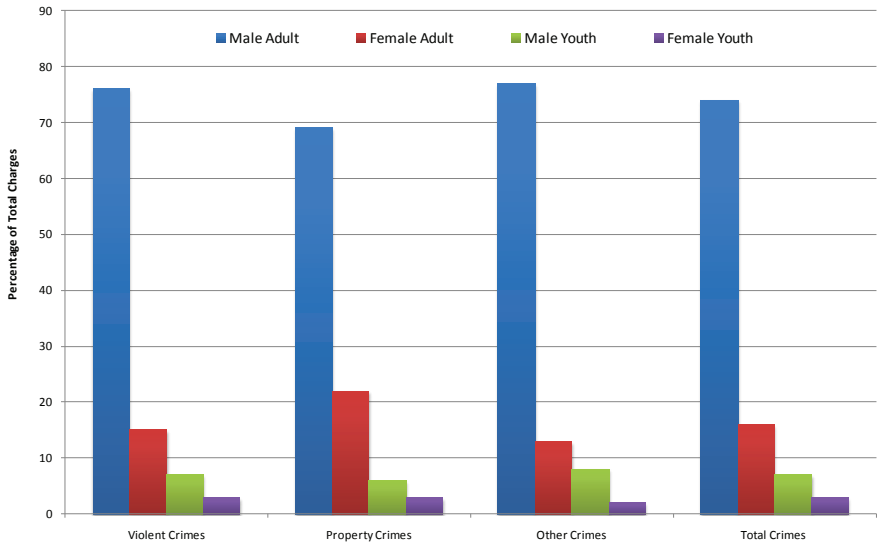
There is no job security to speak of; you have to fend for yourself. You can be working only six months and then off for six months. Some companies have pension plans; most do not. Workers may have their own contributions. There could be some, could be none. I have lived through some of this and have learned from it.

When I focus on my health I do really well. When I choose not to, I have a poor record.

Key Informant Interview #1, August 010

2008 Profile of Crime in BC

Persons Charged as Percentage of Total Persons charged [45]

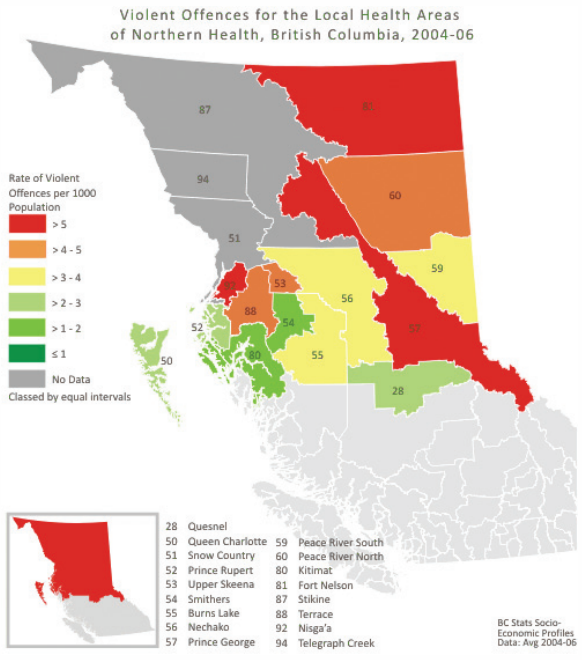


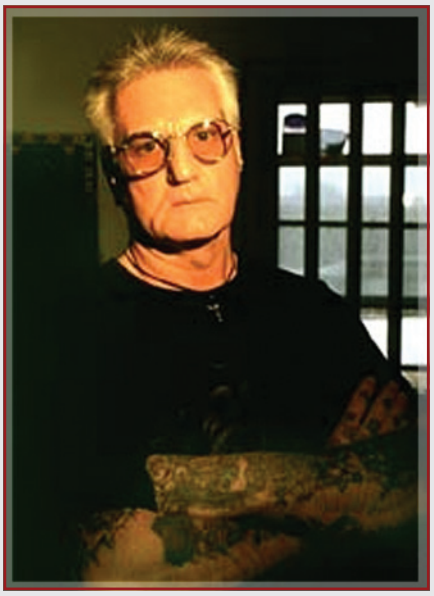
In 2004 in Canada, approximately 83% (43,459) of the 52,526 adults charged with an offence and 76% (5,112) of the 7,703 youths charged were male. This male domination of crime statistics has remained constant over the last decade.

(See: Men and Crime: British Columbia Crime Trends 1999 – 2008. Ministry of Public Safety and Solicitor General 2009).

The rates of violent crime in some parts of northern BC are much higher than those of the province, with the exception of areas in and around Vancouver within the Vancouver Coastal Health catchment and New Westminster in the Fraser Health area

(From: Alcohol and Other drug use in BC. Centre for Addictions Research, University of Victoria).





Inmate Jim Elder, 64, poses for a photo in his cell Monday, March 12 2001. Elder has "been in the system" since 1952.
photo © Phill Snel/Maclean's

Source: CBC Inside Canada's Prisons http://www.cbc.ca/news/interactive/prisons/index.html

"You get sent to jail and it builds your resentments. You become a master criminal; learn to swear better, you come out stronger and meaner. But at the same time, jail can save your life.

Jail saved my life. My mother and wife died in the same 6 month period while I was in jail. The grief and loss were huge. Jail was the life saver.

You become a little child. Are you going to let it happen? I was the toughest guy around, but after that, I never raised a hand again."

Focus group #1,
Warrior Caregivers
Story Telling Circle, August 11, 2010

"CALLING IT QUITS": MEN AND SUICIDE

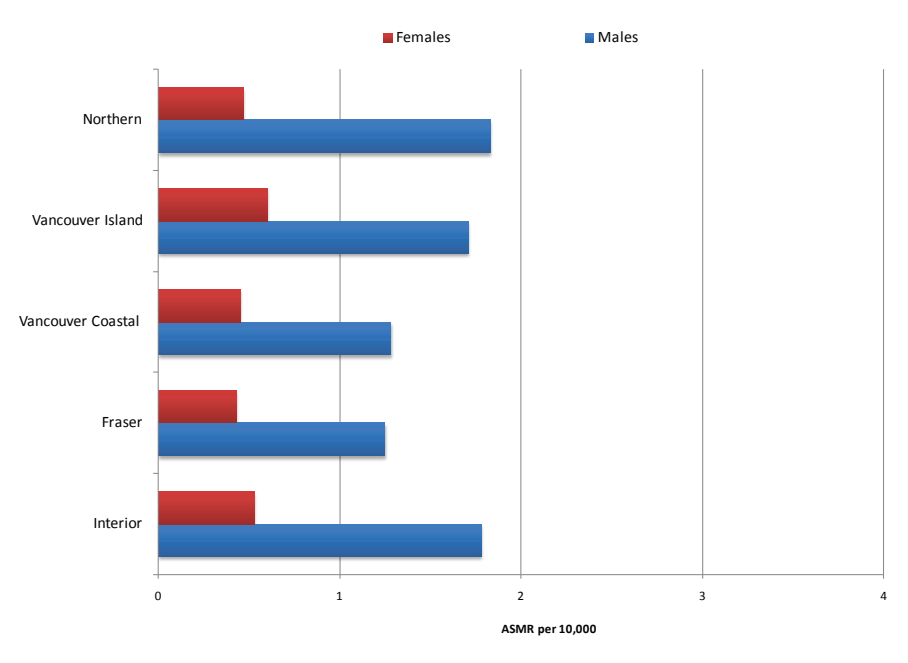
"But as men we are trained, told we can't cry, can't show emotions, we have to be invincible, in control of situations. This is what has been made of us – modern day barbarians. [We are] Supposed to handle everything, job, self, and everything. Until our emotions get the best of us and we have outbursts."

Focus group #1, August 11, 2010.

Men kill themselves in far greater numbers than women. In Canada, the male to female ratio for suicide is 4 to 1.

The table below shows male versus female suicide rates for all the health authority regions in BC.

Age Standardized Mortality Rates - Suicide: 2003 - 2007



"When they take you into jail, the first thing they ask you is "have you any thoughts of killing yourself?" and the answer is "hell yeah." You think about different ways of doing it. What is the point of it all?"

Focus group #2, August 18th, 2010.

Gender paradoxes of public health: Men approach and consume medical services asking for help only half as often as females do – but die five (European Union) to 15 (Russian Federation) years earlier [9]. We also know that today between 70–90% of all suicides are committed while in a clinical condition of major depression and a consecutive depressive distortion of emotional and cognitive perception [15– 17]. Unexpectedly and paradoxically, however, men commit suicide 3–10 times more often than women [16,18–20] – despite being only half or even less frequently diagnosed as depressive as women [21,22]. Furthermore, suicide attempts are much more frequent in females. Using more violent/lethal methods, however, males are markedly over represented among suicide victims [16, 18–20, 23]. The probable reason for this is the non-detection of male depressive conditions – and it is recognised that suicides caused by clinical depression are generally more decisive and violent [24].

A gender-specific scientific challenge: Men's shortcomings in male help-seeking behaviour, as well as their lack of compliance and strength to show weakness in good time, may lie behind the fact that, in research, different types of 'suicidal behaviour' can be attributed to gender-specific and demographically different groups. Thus, we have one population that completes suicides or commits aggressive, decisive suicidal attempts (that may often be failed suicides) and consists predominantly of males, while the other population commits repetitive, multiple and less intentional acts of self harm and consists predominantly of females [16, 18, 19]. In this latter group, many suicide attempts have the character of a 'cry for help' and, as such, must often be considered to be suicide prevention measures [61]. This makes it scientifically questionable to cluster together completed suicides and multiple suicide attempts into a category of 'suicidal' or 'self-harming' behaviour. That is, however, often done today in investigations into risk factors in order to gain statistical power in research settings where completed suicides are statistically events too rare to draw significant conclusions from.

From: Wolfgang Rutz, Zoltan Rihmer, Suicidality in men - practical issues, challenges, solutions, The Journal of Men's Health & Gender, Volume 4, Issue 4, December 2007, Pages 393-401, ISSN 1571-8913, DOI: 10.1016/j.jmhg.2007.07.046.

http://www.sciencedirect.com/science/article/B7GW7-4R8KT7H-8/2/ad2686bd12ff8e124be95439cb7a9230

The foregoing review of the data and the corroborating input from men reflecting on their own experiences in the North makes it clear that the state of men's health in northern BC is far from ideal. Part 6 discusses promising practices underway in other jurisdictions and a selection of strategic activities that could make a difference.

PART 5

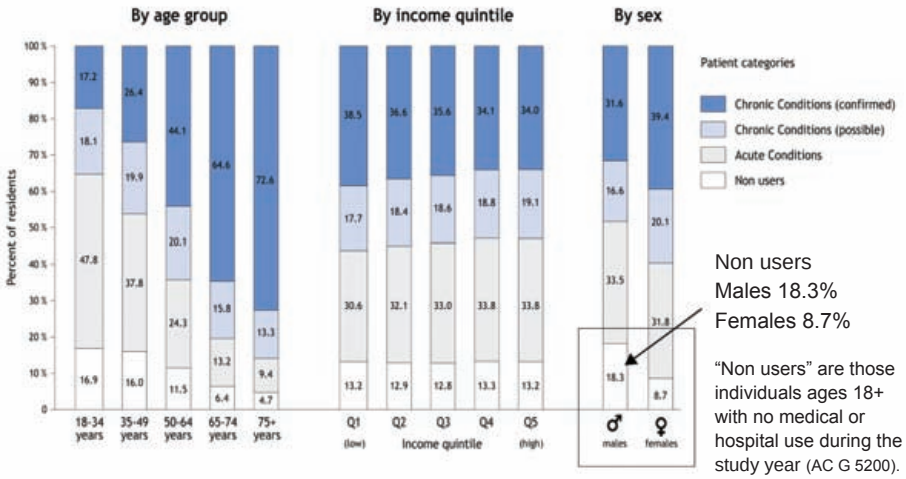
WHERE ARE THE MEN?

Non-users of Health Services
High Impact – High Prevalence
Persons in Residential Care
Sex and Gender in Health Services Research

NON-USERS OF HEALTH SERVICES

In 2005, the BC Centre for Health Services and Policy Research published "Chronic Conditions and Co-morbidity, Among Residents of British Columbia".[46] The focus of this report was co-morbidities, but it also briefly looked at non-users of health services.

"Non-users" were defined as those individuals ages 18 + who had no medical or hospital use during the study year. The graphic below indicates that twice as many men as women are non users of health services.



Adapted from Table A.1 Chronic Conditions and Co-morbidity Among Residents of British Columbia: CHSPR: 2005.

There are serious concerns that men die unnecessarily because of undiagnosed and untreated prostate and other cancers. Sexual abuse is an under estimated reason for men not going to their doctors for medical exams.

Participant at NE Aboriginal Health Improvement Committee meeting, November 2010.

Men are less trusting than women. When a mechanic tells a man he needs a new engine, most men will assume the mechanic is wrong and check the engine themselves or get another opinion.Why would a man go to a doctor for health advice, when most doctors will just say "maybe we could try these pills for a few weeks and see if you feel any better". A mechanic who was that uncertain would be out of business in a week.

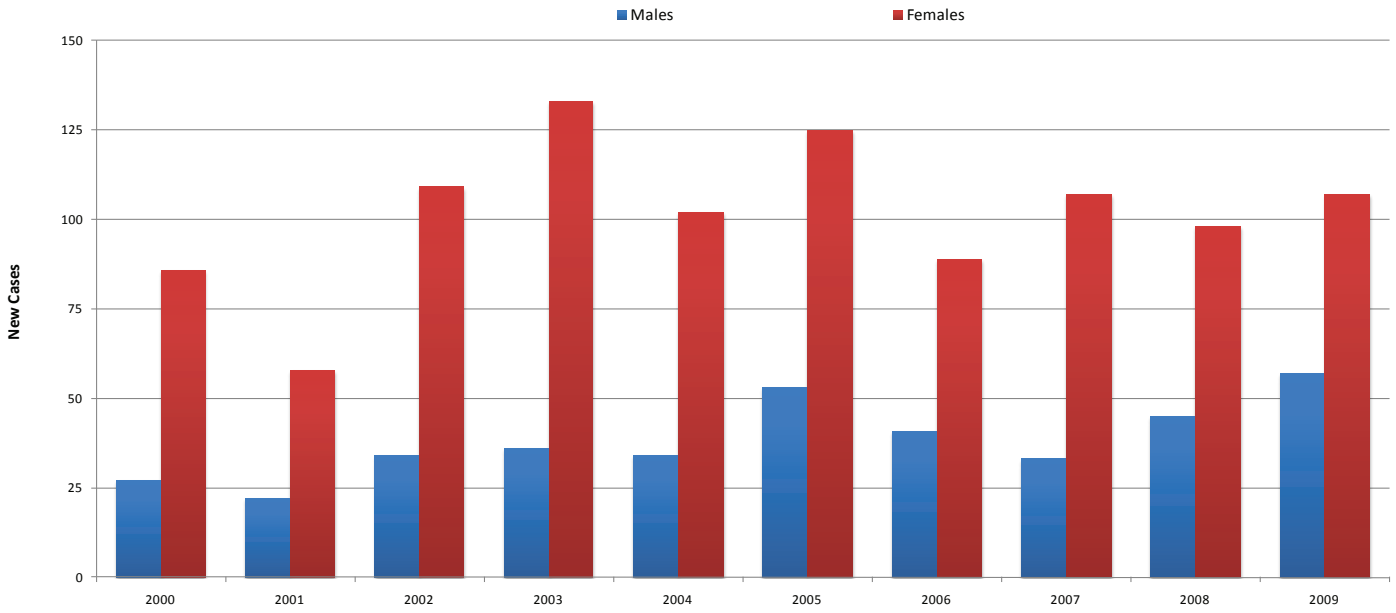
From discussion at a men's breakfast meeting in Prince George

NON-USERS OF REPRODUCTIVE HEALTH SERVICES

Most of the reproductive health research and service-delivery focus has been framed by women's reproductive needs. Moreover, women have been expected to be responsible for related issues such as contraception, birth and childcare. Men have been relative onlookers. This lack of balance in reproductive services and roles does a disservice to both sexes.

For example, Chlamydia, one of the most common sexually transmitted infections (STI) is caused by the bacterium Chlamydia trachomatis. This STI can be spread from one partner to another during vaginal, anal, or possibly oral sex. An untreated infection can lead to complications that make it difficult or impossible for a woman to become pregnant. While either partner is likely to be infected, it is most often the woman who is tested and treated, as shown below.[47] [48]

Newly Positive Tests for Chlamydia Infection in Northern BC by Sex: 2000 – 2009 [49]



"Reproductive health generally has been synonymous with women's health. Clinical training in reproductive health typically has been provided through the specialties of obstetrics and gynaecology.

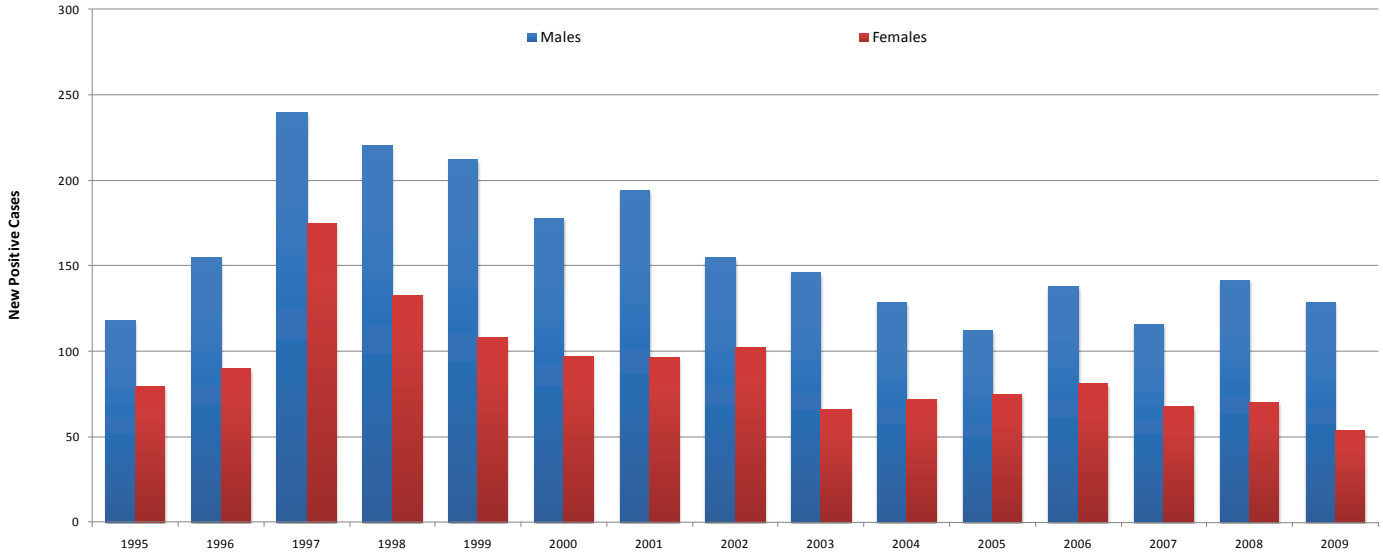
For men, however, there is no comparable clinical practice that addresses their unique reproductive health needs. Moreover, while there are many maternal and child health and women's health centers in both the public and private sectors, there are no equivalents that target men's needs. Indeed, services for men typically are housed in settings where staff lack training in male sexuality and sexual health, where providers' assumptions about men's interest in reproductive health may cause them discomfort and where the environment itself, from the decor to the posters, literature and brochures, may not reflect men's interests or needs."

From Isaiah Ndong, et al. Men's Reproductive Health: Defining, Designing and Delivering Services Family Planning Perspectives, Volume 25, Supplement, January 1999

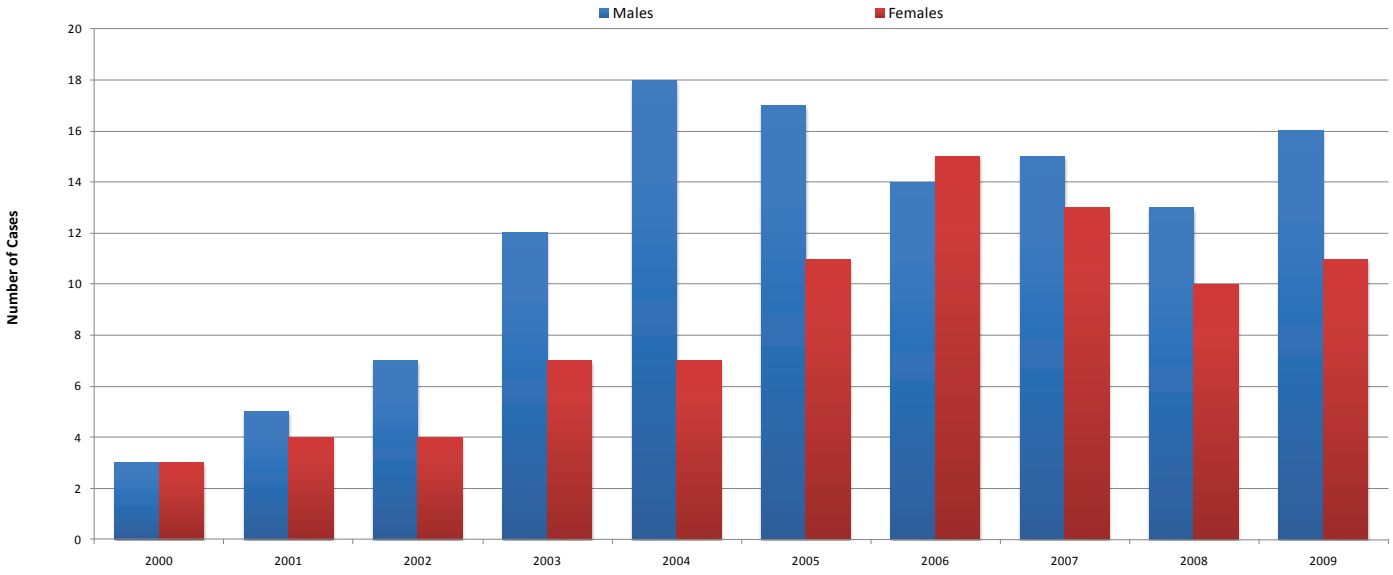
Hepatitis C (HCV) is often seen as the canary in the coal mine of HIV infection, because the principal risk factors for both HCV and HIV are similar. The most common risk factors are injection drug use (IDU) and sexual contact with an injecting drug user.[50] [51]

HCV/HIV are 100% preventable. Men represent 2/3rds of new cases. Given that infected men are potential sources of transmission to others including their female contacts, finding ways to ensure that men access both preventive and treatment services is especially important.

New Positive Tests for Hepatitis C in Northern BC by Sex: 1995 - 2009 [52]



New Positive Tests for HIV in Northern BC by Sex: 1995 - 2009 [53]

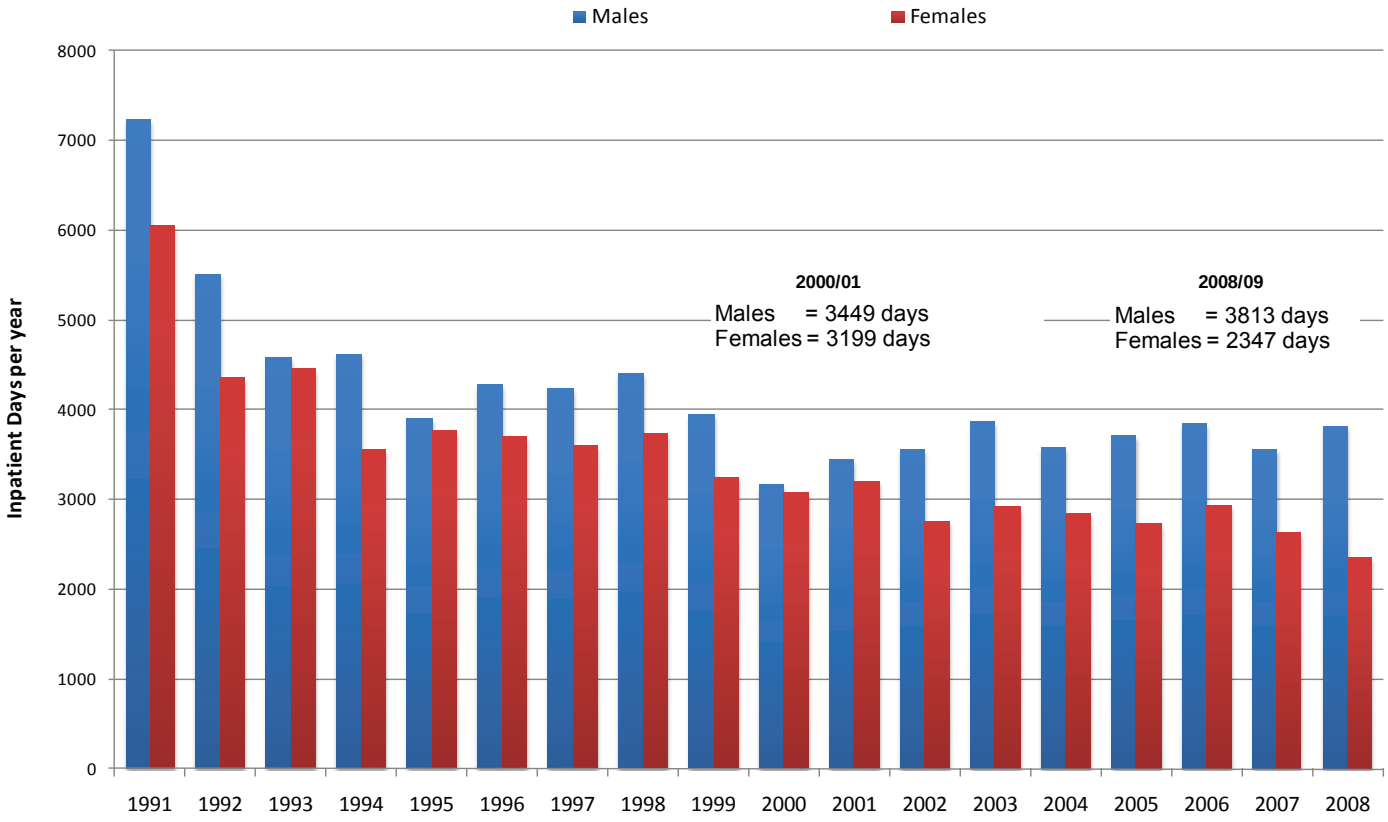


NON-USERS OF HEALTH SERVICES - PREVENTABLE ADMISSIONS

Preventable Admissions, also known as admissions for Ambulatory Care Sensitive Conditions (ACSC) are conditions where hospital admission is usually not needed if patients have timely access to appropriate services and are well managed in the community.

The graph below shows the number of hospital days attributable to ACSC. There has been a general decrease in ACSC over time. However, the gap between the genders has widened. The table at the bottom of the page shows where the gaps exist.[54]

Preventable Admissions in Northern BC: 1991 - 2008 [55]



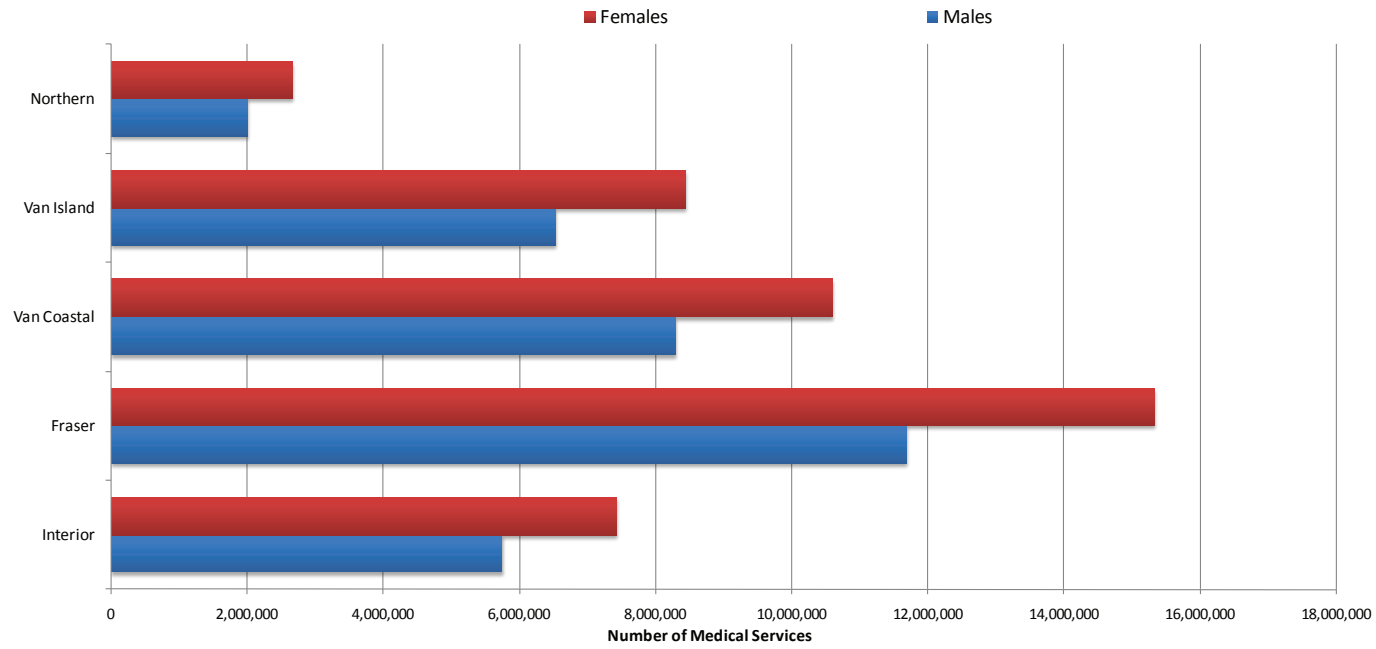
Summary of ACSC: Hospital days by Gender for 2008-09 [56]

Condition Description	Hospital (Inpatient) Cases		Hospital (Inpatient) Days	
	Male	Female	Male	Female
Grand mal seizures	104	52	210	156
COPD	201	157	1,303	1,086
Asthma	49	68	114	198
Heart Failure	122	48	839	219
Hypertension	23	23	179	52
Angina	163	73	627	250
Diabetes	129	127	541	386
Total ACSC	791	548	3,813	2,347

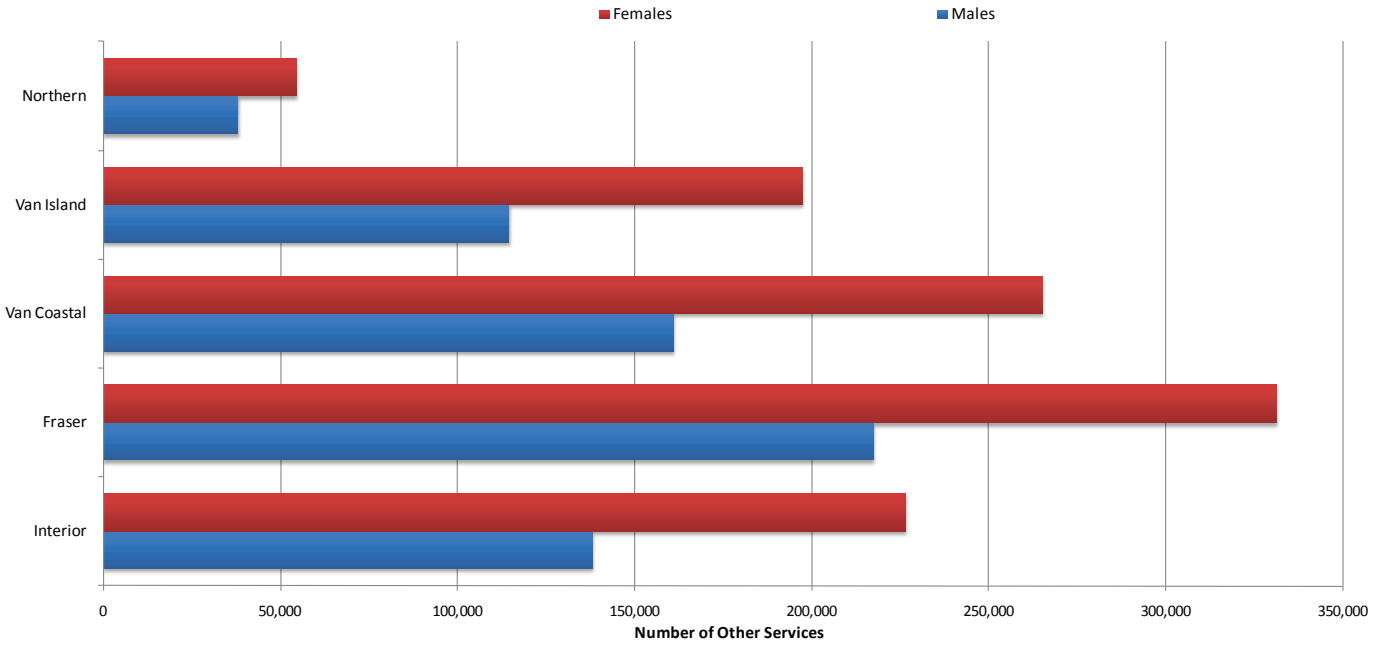
NON-USERS OF HEALTH SERVICES - FEE FOR SERVICE

The BC Ministry of Health's fee-for-service billing information shows that during 2008-2009 men used fewer medical and other practitioner services than women. Other practitioners include: Chiropractors, Naturopaths, Physical-therapists, Osteopaths, Oral Surgeons, Podiatrists, Optometrists, Dental Surgeons, Oral Medicine, Orthodontists, Massage Practitioners, Acupuncture and Midwives.[57]

Medical Services by Gender and Health Area: 2008 -2009 [58]



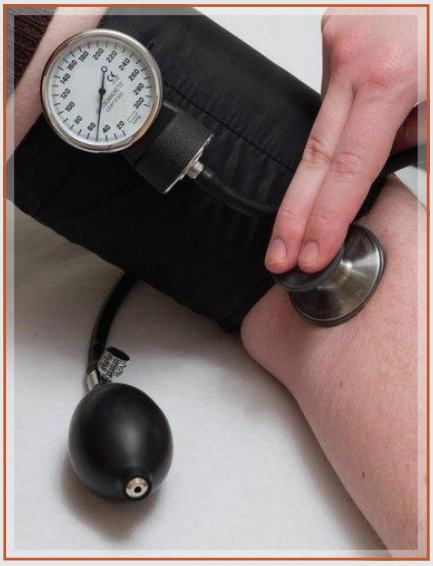
Other practitioner services by Gender and Health Area: 2008 -2009 [59]

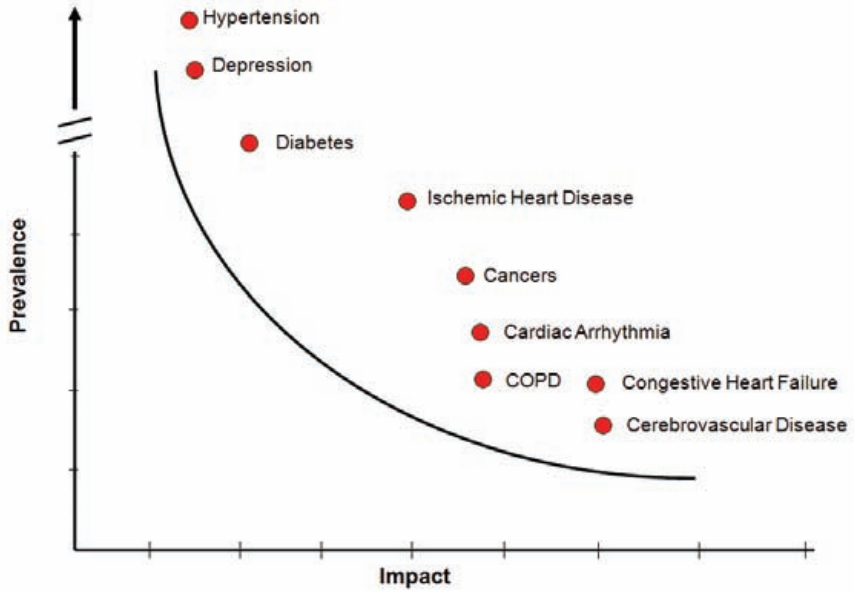


HIGH IMPACT / HIGH PREVALENCE CONDITIONS

In 2005 the Centre for Health Services and Policy Research published "Chronic Conditions and Co-morbidity Among Residents of British Columbia." [60]

The impact of chronic conditions and co-morbidity on both expected and actual utilization of health care services was explored. Chronic conditions were classified according to both prevalence and impact, since both prevalence and the expected impact of a chronic condition contribute to overall health services utilization.[61]





Source: Adapted from Figure 4: Chronic Conditions and Co-morbidity among residents of British Columbia. CHSPR 2005

Prevalence was estimated using treatment prevalence rates in the study population.

Impact was based on expected short-term resource use and outcomes as estimated, using Adjusted Clinical Groups (ACGs) and cost weights from previous research.

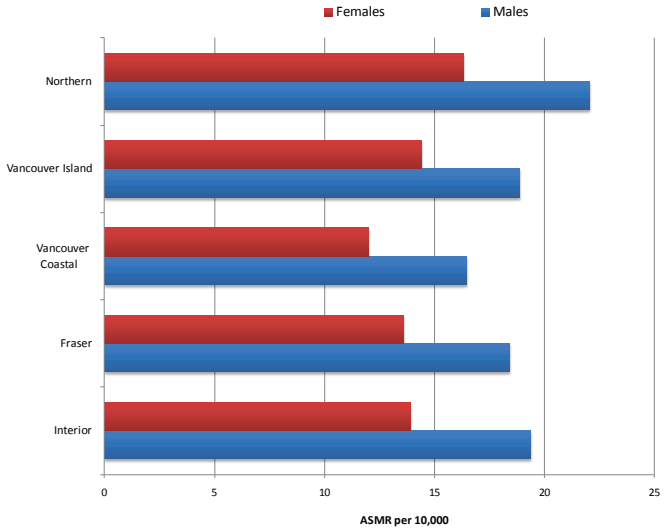
When looking at the mortality data for almost every one of the high impact / high prevalence conditions shown above it is clear that men have poor health outcomes as evidenced by their increased risk of dying from each of these conditions.

HIGH IMPACT / HIGH PREVALENCE CONDITIONS - MORTALITIES

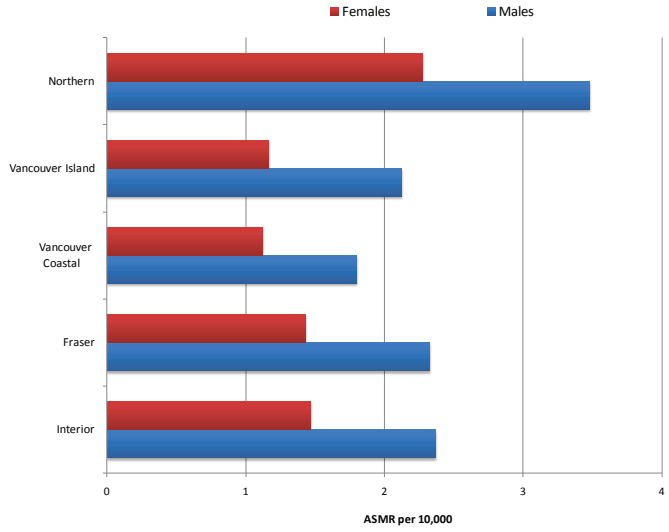
On this page, is a summary of the sex specific mortality rates for 4 of these identified conditions.

The graphs below show the Age Standardized Mortality Rate (ASMR) according to Health Authority and gender for the 5 year period 2003 – 2007. [62] This indicator essentially quantifies the relative risk of death from a particular condition. For cancers, diabetes and ischemic heart disease, men are at significantly greater risk than women.

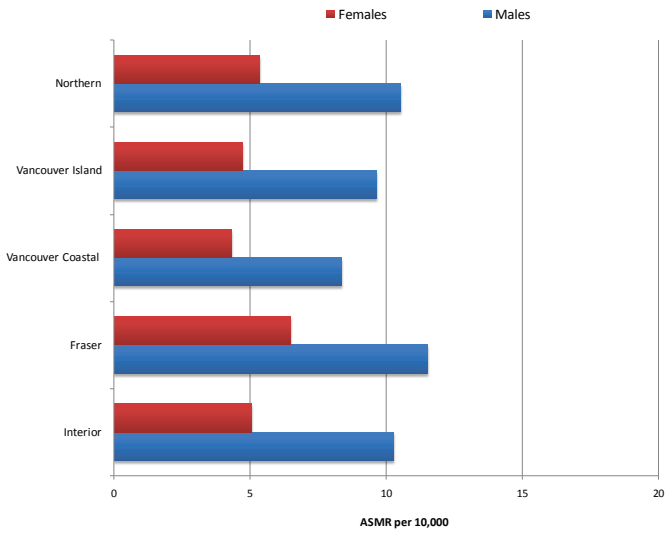
ASMR - All Cancers: 2003 - 2007



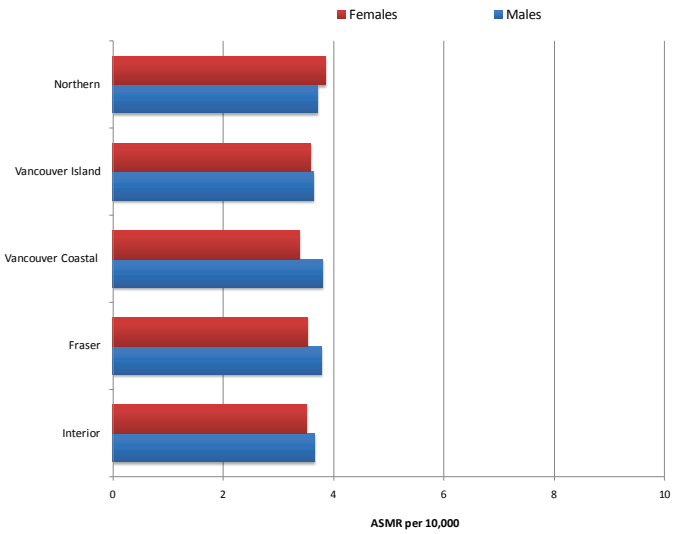
ASMR - Diabetes Mellitus: 2003 - 2007



ASMR - Ischemic Heart Diseases: 2003 - 2007



ASMR - Cerebrovascular Diseases: 2003 - 2007



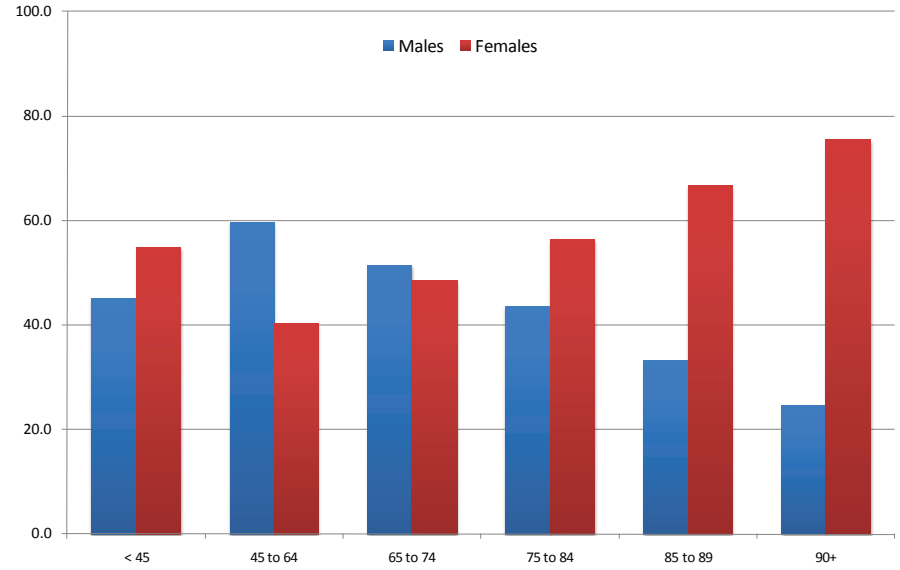
PERSONS IN RESIDENTIAL CARE BY GENDER AND AGE GROUP

The following is an examination of how the different age groups and genders use residential care services. The graphs below show, according to age group, the contribution that each gender (M/F) makes to the total number of clients in that age group.[63] Up until about age 70, the use of residential care by men and women is roughly the same, however, as any visit to a seniors care facility will demonstrate, most of the elderly clients are women.

Northern BC Residents: 2008 - 09

Average client age Northern BC

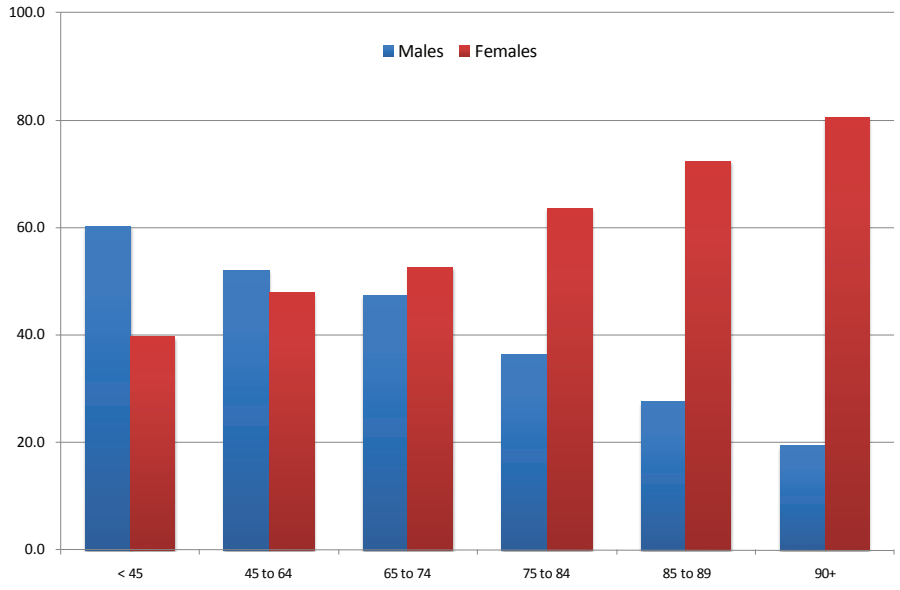
Male	78 years
Females	82.3 years



BC Residents Overall: 2008 - 09

Average client age BC overall

Male	79.9 years
Females	84.7 years



SEX & GENDER IN HEALTH SERVICES & POLICY RESEARCH

"..From the foregoing analysis, there is no doubt that Canada has a male mortality problem of great significance…"

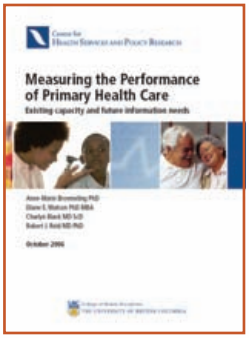
A New Perspective on the Health of Canadian: a working document. Marc Lalonde, 1974

"…It is important that these responses recognize and incorporate critical differences in sex and gender across the life cycle. Considerable variety exists in the experiences of men and women; therefore, it is important to avoid making simple assumptions about the role of sex and gender in people's lives."

Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction. BC Ministry of Health Services, 2004.

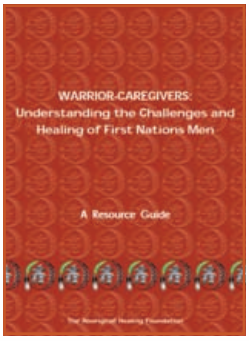
"…The morbidity burden of high users suggests that improved system efficiency is likely to be found through carefully targeted case management interventions directed at high users and their care givers rather than through blunt policy instruments that are insensitive to relative differences in underlying need for care..."

Conspicuous Consumption: Characterizing High Users of Physician Services in One Canadian Province. Journal of Health Services Research and Policy. 2003 October;8 (4):215-224. Reid, Evans, Barer, Sheps, Kerluke, McGrail, Hertzman, Pagliccia N



"..It is important to understand the demographic, health status and other population characteristics that influence the need and demand for Primary Health Care…behavioral, psychosocial, social support and health related attitudes and preferences must also be recognized."

Measuring the Performance of Primary Health Care: Existing Capacity and Future Information Needs. BC Centre for Health Services and Policy Research. 200



"…First Nations men are beginning to examine how their roles have changed and to look at their gender issues.

Positive gender identity contributes to overall personal well-being and, in turn, helps build stronger families and communities…"

Warrior Caregivers: Understanding the Challenges and Healing of First Nations Men. Published by the Aboriginal Healing Foundation

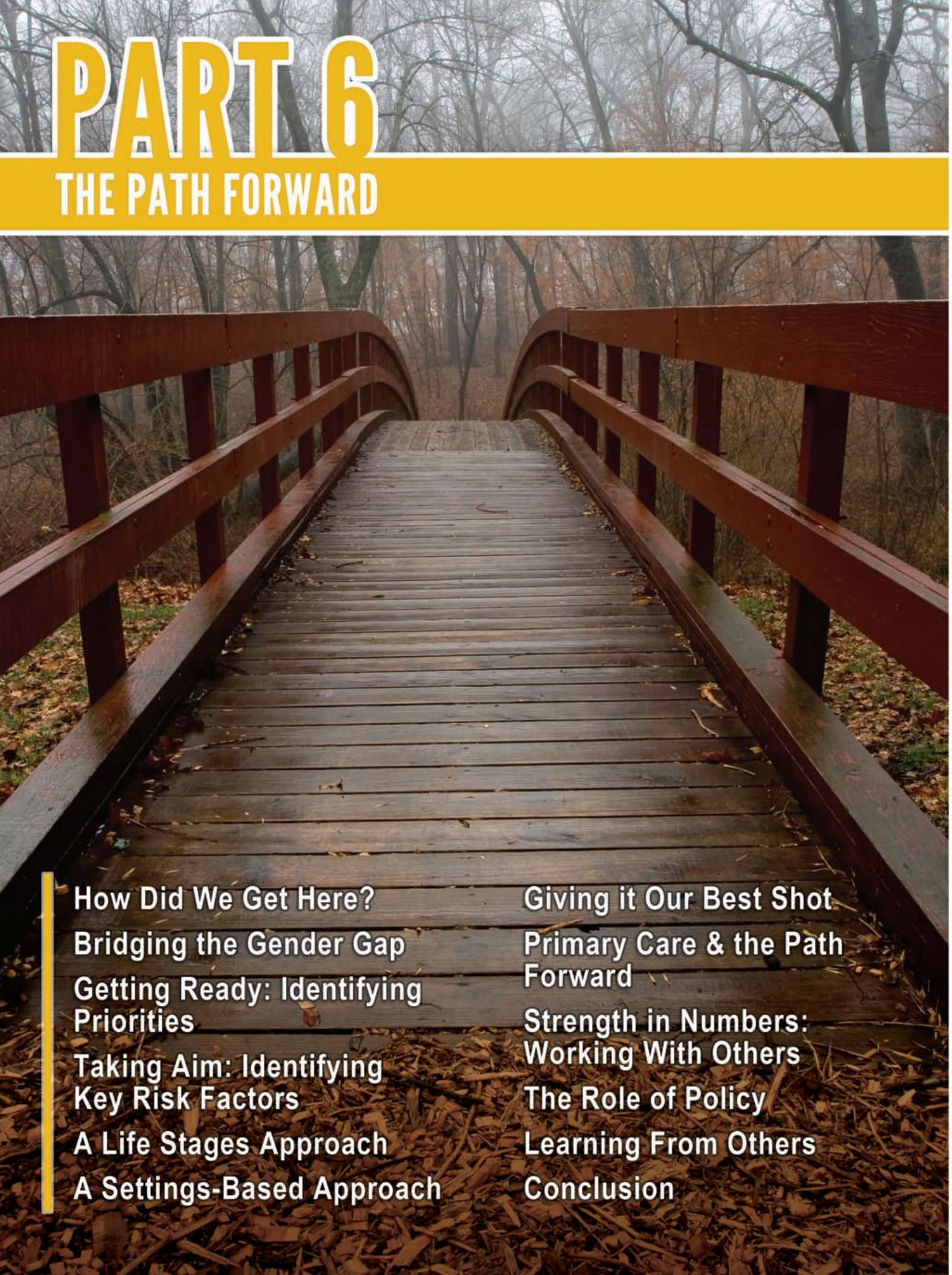
There are no winners. The health and wellbeing of the male suffers, but there is a cost to the medical community as well. The level of service to all patients decreases and the cost of health care rises for men's conditions that could have been prevented. Beyond that, if there are families involved, financial hardship and other stresses can arise. This can lead to mental health problems for family members.

If the poor health issue persists local merchants may suffer as well as the local Employers. The negative influence continues to grow and spread and the cycle continues. First the patient gets affected then the services, loss of work time and physician time; it's all snow balling. It is hard on local employers already having trouble filling positions; then hard on the community, the lost revenue. It cycles and grows. We have enough trouble funding medical services as it is, let alone unnecessary and costly services – and that all rooted in men's problems.

Key Informant Interview KI# 1: 1, Facilitated by Theresa Healy Ph.D. Northern Health. August 2010.

PART 6

THE PATH FORWARD



HOW DID WE GET HERE?

By failing to adequately consider the unique characteristics of men up to now, we have been delivering health services to men in an unconsidered and largely reactive way. Prevention and early intervention services have been delivered in health units and stand alone clinics that are only open for the most part, during the hours that many men are at work.

Preventive public health services are offered almost exclusively by female staff and are focused primarily on mothers and their children. Men often report feeling uncomfortable in health unit and clinic settings and avoid contact with these settings as much as they can.

"… the provision of family planning services to women traditionally has been clinic-based. Creative social marketing strategies aimed at bringing more men into clinic settings will likely be necessary, but they may not be sufficient. Making sure that services reach men often means going outside the clinic setting to seek out men in their own environments."

From: Men's Reproductive Health: Defining, Designing and Delivering Services, 1999.
Found at: http://www.guttmacher.org/pubs/journals/25s5399.html

BRIDGING THE GENDER GAP

The feminist movement can take well deserved credit for bringing women's health issues to the forefront from the late 1960s to the present day. Men's health has not had a similar vocal, informed and active voice, although there have been a few pioneers who have recognized men's health as worthy of special attention and initiated activities designed to reach out to men in their own environments. One example is the "Dads and Lads" barber shop clinics in England in the mid 1990s *(see Formal health services in informal settings: findings from the Preston Men's Health Project in the Journal of men's health, Volume 4, Issue 4, Pages 440-447 (December 2007).* Bernard Denner's work in Australia has been a beacon of enlightened and effective approach to men's health *(see CAMH – Centre for the Advancement of men's health at http://www.mannet.com.au/camh/nav_link/bjd.htm).*

The earliest move towards a formalized approach to men's health in Canada may have been the emergence of the Toronto Men's Health movement in 2000. These early forums and workshops focused mainly on disease and sickness issues such as prostate and testicular cancer, and men's health advocacy in other countries has generally adopted that same focus. More recently, though, men's health has begun to be explored from a more preventive, upstream perspective.

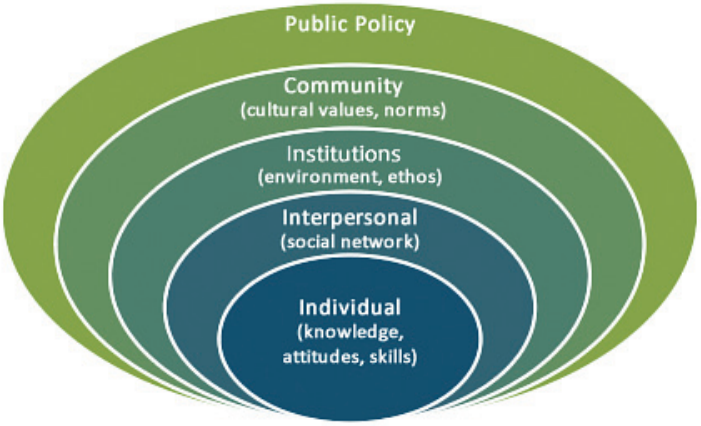
"We need everything women do, except after 5 pm."

Focus Group #1,
Warrior Caregivers
Story Telling Circle, August 2010

Of importance in this emerging trend is the growing recognition that men, for the most part, simply do not access health care services very much. Advocates for men's health have begun to use a "go to where men gather" approach. This means that health care outreach must find ways to insert itself into such locations as pubs, barber shops, fishing derbies, hockey and curling rinks, shift changes at the mill and truck stop restaurants.

"Ready, Aim, Fire"

There is no magic bullet that will address the issues within men's health that have been generations in the making. However, it has been demonstrated time and again that large scale change to the status of a population requires work at all levels. Taken from research in the field of addictions, the model to the right illustrates how targeted and effectively designed interventions at all levels could significantly improve men's health.



The graphic used by the Centre for Research on Addictions to explain the overlapping factors that impact addictions

GETTING READY: IDENTIFYING PRIORITIES

There are many complex issues underlying men's poor health status in northern BC. Measurable improvements in outcomes for men at a population level will require a broad focus. However, we cannot do everything at once, so we will need a way of determining where to begin. For some groups of men with the poorest health outcomes (in particular young men and Indigenous men) additional attention will be required to help reduce health inequalities. We know that focusing on the most vulnerable populations results in improved health for all. Therefore, it may be wise to focus initially on specific groups of men at increased risk, as outlined below.

Priority Group	Key focus areas	Risk factors
Indigenous men have poorer health outcomes than all other groups of men and women on almost all health measures.	Suicide, violence, accidents and injuries, depression, ischemic heart disease	Tobacco, alcohol and drug use, low fruit and vegetable intake, high cholesterol, low income, unemployment, poor mental health
Young men (15–34) die at two to three times the rate of young women, with the majority of this mortality difference due to avoidable factors.	Suicide, accidents and injuries, depression, violence	Tobacco, alcohol and drug use, low fruit and vegetable intake, high cholesterol, low income, unemployment, poor mental health, traditional notions of masculinity

TAKING AIM: IDENTIFYING KEY RISK FACTORS

A focus is also required on a range of upstream (broad) and downstream (specific) risk factors that impact on men's health. While risk factors will vary significantly between groups of men and for particular conditions, a number of factors have a particularly large impact and may offer quick wins to the overall health status of northern men.

Risk factors	Potential health effects	Men particularly affected
Tobacco is the greatest single contributing factor to men's burden of disease, and men's smoking rates remain higher than women's	Lung cancer, chronic obstructive pulmonary disease, other cancers, ischemic heart disease, stroke	Low socioeconomic status men, young men, indigenous men
Obesity or being overweight is around a third more common among men than women and becoming more prevalent	Cardiovascular disease, type 2 diabetes, hypertension, metabolic disorders	Older men, low socioeconomic status, rural men, men with low education
Low fruit and vegetable consumption has a major impact on men's health, and contributes to around double the burden of disease to men compared with females	Ischemic heart disease stroke, lung cancer, gastric, bowel and esophageal cancers	Younger men, men with lower education or lower income
Excessive alcohol consumption can increase the potential for short-term and long term health problems and is far more common among men than women	Increased risk of injury or accidents	Non-tertiary education, income above $50k, being in a de facto relationship, divorced, separated, or never married
Low health service usage. Men who have less frequent check-ups with a GP, lower use of mental health services, less frequent blood pressure testing and lower participation in bowel cancer screening	Delayed diagnosis and treatment for a wide range of physical and mental health problems, suicide	Rural men, men strongly identifying with traditional notions of masculinity

A LIFE STAGES APPROACH

Understanding the different situations and needs of boys and men throughout the life course will provide clues about what we need to do differently.

Boys 0-14 years

Many of the determinants of health for men are first encountered by boys in childhood with effects that last a lifetime. The years between birth and age 5 are pivotal, and yet these are years where contact with services and supports may be limited for boys and their caregivers.

Adolescents and young men (aged 15 to 24 years)

This is a key time for shaping and consolidating health related values, attitudes, and lifestyles, and for making decisions about behaviours that have consequences for future health. This period is also characterized by peer influence and experimentation with substances, such as tobacco, alcohol and drugs, as well as with sexual relationships. In addition, the self-perceived invulnerability of young men, their inexperience in life events and lack of training put them at higher risk for injuries or occupational mishaps.

Adult men (aged 25 to 64 years)

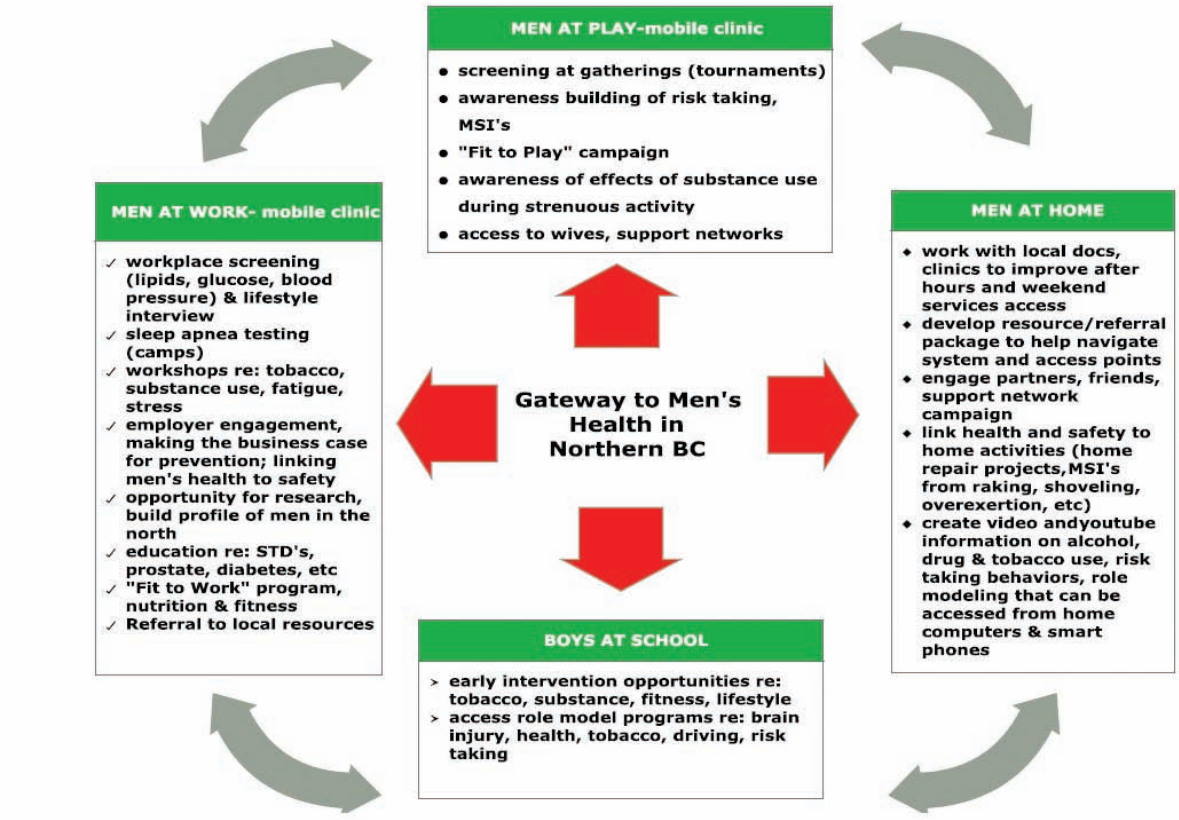
This is a time of major life events, like marriage, fatherhood, separation or divorce, which require considerable adaptation and skill. For adult men, a major influence on health is the workplace. Investment in men's health at this stage and earlier can increase the years of productivity for a man, which benefits families, the economy, and society at large. Leaving the workforce due to disability or retirement can shrink men's social networks; of men at retiring age often experience psychological and social difficulties as they transition away from breadwinner to being at home full-time. In terms of physical health, men may begin to notice impacts of previous unhealthy lifestyles and behaviours, and previously minor symptoms may increase.

Older men (aged 65 years and over)

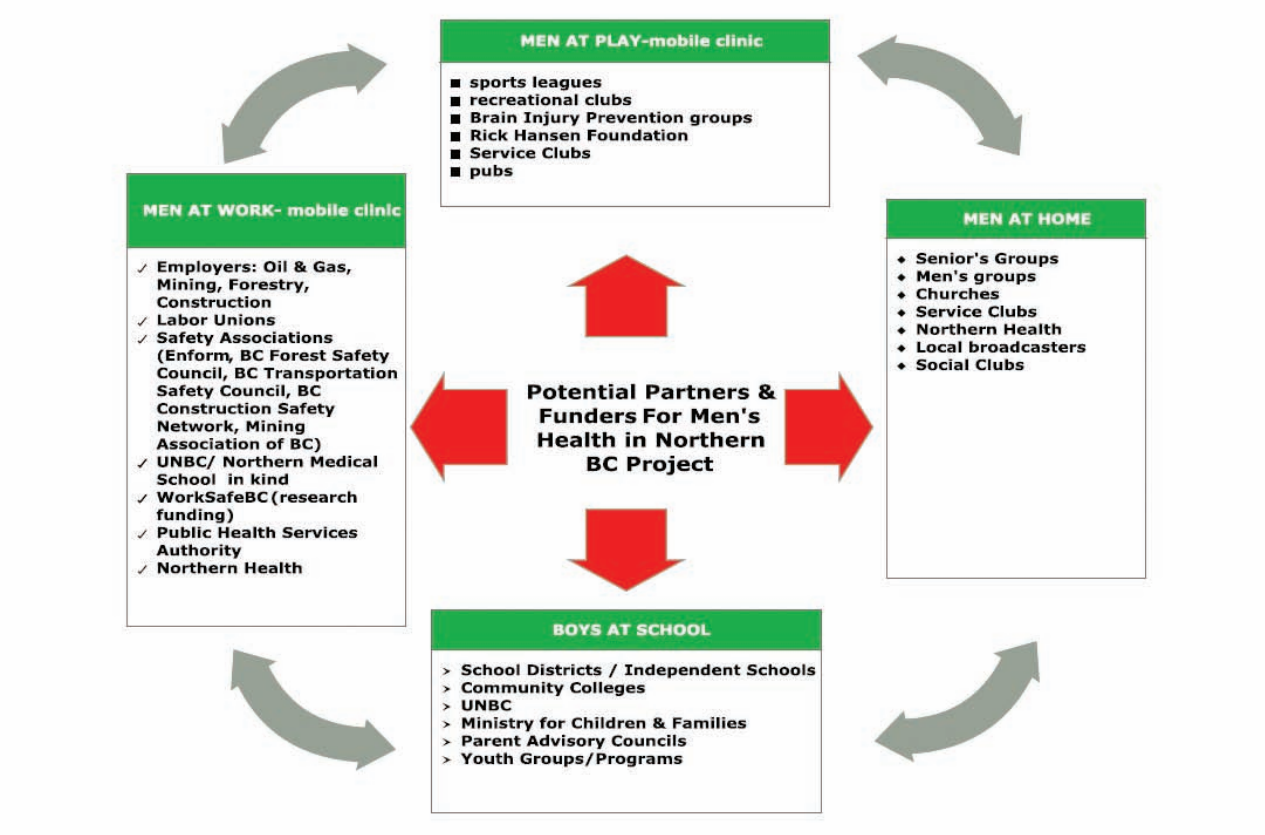
Old age is often a period of multiple losses: employment, financial independence, and physical fitness. Many men in this age range are concerned about deteriorating health, limitations to quality of life, chronic illness and disability that may make them more dependent on their families.

A SETTINGS-BASED APPROACH

It has been clearly illustrated throughout this report that health outcomes do not happen in a vacuum. They are the result of a complex interaction of a number of factors, many of which are determined by the environments within which boys and men live, learn, work and play. To address health, we must influence all of these environments, maximizing the opportunities for healthy choices and supportive environments. A vision for a comprehensive settings approach to improving the health of men in Northern BC might look like this:



By identifying the stakeholders and partners who most influence the lives of men and boys, we can begin to think about who we need to collaborate with in each of these settings:



GIVING IT OUR BEST SHOT

Northern Health has made Population Health a pillar in its strategic plan. This approach does not blame individuals for their situations, nor does it seek band-aids to apply after harm has been done. Rather, Population Health seeks to find, understand and address the complex web of environmental, physical, social and economic factors that shape and influence men's health.

One of the major resources we have is the voices of men themselves. This is why we have undertaken focus groups and interviews with men and why we have brought these voices forward throughout the report.

Within our strategic plan, Northern Health has undertaken to shift our approach to developing and delivering services. We are working to develop integrated primary care services that include a commitment to helping improve the health of people in our communities in addition to providing them with high quality health services. Intersectoral collaboration is a key to achieving population health objectives and we feel that the changes we are making will assist in our efforts to see improved health outcomes for men.

PRIMARY CARE AND THE PATH FORWARD

The present focus on primary care homes and primary health care integration within Northern Health provides a unique opportunity to reconsider the delivery of primary health services for men.

Northern Health has effectively used the DIGMA, or Doctor Initiated Group Medical Appointment, to address specific diseases. Initial feedback from men suggests that this is a very useful approach for men, who may be unable or reluctant to share personal information “one on one” with a caregiver, but who are able to actively participate in a shared discussion with other men.

See: Bruce B. Campbell, Daniel Gosselin, High patient satisfaction amongst males participating in men’s educational group appointments (MEGA) for routine physical exams The Journal of Men’s Health & Gender, Volume 4, Issue 3, September 2007

The development of electronic medical records (EMR) and the emphasis on evidence based practices in physician offices, as well as a new interest in developing partnerships with local governments, learning institutions, industry, employers, the business community, service groups, etc., are aligning to create an environment that challenges the status quo and encourages creative approaches to service planning and delivery for all community members, including men.

STRENGTH IN NUMBERS: WORKING WITH OTHERS

Northern Health has made a commitment to partner with communities to identify and act on key issues and to support northerners to live free of illness and disease and to manage the chronic diseases that they do have more effectively. We are learning that this approach can be very successful.

For example, in response to community concerns about air quality in the Bulkley-Nechako air shed, we became a partner in the woodstove replacement program. Now, each year, over 18,000 kg of particulates are prevented from entering the atmosphere.

Another example: Since 2001, HEAL and Northern Health have been working with communities as they plant seeds of health in Northern British Columbia. The HEAL vision is to support grassroots community based groups to make changes that improve health. We do this through community seed grants, learning events, linking people to information, champions and other resources. HEAL has been recognized nationally as a best practice.

The Southside Health & Wellness Centre: The centre embraces all that is positive about a vision of sustainable change. It is a healing centre that is client focused and community minded. It is also a five-year success story which began when First Nations leaders in the area known as southside [Francois Lake, 225 km. west of Prince George, BC] envisioned an expanded health and wellness centre for all residents Aboriginal and non-Aboriginal -- in this remote region in northern British Columbia. Sustainable change for Northern Health is being pursued through a focus on enhancing the way Primary Health Care services are delivered. The vision encompasses a health care system founded in primary care and community, where every resident has a primary care home, providing access and comprehensive, coordinated care. Development of multidisciplinary professional teams will establish long-term healing relationships with patients and to help northerners both manage their health and build healthier communities.

RoadHealth: In response to the high death and injury rate from Motor Vehicle Crashes in the North, Northern Health in 2005 implemented the Road Health project in conjunction with a variety of stakeholders including the RCMP, Coroner, ICBC, Worksafe BC, the BC Forest Safety Council and others. The project successfully mobilized the major role players but more importantly has been able to create citizen engagement and the understanding that road safety is everyone's business. It is axiomatic that major health issues, like Road Traffic Injuries, are far too important to leave to any one agency and that they require broad coalitions and sustained responses that include the community members who are at risk. In the case of road safety or the health of men and boys, that means all of us.

MAKING THE HEALTHY CHOICE THE EASY CHOICE: ROLE OF POLICY

It has been well documented that men are more likely to have adverse lifestyle patterns, poor health service utilization particularly preventative health services and shows a poor uptake of health promotion messages. If men at present do not come to the health services, and then men's health programs may need to journey to where men are gathered, be it the workplace, the football or the pub. Indeed the MAN Model was developed to specifically address the problem of reaching men and getting them to discuss their health concerns in a culturally relevant way.

Bernard Denner,
MAN Model……Health Promotion

The most significant improvements to the health of populations throughout history have been attributed, not to individual based service delivery approaches, but to broad social policy and legislation aimed at improving living conditions for all. Water sanitation and immunizations are among these, but more recent examples include drinking and driving legislation, seatbelt laws and smoke-free by-laws.

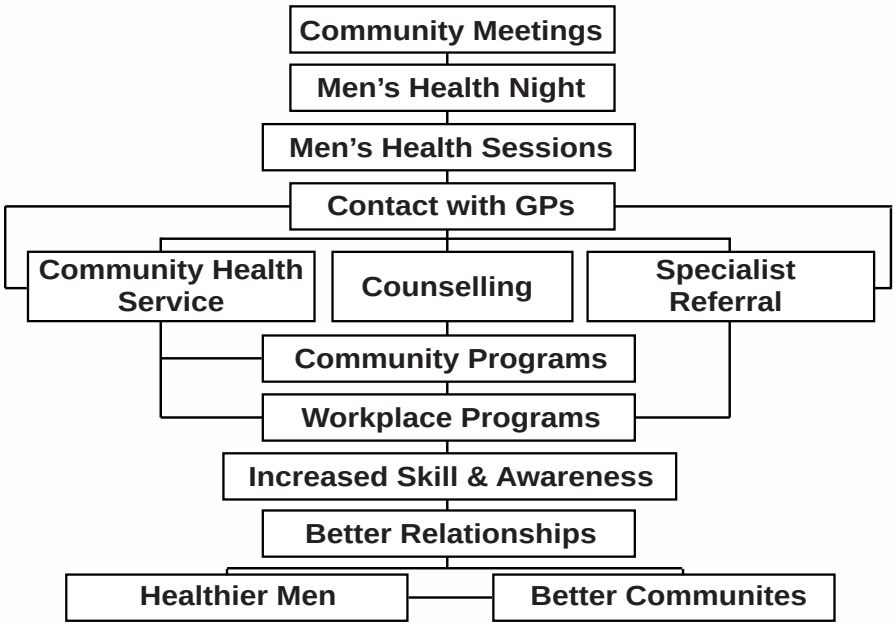
Northern Health, in its commitment to a population health approach, has a role in advocating for and supporting legislative and social policy changes that impact on the determinants of health and, ultimately, on the health outcomes of the populations it serves. Northern Health is working to connect with local governments with regard to community planning and land use to ensure good access and opportunities for healthy and active lifestyles, we are partnering with concerned citizens and coalition groups to address issues of air quality, sustainable industrial practices, potential hazards and food security. We are connected with provincial initiatives aimed at addressing healthy food in public buildings, improving the nutrition available in restaurants, increasing health literacy, and reducing the negative impacts of poverty and social isolation.

Social Policy and Legislative change can work like a kind of power tool to rapidly improve conditions that impact the health status of northern men. In particular, policies regarding lengthened parental leave for new fathers, a living wage, income security, education and skills training for displaced workers, and family friendly workplaces speak specifically to supporting men and their important role within society.

DON'T RE-INVENT THE WHEEL: LEARNING FROM OTHERS

One of the most promising approaches to improving men's health has been the development of the MAN model, a process for taking health care information and screening services to where men are already gathering. The chart on pg. 59 illustrates this approach developed in Australia under the leadership of Bernard Denner. This pathway focuses not just on empowering men to take action on their own health issues but works with caregivers to ensure that "male-friendly" support services are in place.

The MAN Model is a pathway for the education and empowerment of men to deal with their health needs preventively rather than reactively



The MAN (Men's Awareness Network) pathway

Despite the efforts of the health care industry to raise men's awareness and participation in attending to their own health needs, men continue to be very poor consumers of health care services. Also, men are still at a higher risk of dying and becoming disabled at an early age than their age matched female counterparts. Many public health programs have been available for many years, yet it appears that men will continue to undertake "risky behaviour" despite many efforts to dissuade them. It has been well documented that men are more likely to have adverse lifestyle patterns, poor health service utilization particularly preventative health services and shows a poor uptake of health promotion messages. If men at present do not come to the health services, then men's health programs may need to journey to where men are gathered, be it the workplace, the football or the pub. Indeed the MAN Model was developed to specifically address the problem of reaching men and getting them to discuss their health concerns in a culturally relevant way. The success of this approach is evidenced in the number of men attending the 'Just For Men' Men's Health Nights, their response rates for filling out questionnaires and their subsequent involvement in follow up health sessions within their communities.

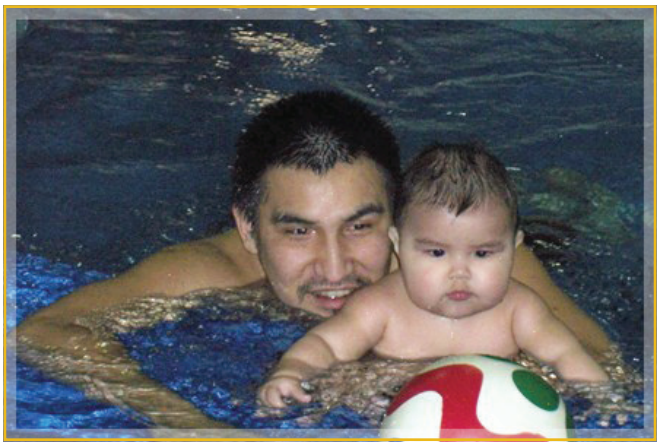
Bernard Denner, MAN Model……. Health Promotion

You have to learn to take management of your own health, people will help you but you have to do it first and the first step is asking questions. You have to pluck up the nerve to ask. Inside you are thinking I am not going to ask that – that's stupid. Then when you do ask you realize the answer isn't helpful. Like, when I asked my doctor about my sleeping problem, he said "put a bag over the alarm clock; your work schedule trained you not to sleep well." So, I didn't bring it up again. But, at a Diabetes Group Medical Appointment I finally asked again. This time the doctor asked the group. Every one of us had the same problem. We were learning together as a group, including the doctor. Maybe he just doesn't have the time one on one to explore and answer every question one on one.

It is clear that several heads are better than one. The doc doesn't have time; but learning as group we find strength in numbers; we have 14 of us in there together every 2-3 months, learning about not just diabetes but all of its implications on our health and we are getting further along. Everyone has the opportunity to ask questions. As a group we learn how many have experienced the same thing, and that we may not have correct info. And I learnt I wasn't the only one with a sleep disorder; or even the worst one.

KI#1 August 2010.

CONCLUSION: TOWARD HEALTHIER NORTHERN MEN



As the preceding sections demonstrate, staying away from doctors does not necessarily imply that men are enjoying good health. Supporting men to access services in appropriate and timely ways could not only improve the cost-effectiveness, and usefulness of health services for men, but also could have a significant effect on the length, quality and productiveness of men's lives.

Men in the North face additional challenges: social and geographic realities in the north often interact with gender and negatively impact men's health. Dangerous work conditions, risky recreational choices, extreme weather, long distance travel, and limited First Response and trauma care services are some of these realities.

Our system is not as responsive and accessible as it could be for minority groups and marginalized populations including aboriginal people. Cultural and gender biases in the system need to be identified and addressed. The majority of health care workers are female, for example, which may be an unrecognized barrier to their work with male clients. As one gentleman put it, "*I am not going talk to a chit of a girl who looks like my granddaughter about these things.*"

Northern Health is committed to addressing the health service issues raised in this report. We plan to start by engaging northerners across communities and sectors in a broader discussion early in 2011.

The data generated by the RoadHealth coalition points to the gains that can be made when a crucial issue is approached by many partners working together. The majority of the participants in the RoadHealth conferences have been men, and much of the work has involved male workers such as loggers, truckers and oil patch workers. The significant gains we have seen as RoadHealth has moved forward have mostly been improvements in male outcomes.

Understanding the risk factors for men, as well as the barriers to service that they experience are key elements to improving their health outcomes. Actively listening to men from a variety of social and geographic settings will point to potential solutions. Paying attention to men and their lived experiences should also help to raise their awareness about the care and maintenance of their own bodies.

> ***"Why doesn't Northern Health put on a series of ads, to educate men and get men talking about health? Yes, the language would have to be rough and tough to get men to listen, but get men talking."***

In every focus group or interview, this idea generated agreement. One focus group began to enthusiastically script ideas for *ads targeting men and their health issues*.

RECOMMENDATIONS

Some initial recommendations have already emerged from the work undertaken for this report, supported by statistics, examples of successes experienced elsewhere, and echoed by the voices of northern men:

1. **Pay attention to men:** Support and conduct more research on men's health and living conditions, their health status and the health care services they need and how those services should be delivered.
2. **Listen to men:** Conduct ongoing community consultations with men in suitable locations that support their involvement.
3. **Learn with men:** Support an annual men's health conference to consolidate knowledge and gains from the formal research and consultation activities.
4. **Speak to men in language they recognize:** Involve Northern Health's Communications department as a leader in the design of men's health messaging. In particular, involve "real" men in the creation of health promotion ads that speak to a range of issues from a male perspective, with the underlying message of "Don't be afraid to speak up about men's health."
5. **Increase collaboration with industry and business partners:** Utilize existing structures (such as workplace health and safety meetings and retirement planning workshops) to increase health promotion and education activities.
6. **Build partnerships:** Improve access to health care for marginalized men and men with specific needs by working with community agencies that have a respected reputation and content expertise. For example, to improve service to men leaving prison or struggling with violence, collaborate with John Howard; for fathers leaving prison work with Kikino's Warrior Caregiver program.
7. **Improve health systems and structures:** Design and deliver innovative outreach services, such as Men's Night Out. Ensure that Primary Care Homes in Northern BC are actively planning to include men and their health issues and needs as they develop new and innovative models of service delivery.

This preliminary report has the potential to act as a road map, marking the way to improved health outcomes for men. It will help guide efforts to design, implement and evaluate Northern Health work in the region. Other jurisdictions, such as Australia and Great Britain, have made significant advances in Men's Health. We can learn from them, as well as from our own experiences in targeted initiatives like Road Health.

This Report underscores the essential role of men in the fabric of families, society and the health of their communities. It is impossible to adequately discuss the multitude of issues pertaining to men's health in one report but we do know that we cannot hope to improve the health of our communities without considering and involving the fathers, sons and brothers who live in them. We hope this report will serve as a catalyst that will stimulate discussion and action going forward. We are hopeful that men who neglect their health, and health services designed without sufficient attention to how men will use them, will increasingly be things of the past.

REFERENCES

Dan Bilsker and Larry Goldenberg. *A Roadmap to Men's Health: Current Status, Research, Policy & Practice, Men's Health Initiative of British Columbia, Centre for Applied Research in Mental Health & Addiction*.

Northern Region: Accidental Workplace Deaths 2005 – 2010 YTD. BC Coroners Service; Ministry of Public Safety and Solictor General. Special request for Northern Health. November 2010.

ICBC Business Information Warehouse. Special Request for Northern Health. Request #R010RDS0245-0.

Chronic Conditions and Co-morbidity Among Residents of British Columbia. CHSPR 2005.

Men and Crime: British Columbia Crime Trends 1999 – 2008. Ministry of Public Safety and Solicitor General 2009

Northern Health Vision: A Picture of 2015
http://www.northernhealth.ca/About/documents/NorthernHealthStrategicPlan.pt

Reid, Haggerty, McKendry. As cited in; *Chronic Conditions and Co-morbidity Among Residents of British Columbia*. CHSPR 2005. http://www.chspr.ubc.ca/node/109

Why Health Care Renewal Matters: Lessons from Diabetes. Health Council of Canada.
http://healthcouncilcanada.ca

Primary Health Care Charter: a collaborative approach. British Columbia Ministry of Health: 2007.
http://www.primaryhealthcarebc.ca/library/publications/year/2007/phc_charter.pdf

Northern Cancer Control Strategy: *Final Report. 2005*. This report is available through Northern Health

Healthy Pathways Forward: A Strategic Integrated Approach to Viral Hepatitis in BC. BC Ministry of Health, 2007. http://www.health.gov.bc.ca/library/publications/year/2007/healthypathwaysforward.pdf

Defining and measuring gender: A social determinant of health whose time has come. *International Journal of Equity in Health* 2005; 4: 11. Published online 2005 July 13.
doi: 10.1186/1475-9276-4-11

Kitty Lawrence, Methodologic and ethical ramifications of sex and gender differences in public health research Gender Medicine Volume 4, Supplement 2, 2007, Pages S96-S105

First Nordic Conference On Abuse Of Anabolic Androgenic Steroids And Anti-Doping Work September 20-21, 2007, Uppsala (Sweden)

Bernard Denner, *MAN Model – Health Promotion*. No date

SOURCES CONSULTED

Aboriginal Healing Foundation of Canada, *Warrior Caregivers: Understanding the Challenges and Healing of First Nations Men*.

Bruce B. Campbell, Daniel Gosselin, High patient satisfaction amongst males participating in men's educational group appointments (MEGA) for routine physical exams, *The Journal of Men's Health & Gender*, Volume 4, Issue 3, September 2007, Pages 266-270, ISSN 1571-8913, DOI: 10.1016/j.jmhg.2007.06.003.
(http://www.sciencedirect.com/science/article/B7GW7-4PG2KX6-2/2/b018ee136a1e98a13b9755aa6e1b144f)

CBC News, "Sexual-health clinic draws few young men" CBC News April 7, 2010
http://www.cbc.ca/canada/british-columbia/story/2010/04/07/sexual-health-young-men.html

Kierans, Ciara, Steve Robertson, Michael D. Mair, Formal health services in informal settings: findings from the Preston Men's Health Project, *The Journal of Men's Health & Gender*, Volume 4, Issue 4, December 2007, Pages 440-447, ISSN 1571-8913, DOI: 10.1016/j.jmhg.2007.08.006
(http://www.sciencedirect.com/science/article/B7GW7-4R8M0KJ-1/2/dc961b6c7c4e68f61f5b55f1eb068970)

Men's Health and Wellbeing Strategy Background Paper. Published by the Policy Coordination and Projects Branch, Victorian Government Department of Health, Melbourne, Australia, March 2010

Ndong, Isaiah et al. Men's Reproductive Health: Defining, Designing and Delivering Services Family Planning Perspectives, Volume 25, Supplement, January 1999

PHSA and the BC Centre for Excellence on Women's Health, *Talking a Second Look: Analyzing Health Inequities in British Columbia with a Sex, Gender and Diversity Lens*. November 2009

Reid RJ, Conspicuous Consumption: Characterizing High Users of Physician Services in One Canadian Province. *Journal of Health Services Research and Policy*. 2003 October; 8 (4):215-224. Evans RG, Barer ML, Sheps S, Kerluke K, McGrail K, Hertzman C, Pagliccia N

Rutz, Wolfgang and Zoltan Rihmer, Suicidality in men - practical issues, challenges, solutions, *The Journal of Men's Health & Gender*, Volume 4, Issue 4, December 2007, Pages 393-401, ISSN 1571-8913, DOI: 10.1016/j.jmhg.2007.07.046.
(http://www.sciencedirect.com/science/article/B7GW7-4R8KT7H-8/2/ad2686bd12ff8e124be95439cb7a9230)

Silva , Marc A Body Image Dissatisfaction: A Growing Concern Among Men *Newsletters for Mental Health, MSOE Counselling Services April 2006*

White, Allan K. "Men's Health in the 21st Century." *International Journal of Men's Health* 5.1 (2006)

OTHER RESOURCES RECOMMENDED

Finding Our Way: A Sexual and Reproductive Health Source Book for Aboriginal Communities created by the Aboriginal Nurses Association of Canada and available from Planned Parenthood.
Also available at: http://www.anac.on.ca/sourcebook/toc.htm

Health Canada's site for men's health: http://www.hc-sc.gc.ca/hl-vs/jfy-spv/men-hommes-eng.php

Lifemd.com: http://www.menshealthcanada.com /

American men's health site: http://www.nlm.nih.gov/medlineplus/menshealth.html

Journal of Men's Studies: found at: http://mensstudies.metapress.com/content/h75255576606/?p=87252afe454a44a093a584b6e53d874a&pi=0

International Journal of Men's Health: http://mensstudies.metapress.com/content/120391/ \

Center for Addictions Research BC Alcohol Pricing, Public Health and the HST: Proposed Incentives for BC Drinkers to Make Healthy Choices. University of Victoria, 2009. Available at: http://carbc.ca/Home/Publications.aspx

Bruce B. Campbell, Daniel Gosselin, High patient satisfaction amongst males participating in men's educational group appointments (MEGA) for routine physical exams, *The Journal of Men's Health & Gender*, Volume 4, Issue 3, September 2007, Pages 266-270, ISSN 1571-8913, DOI: 10.1016/j.jmhg.2007.06.003. (http://www.sciencedirect.com/science/article/B7GW7-4PG2KX6-2/2/b018ee136a1e98a13b9755aa6e1b144f)

D. Bilsker, L. Goldenberg & J. Davison, A Roadmap to Men's Health: Current Status, Research, Policy & Practice. Men's Health Initiative of British Columbia, 2010.

National Men's Health Policy 2008-2013: Working With Men in Ireland to Achieve Optimum Health & Wellbeing. Department of Health and Children, 2008.
Available at: http://www.dohc.ie/publications/national_mens_health_policy.html

Developing a Men's Health Policy for Australia: Setting the Scene. Austrailian Government Department of Health and Ageing.
Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-mens-policy

Men's Studies Press. Available at: http://www.mensstudies.com/home/main.mpx

Men's Bibliography. Published by Michael Flood, Victoria State Government, Australia.
Available at: http://mensbiblio.xyonline.net/

Men's Health and the Health of the Nation: New Zealand Medical Journal
Available at: http://www.nzma.org.nz/journal/121-1287/3418/

Improving Men's Health in New Zealand: A review of the benefits of men's health awareness activities and a proposal for the development a targeted men's health program.
Available at: http://www.healthwest.co.nz/documents/MensHealthinNewZealand.pdf

Journal of Men's Health. Available at: http://www.jmhjournal.org/

Men's Health Around the World: a Review of Policy and Progress in 11 Countries, 2009. Published by European Men's Health Forum. Available at: http://www.emhf.org/index.cfm/item_id/695

Reports and Publications of the European Men's Health Forum
http://www.emhf.org/index.cfm/item_id/22/CFID=10147180&CFTOKEN=62603364&jsessionid=ce3073cd5c50$3F$25vz/

Applications of masculinity in a Chronic Diseases Context. International Journal of Men's Health.
http://www.thefreelibrary.com/
Applications+of+masculinity+theories+in+a+chronic+illness+context.-a0140911975

International Journal of Men's Health
http://www.thefreelibrary.com/International+Journal+of+Men's+Health-p214

Men Engage : Boys and Men for Gender Equality. Available at: http://www.menengage.org/

BIBLIOGRAPHY

1 Gender Inclusive Health Planning: A Guide for Health Authorities in British Columbia. BC Ministry of Health Services, 2001. http://www.health.gov.bc.ca/library/publications/year/2001/gender_inclusive.pdf

2 Rabbi Elliot Kukla, *A Created Being of Its Own: Toward a Jewish Liberation Theology for Men, Women and Everyone Else*, found at: http://www.transtorah.org/PDFs/How_I_Met_the_Tumtum.pdf

3 Faye (Fabian Paquette) is listed in the missing and murdered native women list at http://www.missingnativewomen.org/bc.htm

4 British Columbia Socio-economic Profiles: 2009, BC Stats. http://www.bcstats.gov.bc.ca/data/sep/choose.asp

5 Children at Risk in Northern BC: Discussion Document, Northern Health, April 2009. Community Health Information Portal, Northern Health, 2009. chip.northernhealth.ca

6 Pathways to Health and Healing: 2nd report on the Health and Wellbeing of Aboriginal People in British Columbia. BC Provincial Health Officer's Annual Report 2007. http://www.hls.gov.bc.ca/pho/reports/

7 Human Early Learning Partnership; the Early Development Index: a Population Health Perspective. http://www.earlylearning.ubc.ca/research/initiatives/early-development-instrument/

8 British Columbia Socio-economic Profiles and Indices: 2010: BC Stats. http://www.bcstats.gov.bc.ca/data/sep/index.asp

9 Regional Socio-economic Profiles and Indices: 2010. Definitions and Sources: BC Stats March 2010. http://www.bcstats.gov.bc.ca/data/sep/glossary.pdf

10 British Columbia Regional-District: Migration Components. BC Stats: released January 2010. http://www.bcstats.gov.bc.ca/data/pop/mig/rdcomp.pdf

11 Persons aged 65+ and 75+ by Health Authority; 2010 – 2025. BC Stats: PEOPLE 34.

12 Geographic and Statistical Profile of Aboriginal Peoples 2006: BC Stats. http://www.bcstats.gov.bc.ca/data/cen01/abor/ha06_ab.asp

13 Geographic and Statistical Profile of Aboriginal Peoples 2006: BC Stats. http://www.bcstats.gov.bc.ca/data/cen01/abor/ha06_ab.asp

14 Statistics Canada Census 2006 Definitions: http://www12.statcan.gc.ca/census-recensement/2006/ref/dict/pop127-eng.cfm

15 Source: BC Stats: Regional Socio-economic Profiles and Indices. http://www.bcstats.gov.bc.ca/data/sep/index.asp

16 BC Provincial Health Officers Annual Report 1999. Appendix C: Indicator Definitions. http://www.hls.gov.bc.ca/pho/reports/

17 Technical Assumptions for Population Forecasting in BC: Page 8. BC Stats, July 2009. http://www.bcstats.gov.bc.ca/data/pop/pop/popproj.asp

18 World Health Organization, Pacific Region: Australia – Health Situation and Trends Report. http://www.wpro.who.int/countries/2008/aus/health_situation.htm

19 World Health Organization: World Health Report: 1999: Making a Difference. http://www.who.int/whr/1999/en/whr99_en.pdf

20 BC Cancer Agency: Regional Cancer Statistics 2007. http://www.bccancer.bc.ca

21 BC Cancer Agency: Regional Cancer Statistics 2007. http://www.bccancer.bc.ca

22 24 Hour Roadside suspensions in North Central BC: 2007 – 2009. ICBC, Business Information Warehouse. Special request for Northern Health: Project # 2010RDSO245-0. January 2010.

23 Hospitalizations: Counts and Rates Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities.Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring (AOD)Project: March 2010. http://carbc.ca/AODMonitoring/tabid/541/Default.aspx

24 Mortality Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities 2002-2008 Per 100,000 Resident. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring Project: March 2010. http://carbc.ca/AODMonitoring/tabid/541/Default.aspx

25 BC Health and Wellness Report – Northern Health and Provincial Health Services Authority -2007.

26 Health Status: How Healthy Are We? Northern Health: Community Health Information Portal. http://chip.northernhealth.ca/

27 The Health of Canada's Communities. Supplement to Health Reports, volume 13, 2002 Statistics Canada Catalogue 82-003 http://www.statcan.gc.ca/pub/82-003-s/2002001/pdf/82-003-s2002002-eng.pdf

28 Human Early Learning Partnership; the Early Development Index: a Population Health Perspective. http://www.earlylearning.ubc.ca/research/initiatives/early-development-instrument/

29 Early Childhood Health Interventions Could Save Billions in Health Costs Later in Life. John Hopkins Bloomberg, School of Public Health, Public Health News Centre May 15, 2009. http://www.jhsph.edu/publichealthnews/press_releases/2009/guyer_early_childhood.html

30 Youth at Risk Index: BC Stats Socioeconomic Profiles and Indices. http/sep/index.aspp://www.bcstats.gov.bc.ca/da

31 BC Ministry of Education. FSA FAQ. http://www.bced.gov.bc.ca/reporting/

[32] BC Ministry of Education: District Reports. FSA scores, February 2010. http://www.bced.gov.bc.ca/reporting/district_data_summary.php

[33] BC Coroners Service: Northern Region Motor Vehicle Incident Fatalities 1997 – 2009.

[34] 24 Hour Roadside suspensions in North Central BC: 2007 – 2009. ICBC, Business Information Warehouse. Special request for Northern Health: Project # 2010RDSO245-0. January 2010.

[35] Injuries, Hospitalized Days and Direct Care Costs, by age group and sex: 2008-09. Data acquired through the BC Injury Research Prevention Unit (BCIRPU): Online-tool. Prepared by: J. Haggerstone, Northern Health: July 2010. http://www.injuryresearch.bc.ca/categorypages.aspx?catid=10&catname=Online%20Data%20Tool

[36] Injuries, Hospitalized Days and Direct Care Costs, by age group and sex: 2008-09. Data acquired through the BC Injury Research Prevention Unit (BCIRPU): Online-tool. Prepared by: J. Haggerstone, Northern Health: July 2010. http://www.injuryresearch.bc.ca/categorypages.aspx?catid=10&catname=Online%20Data%20Tool

[37] Media Release, Centre for Addictions Research in BC, Dec 2009.

[38] Hospitalizations: Counts and Rates Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring (AOD) Project: March 2010. http://carbc.ca/AODMonitoring/tabid/541/Default.aspx

[39] Hospitalizations: Counts and Rates Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring (AOD) Project: March 2010. http://carbc.ca/AODMonitoring/tabid/541/Default.aspx

[40] Hospitalizations: Counts and Rates Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring (AOD) Project: March 2010. http://carbc.ca/AODMonitoring/tabid/541/Default.aspx

[41] Hospitalizations: Counts and Rates Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring (AOD) Project: March 2010. http://carbc.ca/AODMonitoring/tabid/541/Default.aspx

[42] Mortality Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities 2002-2008 Per 100,000 Residents. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring Project: March 2010.

[43] Mortality Attributable to Alcohol, Tobacco, and Illicit Drugs for BC and Health Authorities 2002-2008 Per 100,000 Residents. Prepared for Northern Health by the BC Centre for Addictions Research: Alcohol and Other Drug Monitoring Project: March 2010.

[44] British Columbia, Local Area Economic Dependencies: 2006. BC Stats, March 2009. http://www.bcstats.gov.bc.ca/pubs/econ_dep.asp

[45] British Columbia Crime Trends 1999 – 2008. Ministry of Public Safety and Solicitor General 2009.

[46] Chronic Conditions and Co-morbidity Among Residents of British Columbia. BC Center for Health Services and Policy Research: 2005. http://www.chspr.ubc.ca/node/109

[47] BC Centre for Diseases Control: Diseases and Conditions, A – Z: Chlamydia overview. http://www.bccdc.ca/dis-cond/a-z/default.htm

[48] BC Centre for Diseases Control: Diseases and Conditions, A – Z: Chlamydia overview. http://www.bccdc.ca/dis-cond/a-z/default.htm

[49] BCCDC Sexually Transmitted Infection (STI) Cubes. Accessed May 28, 2010.

[50] BC Centre for Disease Control: Diseases and Conditions A – Z: Hepatitis C overview. http://www.bccdc.ca/dis-cond/a-z/default.htm

[51] Healthy Pathways Forward: A Strategic Framework for Viral Hepatitis in British Columbia. http://www.health.gov.bc.ca/library/publications/year/2007/healthypathwaysforward.pdf

[52] BC Centre for Disease Control. Hepatitis C Cubes. Accessed January 2010.

[53] BC Centre Disease Control – HIV Cubes. Accessed January 2010.

[54] Discharge Abstract Database (DAD). Acquired through Quantum Analyzer. January 2010.

[55] Discharge Abstract Database (DAD). Acquired through Quantum Analyzer. January 2010.

[56] Discharge Abstract Database (DAD). Acquired through Quantum Analyzer. January 2010.

[57] Medical Services Plan Information Resource Manual 2008 /2009. http://www.health.gov.bc.ca/msp/paystats/

[58] Medical Services Plan Information Resource Manual 2008 /2009. http://www.health.gov.bc.ca/msp/paystats/

[59] Medical Services Plan Information Resource Manual 2008 /2009. http://www.health.gov.bc.ca/msp/paystats/

[60] Chronic Conditions and Co-morbidity Among Residents of British Columbia. BC Center for Health Services and Policy Research: 2005. http://www.chspr.ubc.ca/node/109

[61] Chronic Conditions and Co-morbidity Among Residents of British Columbia. BC Center for Health Services and Policy Research: 2005. http://www.chspr.ubc.ca/node/109

[62] BC Vital Statistics Data Warehouse (Vista). J Haggerstone, Northern Health Acquired January 2010.

[63] Data is from the CC Data Warehouse. Acquired, through Quantum Analyzer, January 2010.

[64] A New Perspective on the Health of Canadian: a working document. Marc Lalonde, 1974. http://dsp-psd.pwgsc.gc.ca/collection_2009/sc-hc/H31-1374E.pdf

[65] Conspicuous Consumption: Characterizing High Users of Physician Services in one Canadian Province. BC Centre for Health Services and Policy Research: 2003

[66] Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction. BC Ministry of Health Services, 2004. http://www.health.gov.bc.ca/library/publications/year/2004/framework_for_substance_use_and_addiction.pdf

[67] Measuring the Performance of Primary Health Care: Existing Capacity and Future Information Needs. BC Centre for Health Services and Policy Research: 2006.

[68] Warrior caregivers: Understanding the challenges and Healing of First Nations Men: Aboriginal Healing Foundation http://www.ahf.ca

FOR MORE INFORMATION

Please Contact the Population Health Team

Centre for Healthy Living
1788 Diefenbaker Dr.
Prince George, BC, Canada V2N 4V7

Phone: (250) 649-7061
Fax: (250) 612-0810

More resources can be found at:

www.northernhealth.ca/YourHealth/HealthyLivingCommunities.aspx

http://chip.northernhealth.ca/

Community Health Information Portal
northern health

northern health
the northern way of caring

reorder #1716