Chapter 6 Men, lifestyle and health

Women suffer - men die is a new book about public health from a gender perspective. The title is a good summary of the health differences between men and women. Boys / men have a higher risk of death than girls / women right from the first year of life. However, absenteeism from work because of illness and the use of preventative and other health services is lower among boys/men than girls/women. Although the difference in life expectancy between men and women has lessened in the last decades, statistics from 2007 still show that women have a five-year higher life expectancy than men. There are also gender differences in cause of death that cannot be contributed solely to biological factors, but are connected to social situations and lifestyle where also cultural expectations of men and boys play a role.

Men have a more positive evaluation of their own health than women do. There are factual reasons for this discrepancy, but illness is also perceived and/or accepted in different ways by men and women. The attitude that admitting illness or weak health is contrary to the stereotypical male ideal is still prevalent. In the Gender Equality Survey, more men than women express that they are satisfied with their body, and fewer men report having such ailments as headache, backache, pain in the shoulders etc. At the same time, more men than women report that they experience a reduction in their quality of life or low quality of life because of illness.

Much of the Norwegian research done on men and how they handle illness is of a qualitative nature. The results of this research indicate that there is a typical male way of handling illness that is unfortunate for the man himself. This shows up in three major arenas: in social contact, in work, and in the use of health services. Looking at the statistics according to gender, however, can be misleading. Many of the differences that often are explained by gender may have other causes such as age, socio-economic status and marital status. There is a fundamental principle in society that all people, regardless of gender, residence or any other factor shall have equal access to health and care services. However, there are specific challenges with respect to male and female health issues, and these must be met with both knowledge and resources. Gender-specific information on health, illness and the use of health service is important in order to be able to offer appropriate preventative measures, treatment, care and rehabilitation services for men and women.

The health and care services must also have a gender perspective. Many men suffering from cancer feel that male doctors are too quick and too brusque. These men prefer to go to female doctors. A diagnosis of cancer can be very difficult to deal with if the communication with the health professionals is not good and leads to a lack of proper information. Men do not know what they can expect, what is normal, and how they should react.

The Men’s Panel has also pointed out in its conclusion that there are many gender differences that show up in the area of health. They have proposed that research in this area be strengthened, and that measures to reduce these differences be outlined. The Panel also asks for a clearer gender perspective in the field. The government is of the opinion that it is necessary to obtain information on the causes of gender differences in health. A gender perspective in the health and care services would give all the users of the services better

information about health and lifestyle that would make both genders more aware of how gender affects health.

6.1 Introduction

Health is a concept that can be interpreted in several ways. The Central Statistics Board (SSB) has attempted to find out what"most people" understand about the concept health through depth interviews. People of different genders gave the concept different meanings. It was revealed through these interviews that people in Norway understand the concept of health primarily as physical and mental health, but also a healthy lifestyle and being in shape. Usually one sees health as a characteristic of an individual, but one can also see health as an expression of the relationship between the individual and the individual's environment. Understood in this way, health is not an objective concept, but is also dependent on what kind of expectations the individual has of his or her own body, the health services and the environment in general.

The state of the health in the general population and differences between people in various socio-demographic groups is evaluated according to a number of indices. Self-evaluation is one; life-situation evaluation and professional evaluation from medical professionals are others.

According to statistics, men have a higher risk of death than women— at certain ages, double the risk or more. More men than women die because of accidents, and many more men than women take their own life. However, this gender difference is shrinking, primarily because men are now less prone to die of heart disease and related illnesses. Life expectancy in 2005 was 78,1 years for newborn boys and 82,5 for newborn girls, an increase of almost five and a half years for men and three and a half years for women since the period 1976-1980. This is also a result of gender equality and the shrinking of lifestyle differences between men and women. As time goes on there are fewer typically male and female phenomena. Heart problems have for years been considered as a typical male phenomenon, but in 2000 women comprised all of 46% of the people who died of heart attacks, according to numbers from the Central Statistics Board.

Women live longer, but often suffer more years of ailments than men. More women than men report that they have chronic or recurring pain in their bodies, that they have headaches/ migraines, that they are fatigued, that they have problems sleeping and suffer from a series of other psychological and physical symptoms. Women have more absenteeism from work because of illness than men, and they tend to have more long-term, chronic illnesses.

How can these gender differences be explained? To a certain degree, gender differences in health can be explained by biological factors. But they are also connected to different types of behaviour among men and women. In the research, a hypothesis has been proposed that girl children cry more than boy children because they experience pain differently. Tears also express a desire for comfort from the environment. A possible biological explanation for gender differences leads therefore to gender differences in behaviour. Without a doubt, variations in the types of diseases women and men get can be explained by social factors as well. Men are equally genetically disposed to uncontrollable overeating as women, but women suffer from this illness twice as often as men. Almost one out of ten women is a chronic overeater. This must be explained by social factors.

To the extent that behavioural changes may give men a more objective view of their own health, it is important to support such desired changes. Stereotypical gender roles and

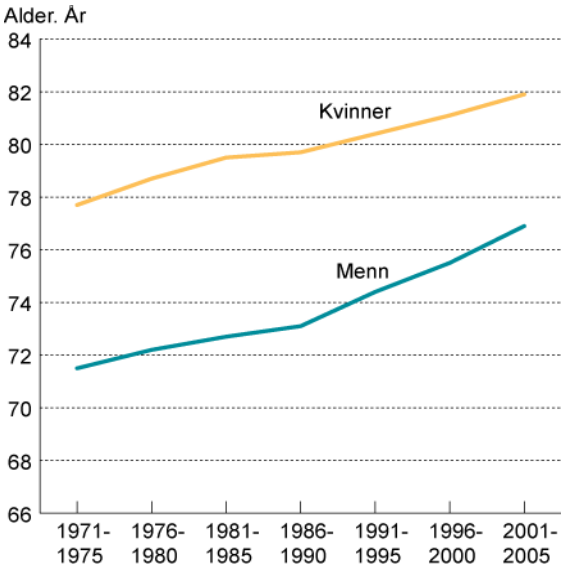
traditional assumptions about masculinity may hinder such changes being made. Men should for example, be more careful about protecting themselves from the sun. But despite warnings from health authorities, many boys and men think it is ”girlish” to put on protective sun lotion. Wherever there are obstacles to desired change, possibly in the form of inherited perceptions, an effort must be made to remove those obstacles. One must evaluate this according to observed gender differences.

Gender differences in life expectancy, reported illness and quality of life and use of health services may be due to biological factors, but they are most certainly also influenced heavily by social factors.

6.1.1 Life expectancy

During recent years men have had a greater increase in life expectancy than women, and the distance between the genders is shrinking. The difference between life expectancy for men and women has been reduced by a third during the past 20 years. In 2006, the average woman could expect to live 4.5 years longer than a man. A higher life expectancy does not however mean the same as more ”healthy” years to live. For some it actually means several more years with declining health or functional problems. One’s state of health declines with age and the instances of injury or illness multiply.

Figure 6.1 Life expectancy from birth 1971 – 2005. Men and women



Source: Statistics Norway

Alder år: Age in years

Kvinner: women

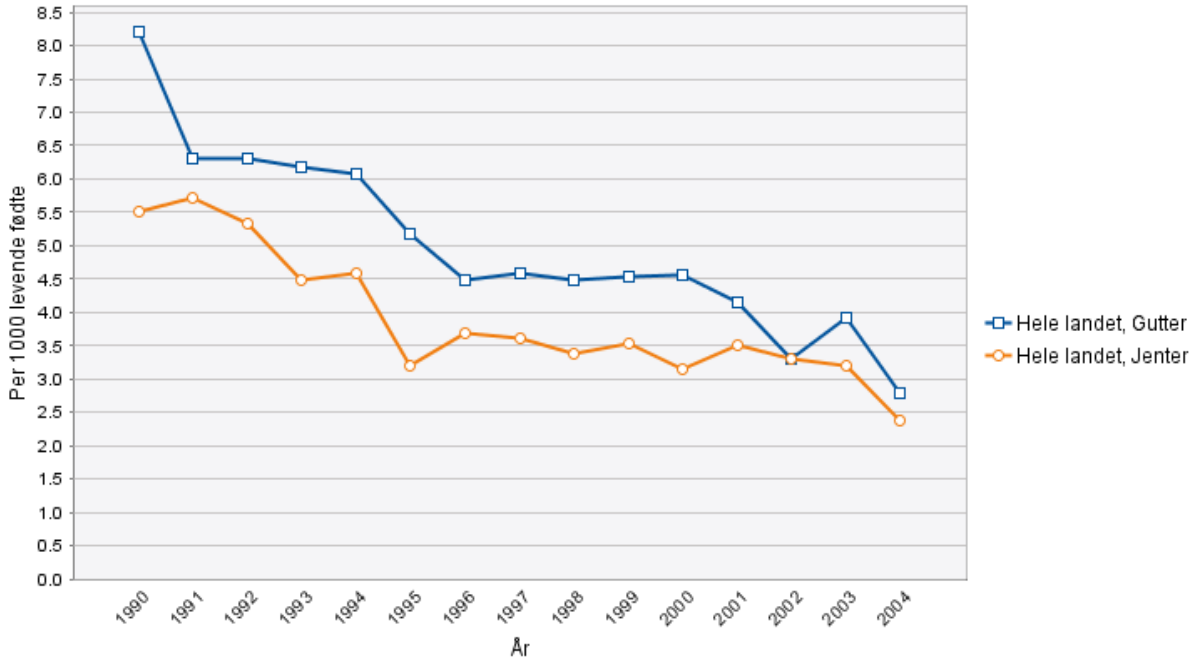
Menn: men

Estimations of life expectancy, with good health or without reduced functioning, shows that men may live shorter lives, but tend to have more healthy years of life than women. ”Healthy Life Years” (HLY) is an indicator that measures how many years a person of a particular age can reckon on living without any functional problems. These calculations show that life expectancy including good health is on average 66.3 years for men and 64.2 years for women

in 2003. When these figures are put next to the ones for general life expectancy one can see that on average 11 of the last years of life for men and just under 18 years of women's lives will be years when health problems set limits for the quality of life. (http://epp.eurostat.ec.europa.eu).

Why differences in life expectancy between women and men have declined in recent decades may be due to a number of medical and social reasons. The risk of infant deaths has been substantially reduced since 1990, and in parallel with this positive development has come reduced differences between the genders. The trend in the risk of death for infant boys and girls is shown in Figure 6.2.

Figure 6.2 Risk of Death for infants 1990-2004



Per 1000 levandefødde: Per 100 born alive

Heile landet, gutar: The whole country, boys

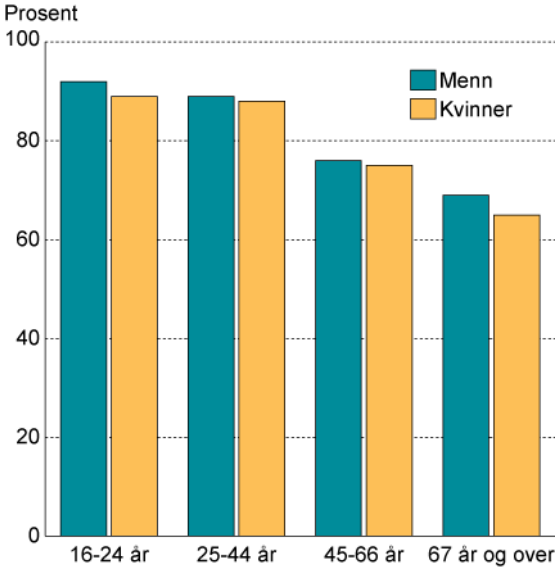
Heile landet, jenter: The whole country, girls

År: year

6.1.2 Self-evaluation of health and quality of life by men

More men than women consider their own health as good or very good. This applies to men and women in different age groups, but differences are greatest among those over 67 years.

Figure 6.3 Men and women with good or very good health in different age groups. Percent. 2005



Source: Central Statistics Board

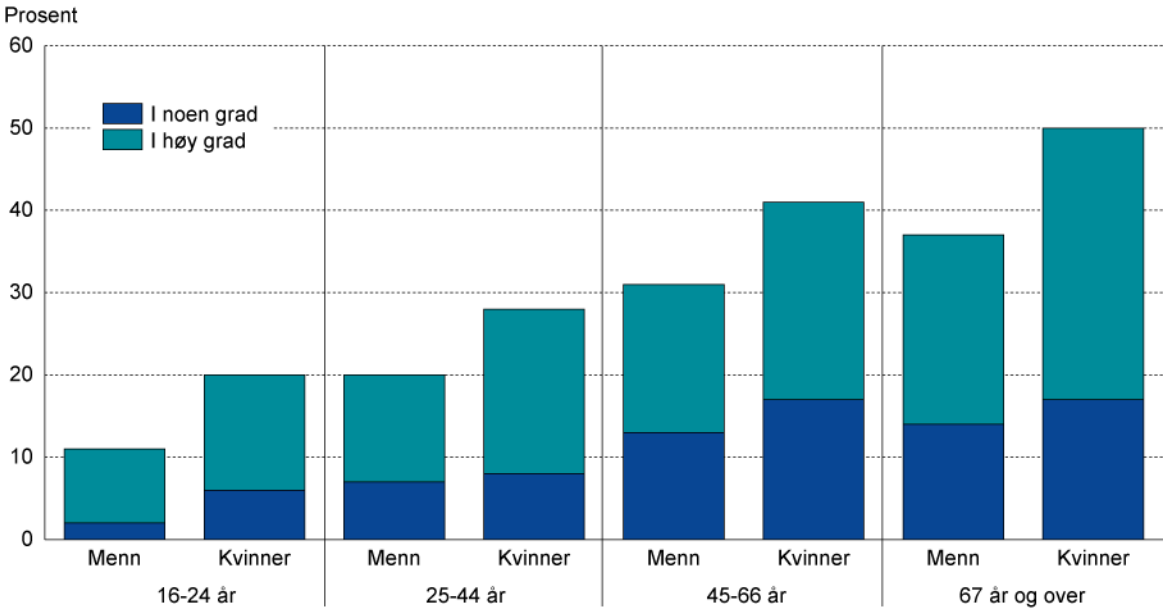
Menn: men

Kvinner: women

Self-evaluation of health is a stable assessment that, according to several studies, may be able to predict the risk of death. There have been small changes in how women and men evaluate their own health in the past decade. Although there are percentagewise fewer elderly people who say that their health is good, it is in this group that we see the most positive development. Among older men, and to a certain extent among older women, the last decade has seen a bettering. (Health and Life conditions survey, SSB)

The state of the nation's health was also measured when men and women were asked in the living conditions survey whether they experience illness or ailments in everyday life that influence them in some or a major way. The responses correlate with the self-evaluations. Fewer men than women report ailments that influence them negatively.

Figure 6.4 Percentage with illness that influences everyday life in some or to a major degree. Men and women, in different age categories. 2005



Source: Central Statistics Board
I nokon/i noen grad: to some degree

I høg/i høy grad: to a major degree

Menn: men

Kvinner: women

The Gender Equality Survey shows the same basic picture as the living conditions survey. Men consistently report better quality of life and health than women. The survey also shows, not surprisingly, that there is a positive connection between regular physical activity and general personal health. Another discovery is a positive correlation between the quality of life a man experiences and the level of gender equality in the couple relationship. Compared to the national average, men who live in equal partnerships report better health and quality of life.

6.1.3 Gender differences in occurrence of illness and illness diagnosis

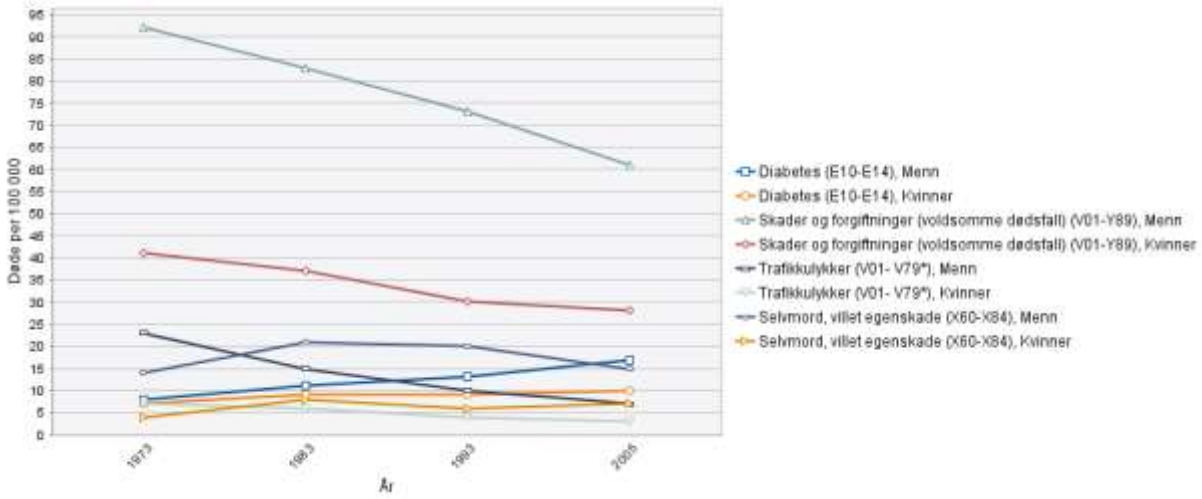
Gender is both biology and culture, and even if the biological similarities between men and women are greater than the differences, men and women distinguish themselves from each other on a number of points. One obvious difference is in the area of reproduction. Women get pregnant, give birth and breastfeed babies. Some of the differences in health problems between men and women may be caused by biology and genetics, but in many cases biology is only one causal factor to be considered when looking at gender differences in health. How notions of femininity and masculinity are socially and culturally formed also plays a role in understanding and explaining why men and women have health failure in different ways, and why risk of death is different for men and women. "There is probably no characteristic that has more and more important implications for health problems and resources throughout life as gender," write researchers Mæland and Haugland. Men die earlier than women; women suffer longer. This may perhaps have a connection with the fact that women suffer from more illnesses that are not fatal. Women also experience more suffering from the same illnesses

that also attack men. From the first year of life, the risk of death is greater for boys. Higher risk of death among younger and middle-aged men may also stem from the fact that men tend to underestimate and under-communicate their suffering. This may mean that they don't get the treatment they need in time and die early. Men also have a lifestyle that increases the risk of accidents and death.

Although differences have declined over the last 30 years, there are still large gender differences when it comes to cause of death. Men are over-represented in the group that die as a result of accidents, injuries or suicide (violent death). Figure 6.5 shows the developments in recent decades. One special feature is the increase in the number of men who die as a result of diabetes. A special challenge here is trying to understand and deal with the increase of diabetes among younger men.

Figure 6.5 Changes in cause of death 1973 – 2005, selection of causes of death.

Source: Norwegian Institute of Public Health



Diabetes… menn: diabetes… men

Diabetes…kvinner: diabetes…women

Skader og forgiftninger(voldsomme dødsfall) menn: Injury and poisoning (violent death)men

Skader og forgiftninger(voldsomme dødsfall)kvinner: Injury and poisoning (violent death)women

Trafikkulykker…menn: Traffic accidents…men

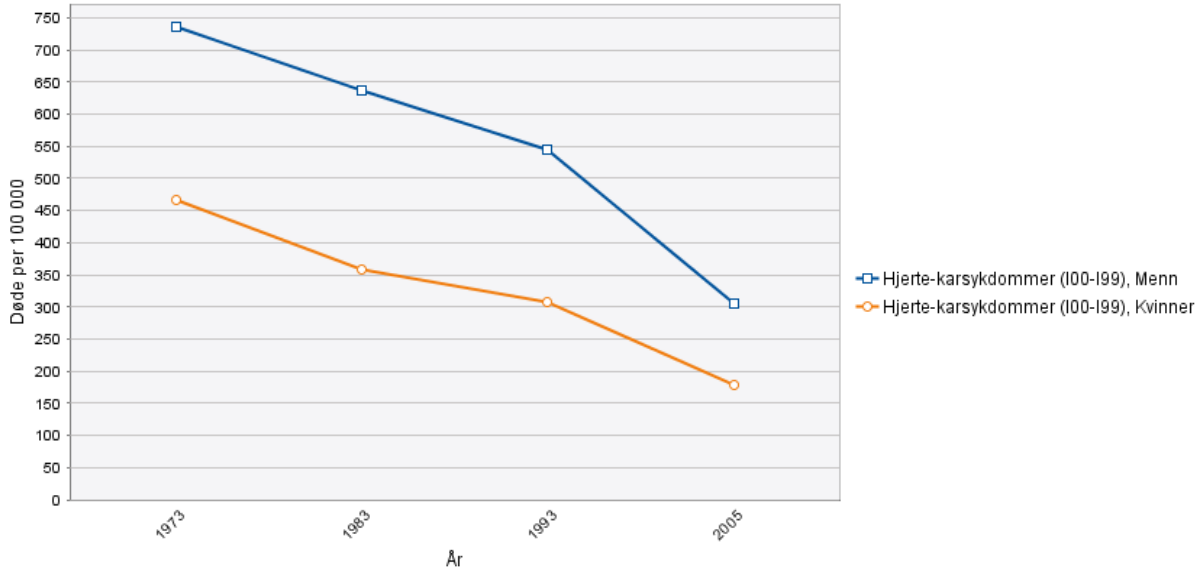
Trafikkulykker…kvinner: Traffic accidents…women

Selvmord, viljet egenskade, men: Suicide, intentional self-harm, men

Selvmord, viljet egenskade, kvinner: Suicide, intentional self-harm, women

Cardiovascular disease can be tied to men and masculinity. In 2005 such diseases are still more prevalent as a cause of death for men than for women. Better medicinal treatment and campaigns to improve public health have reduced the risk of death as a consequence of cardiovascular disease the last 30 years, but the gender differences are still substantial.

Figure 6.6: Death as a consequence of cardiovascular disease 1973—2005, men and women. Source: Norwegian Institute of Public Health



Hjarte- og karsjukdommar …, menn: Cardiovascular disease … Men

Hjarte- og karsjukdommar …, kvinner: Cardiovascular disease … Women

Population surveys show that men experience illness symptoms to a far lesser degree than women. This applies particularly in the youngest age groups, and the results closely match the results from the Gender Equality Survey in 2007 and data from general practitioner surveys. When the population is older, these gender differences decline somewhat, and among persons over 45 years of age, men report a larger number of symptoms than women.

Table 6.1 Percentage who have suffered from various symptoms over a 3 month period. Women and men 16-24 years.2005

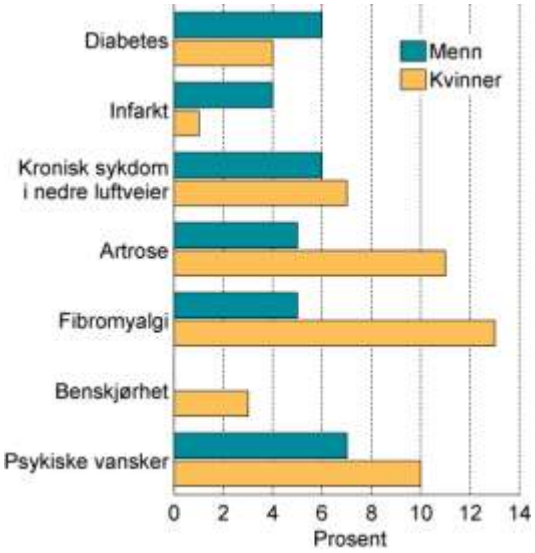
Have in the last three months been experiencing	Men	Women
pain in the body	10	17
headache or migraine	16	30
itching or burning	3	8
nausea or digestive trouble	5	12
dizziness or poor balance	3	9
anxiety or phobias	2	6
a feeling of being “down” or depressed	5	13
irritability or aggression	7	12
concentration problems	10	12
sleep problems	7	14
tiredness or lack of energy	12	29

Source: Central Statistics Board

During the interviews in the Survey on Health and Living Conditions 2005, more men than women in the age range 45-66 say that they have diabetes. There are also more men than

women who go to the doctor for diabetes (SEDA). This is for both types of diabetes. Regular GP's write out more prescriptions for men over 40 years with diabetes, than for women of the same age (prescription registry, FHI). Among younger people there is little difference between men and women. Diabetes increases the risk of heart attack, and men often have heart attacks earlier than women. The incidence increases dramatically with age. In the age group 45-66 years there are four times as many men as women who say that they have had a heart attack. Registration records from regular GP's show that twice as many men as women of all ages go to the doctor with heart attack symptoms. (SEDA)

Figure 6.7 Incidence of specific illnesses. Men and women 45-66 years. Percent. 2005



Source: Central Statistics Board
Diabetes diabetes

Infarkt: infarction

Kronisk sykdom i nedre luftveier: Chronic lower respiratory illness

Artrose: Arthritis

Fibromyalgi: Fibromyalgia

Benskjørhet: Osteoporosis

Psykiske vansker: Psychiatric disorders

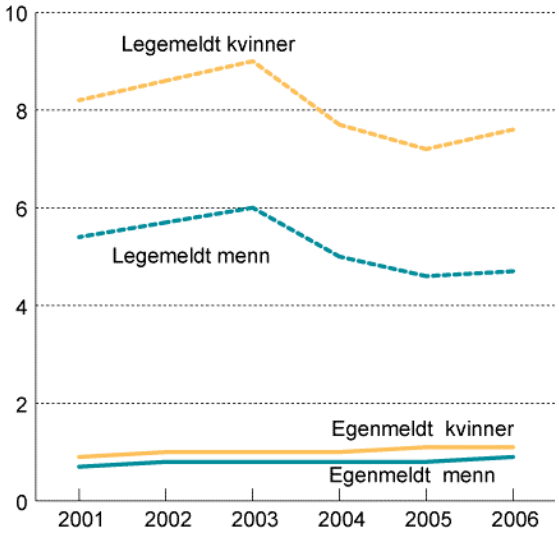
6.1.4 Absenteeism due to illness

If we correct for gender differences in work participation we see that men are less likely to take time off from work because of illness. When we look at the total number of sick-days (both personal and doctor-prescribed) the numbers also show that men have less absenteeism from work due to illness.

The gender differences in the use of leave of absence due to illness (sick-leave practice) also show up in SSB's statistics over absenteeism due to illness, which show that 7,6 % of female

employees and 4,3 of male employees had doctor-prescribed absenteeism from work in 2006. The use of personal sick days is about 1 % of both genders, though somewhat lower for men than for women.

Figure 6.8 Lost work days because of personal and doctor-prescribed sick-days for employees aged 16-69 years, in percent of daily work hours. Quarterly figures. Women and men 200-2006.



Kjelde: Statistisk sentralbyrå
Source: Central Statistics Board

Legemeldt kvinner: women on sick leave prescribed by a doctor

Legemeldt menn: men on sick leave prescribed by a doctor

Egenmeldt kvinner: women on personal sick leave

Egenmeldt menn: men on personal sick leave

The Gender Equality Survey confirmed most of the discoveries that have earlier been made in patient and population surveys. These finds can be summarised in the following way:

- A larger portion of those with higher education exercise and keep fit, women somewhat more than men
- Men generally feel somewhat better about their bodies than women
- Somewhat more women than men say that they suffer from various psychological and physical problems like depression, anxiety, stress, backache and lowered libido.
- Women seem to suffer more problems and discomfort from being overweight.

In the Gender Equality Survey, people over 65 years of age seem to be more comfortable and satisfied with their own body than younger age groups (over 18 years). The survey further confirms a tendency, that has been indicated in other survey, that men (and women) with higher education exercise more often and complain of fewer physical and mental problems than groups with other educational backgrounds.

6.2 Use of health services

Health services should give equal service to the whole population without regard to gender. At the same time, the way in which men and women seem to use the health services is different. The differences may be due to differences in the incidence of certain symptoms, but they may also be due to differences in the way men and women interpret the signals from their bodies.

6.2.1 Use of primary health services

The general practitioner/ regular GP often represent the first meeting a user has with the health services. During childhood and the teenage years, the school health services or public health centres are also important services. Both services are central to illness prevention and wellness work and offer, among other things, individual counselling. A survey of the system of general practitioners shows that men go to the doctor's office less than women. About 65% of the men and 75% of the women seek out their GP in the course of one year. When we look at specific groups, we see that the differences are even greater. For single people between the ages of 25- 44 the difference between men and women is twenty percentage points. In the age group 45-66, there are 105 more women who have been to the general practitioner. In the group of people over 67, there are about equal numbers of men and women who have been to the doctor in the past year. However, among single people over the age of 67, there is a percentage difference of ten points between men and women. Single men seem to face particular challenges in being able to interpret their own body signals, evaluate their state of health and seek out their regular GP.

When we look at how often people have contact with their GP, the gender differences are very clear. Percentagewise there are twice as many women as men who have gone to the general practitioner more than five times the previous year. A report from NAV shows that women between the ages of 20-40 have almost twice as many consultations with their doctor than men in the same age group. This may be explained by the fact that women in their productive years go to the doctor more often in connection with contraception, pregnancy, problems with the reproductive system etc. The survey also shows that men and women over the age of 40 seem to visit the outpatient clinic to the same degree.

Table 6.2 Percentage that have been to a general practitioner the past year, and the percentage that has been to the general practitioner five or more times the past year. Men and women and family phase. 2005

		Visited the general practitioner	More than five visits to the general practitioner
All	Men	65	11
	Women	75	18
Single 16–24 years living with parents	Men	60	6
	Women	70	10
Single 16–24 years, living on own	Men	55	5
	Women	77	14
Single 25–44 years	Men	60	7
	Women	79	21
Couples 16–44 years without children	Men	58	7
	Women	73	17
Single parents	Men	64	8
	Women	74	24
Couples with children who are 0–6 years	Men	60	7
	Women	67	16
Couples with children who are 7–19 years	Men	60	11
	Women	68	15
Couples 45–66 years without children	Men	71	14
	Women	83	19
Couples 67 years and older without children	Men	81	19
	Women	74	16
Single 45-66 years	Men	69	18
	Women	79	24
Single 67 years and older	Men	74	21
	Women	81	19

Source: Survey on Health and Living Conditions, Central Statistics Bureau

After the age of 45 we see a declining difference in the way men and women use the health services. Men over 45 who live in a couple relationships seem to go to the doctor more often than men who live alone, but not more often than women in the same phase of life. After

retirement there are more men than women who have been to the doctor five or more times the past year.

6.2.2 The use of specialist health services

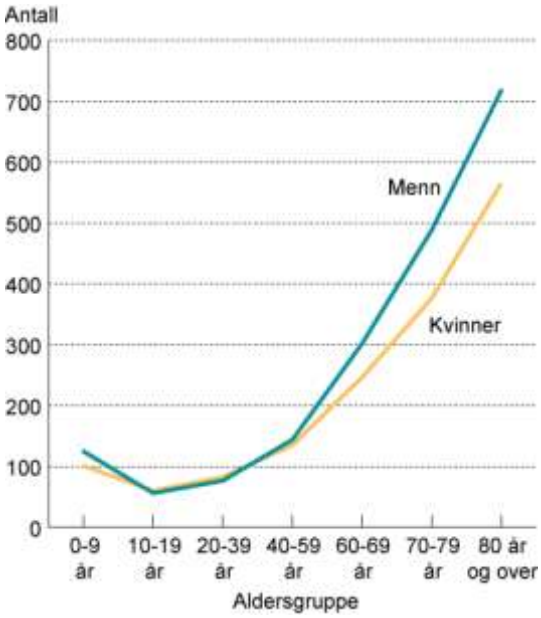
One out of four women and one out of five men have gone to a specialist at a hospital the past year (Survey on Health and Living conditions 2005). Percentagewise there are more women in their reproductive years than men of the same age who have been to a specialist, including specialists at the hospital and in private practice. Leaving out visits in connection with pregnancy and birth brings the female percentage down. Even so, there are more women than men who are referred to a specialist by their doctor (SEDA). The differences between men and women get smaller with age. Among children in the age range 2-14 there are relatively more boys than girls who are referred to specialist health services.

Patient statistics show that men and women have different uses of hospital services, although different use is not the same as being treated differently. Men and women do not always have similar health problems; what the hospital can offer different groups of patients cannot be indiscriminately interpreted as a lack of gender equality. However, data that shows these differences in usage can be a starting point for further studies of gender equality in the hospital sector.

In 2006 there were slightly over 820 000 resident days at somatic hospitals for persons living in Norway. Women stood for 54.3 % of the time spent. The average time per stay however, is about the same for both genders and has remained constant over many years. In 2006 the average stay was 5 days for men and 5.1 days for women. But since women also have more stays it means that men have fewer resident days in hospital per year.

Cardiovascular disease is the most common cause of staying overnight for men and comprises 18% of their hospital stays. Ischemic heart disease like cardiac infarction and angina pectoris (heart cramp) are the most common diagnoses. Men have almost twice as many hospital stays as women for heart disease. Diseases of the brain, like stroke, are almost just as frequent as a cause of admittance for both genders.

Figure 6.9 Full days stays at somatic hospitals per 1000 people by gender and age. Stays related to pregnancy are not included. 2006



Source: Central Statistics Bureau

Antall: number

Menn: men

Kvinner: women

6.3 Reporting of illness by men

Traditional masculinity has focused on strength, self-control, self-mastery, endurance, the ability to act assertively and contempt for physical pain. This has consequences for male health. Men seek out health services less frequently than women, something researchers interpret as an attempt to trivialise or deny the problem. To be sick and weak threatens masculine ideals and often leads men to retreat and suffer in silence when they get health problems. Boys and men have long been socialised to hide their weaknesses and learn to control and suppress emotions, vulnerability and tears. Big boys don't cry, as the saying goes.

The Gender Equality Survey shows that young boys rarely use traditional information channels when they need help or knowledge about something. Boys feel they need to solve the problem on their own and find it not masculine to talk about it. This also applies to sex and relationships. The existing help services are judged by boys to be very girl-oriented and not relevant to their problems. Only 5-10% of the users of the available help and information services for teenagers are boys. But boys make up about 50% of those who use health related Internet and telephone services for youth. Boys obviously need just as much help and information as girls.

Researcher Lilleaas has interviewed men who have had heart attacks and puts forth the premise that a deeply ingrained male *provider logic* lies at the base of how men look at their body, their health and illness. Those interviewed showed through what they said about their

job, career and family provider responsibility that they always have seen themselves as the main provider of the family, even though most of them had wives who worked full-time. Many of the men had worked a great deal. The picture they describe of their bodies before the heart attack is of a"strong, enduring and always working body", writes Lilleaas. The men report proudly that they had never missed a day of work because of illness until the heart attack. This side of traditional masculinity becomes a real problem when it leads men to overlook illness symptoms. However, these same characteristics can influence the course of treatment and rehabilitation in a positive way. One study has shown that these very masculine men show a greater degree of recovery from the time they were admitted to the hospital to one year after being released. The ability to tolerate adversity and show the will to overcome obstacles is also part of the foundation of the image of masculinity.

When men interpret illness as a sign of weakness, something that threatens a man's identity as a proper workingman and hurts his pride as one who never falls ill, they often keep their health problems to themselves. In the "Fatigue Project", where male engineers and leaders were interviewed on how they handled being tired and worn out, researchers Lilleaas and Widerberg found that the way many of the men initially spoke in the interviews gave the impression that they never had had any health problems. It was only towards the end of the interview that they revealed that they had experienced a number of signals that their bodies were being overtaxed. Many suffered from typical stress symptoms which they had not shared with anyone, not even their closest family members. In Chapters 4 and 5 it is pointed out that younger men are the group that works the most overtime. Younger men are also the ones who suffer most from symptoms of chronic fatigue. There was a strong connection made between this fatigue and night shifts, overtime and the like, where men are over-represented. Being chronically tired can lead to an increased risk of accidents.

A study of men who have had heart attacks shows that one common characteristic of all the men was that they didn't talk to other people about how they were feeling. Men resist talking about their own health and consequently under–report illness. Many don't admit that they have any pain or ailments. They go less often to the doctor and don't receive treatment. This means that many men live with problems that could have been treated. For example, prostate infections (prostates) are male health problem that also affect younger men. The illness arises from a bacterial infection and causes various degrees of pain in the lower abdomen. Studies show that young men hesitate to seek help for such vague problems. But by avoiding seeking help they bring much bigger problems upon themselves. Even more serious is when men avoid going to the doctor with symptoms that later turn out to be signs of fatal illness.

More men than women get cancer, and more men than women die of cancer. Men die more often even from types of cancer that normally strike women. Malignant moles are more prevalent among women, but more men die from this form of cancer. The cancer has usually spread by the time the men discover the problem. According to the Cancer Society, the most important reason why more men die is that they wait too long before they go to the doctor. Men either don't feel the symptoms or they don't take them seriously. Many men even overlook symptoms of cardiovascular disease. Many of the men interviewed by researcher Lilleaas had symptoms like pain in the arm or neck and actually felt really unwell. But many of the men trivialised the symptoms or overlooked them because they had too much to do at work. It becomes a gender equality policy challenge when such collective attitudes lead men to avoid health services. Such attitudes must be changed so that men will seek out health services when their body tells them to do so.

6.3.1 Psychiatric health

The healthier a life the men had, the fewer psychological problems they experienced that required intervention. Patient surveys show that women are the ones who experience the most common psychological problems more often, although the problems seem to be expressed in different ways by the two genders. Researcher Dahl describes it in the following manner: "Women and men represent two distinct images of suffering. Women's psychological illnesses are dominated by emotional disturbance and individual misery, while men's psychological problems are more characterised by behavioural difficulties which have big consequences for those closest to them." Studies also show that the two genders have different ideas about what they experience as psychological stress. Women put the most emphasis on problems with relationships and loss, while men report that economic problems, loss of work or problems at work as contributing most to psychological stress.

The reluctance to talk about problems can have the same types of consequences for psychological health as for somatic illness. Many who suffer from anxiety do not go to the doctor. This applies especially to men, who do not talk about such problems because they clash with the idea that to be manly is to be unafraid. Differences between men and women in the case of depression may be explained by looking at the differing abilities of men and women to talk about their emotions. The greatest difference we see between men and women with regards to psychological illnesses is in looking at minor depression. Many more women than men suffer from minor depression. Serious depression is more evenly distributed between the genders, as is bipolar disease (manic-depressiveness). Men tend to want to take care of minor depression themselves and do not seek out health services for help. Unfortunately the problem then gets treated too little or too late, and others do not become aware of the problem until the man attempts suicide or succeeds in taking his own life.

6.3.2 Suicide

Women attempt suicide 10-20 times more often than men. But many more men than women succeed in taking their own lives. We especially see young men with psychiatric disturbances, addicts, alcoholics and older, lonely and depressed men among these statistics. There were 359 men and 170 women who chose suicide in 2004; there are virtually twice as many men as women. This difference has been previously even greater, but from 2003 to 2004 the number of female suicides increased, while the number of male suicides decreased slightly. The explanation of the large difference between suicide attempts and suicides lays in the methods that men and women tend to choose. Women more often take overdoses and survive. Men use more dramatic methods like shooting, hanging or drowning. Newer research indicates that this pattern may be changing, with more men taking overdoses and more women using violent methods like hanging.

6.4 The male lifestyle

The traditional image of masculinity works its way into men's habits in a way that influences their health and risk of death. This image affects nutrition, physical activity, tobacco use, sexual health, mind-altering substances and accident proneness.

Lifestyle habits contribute to gender and social health differences. If we want to decrease these differences we must take measures to make it simpler for everyone to acquire healthy habits. Structural initiatives mean more for public health on a large scale than initiatives primarily geared towards the individual. Normative means such as laws, regulations, guidelines and recommendations are essential, and the effect is greatest if measures targeting several arenas are combined and used simultaneously. Schools, workplaces, local neighbourhoods and health service institutions are large societal arenas where it is important to facilitate healthy lifestyle habits. These are arenas where a large portion of the population spends time every day and can be reached.

6.4.1 Nutrition

When we compare food intake among different groups in the National Nutrition Survey, we see that men tend to eat more of most things than women. This is natural; the men had a 40% higher energy intake than women. This difference can be explained partly by the differing needs of the bodies of women and men. Still, it was the women who stood for a higher intake of vegetables, fruits and berries, skimmed milk, tea and wine.

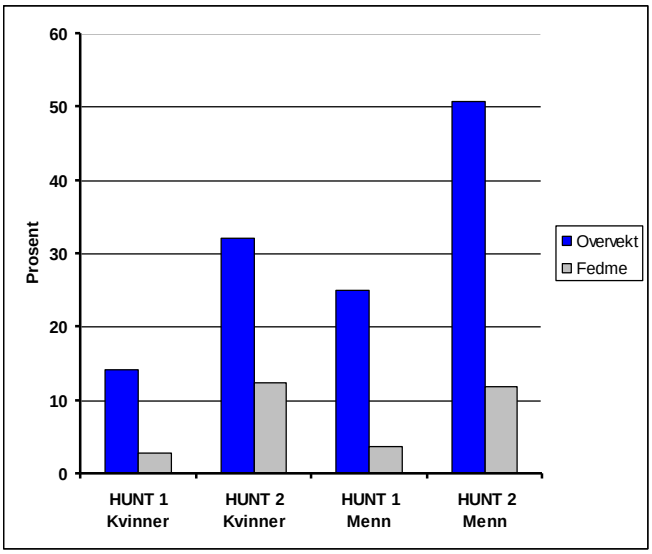
A common practice among men is to go a long time without food, then eat a large meal. Many men think that fruit, vegetables and other healthy foods are not satisfying enough or do not give the energy they need. When a study of men and dieting was done by researcher Lien it was found that many of the men who participated in the study felt that healthy food was ”ladies food”. The idea that concern for nutrition is a female domain has been prevalent in our society, but this may be changing.

With increasing age, we tend to eat less of most kinds of food. This is especially true for types of food like sodas, sweets and snacks, where the consumption was four, five and six times greater among men in the age range 16-29 years than among men in the age range 60-79 years. Intake of foods like potatoes, vegetables and fish was on the other hand lower among the younger men. In 1997, Norkost showed that those with higher education and socio-economic status tended to have a healthier diet than those with less education and lower socio-economic status. Non-smokers and those who exercised regularly also had a healthier diet than smokers and people with sedentary lifestyles.

Men and women with at least 13 years of education had a higher intake of vegetables, fruit, fish, skimmed milk, tea, beer, wine and spirits and a lower intake of potatoes and low-fat milk than those with less than 13 years education. Men with a long period of education had a lower consumption of meat, whole milk, saturated fat, sugar, honey, sweets, snacks and sodas than men with a short education behind them. Both men and women with much education took vitamin and mineral supplements more often than those with less education.

Initiatives on the nutrition front are justified in the Action Plan for Better Nutrition in Norway(2007- 2011)

Figure 6.10 The development in the percent women and men in the age range 20-29 years that are overweight (KMI 25,0 – 29,9 kg/m^2) or obese (KMI ≥ 30kg/m^2) between HUNT 1 (1984-1986) and HUNT 2 (1995-1997)



Menn: men

Kvinner: women

Overvekt: overweight

Fedme: obese/obesity

As Figure 6.10 shows, half of men between 20 and 29 years of age are overweight. This is substantially more than among women. Among all those over 20 years of age the HUNT 2 shows that 53% of men and 40% of women can be characterized as being overweight. From the documentation from Nord-Trøndelag, we understand that there are differences in body weight between the sexes.

6.4.2 Physical Activity

In their so-called ”Fatigue Project”, Lilleaas and Widerberg discovered that many men saw their body as a machine that did not need maintenance, as something one used until it broke. This same attitude has been found among top athletes in a later survey.

In the Gender Equality Survey 2007 men and women are asked about their attitude towards their own body. Results show that men are more likely to be satisfied with their body than women are.

While 64% of men say they are completely or relatively in agreement with the statement ” I feel good about my body”, only 48% of women feel the same. Only 4.6 % of men say they completely disagree with the statement (they did not feel good about their bodies). The numbers may be an expression of substantial gender differences. But they may also indicate that men and women have different satisfaction thresholds for their opinions about their bodies. These numbers also seem to contradict the statistics about other factors that normally are seen to be negative, like obesity/overweight and the like.

When we look at physical activity we see that several Norwegian studies show that men exercise more often than women. The percentage of men between 40-42, who do hard physical labour however, has been halved to 15% during the period 1974-1994. The numbers for women are pretty stable at 3-4%. This may indicate that men have generally become less physically active at work. MMI studies in Norway shows that men tend not to train for reasons relating to gaining more energy, wellness, preventing illness, maintaining a correct weight or body shaping. The reasons men give for training are more often excitement and the possibility of comparing one's strength with others'. Both men and women with higher education exercise more than those with less education. This strong social factor is present in both genders.

The recommendation for adults is to have at least 30 minutes of moderate physical activity daily. In order to get more adult males to do this, it is important to work deliberately to establish activities that have a low threshold for men. The preliminary results from"Green Prescription" scheme show that 76% of the participants are women. The popular, low threshold activities in the scheme, like training to music, staff walking and walking groups have not appealed to men. Men must be involved in developing and organising low threshold activities. The initiatives on this front are described in the Action Plan for Physical Activity 2005-2009.

6.4.3 Tobacco

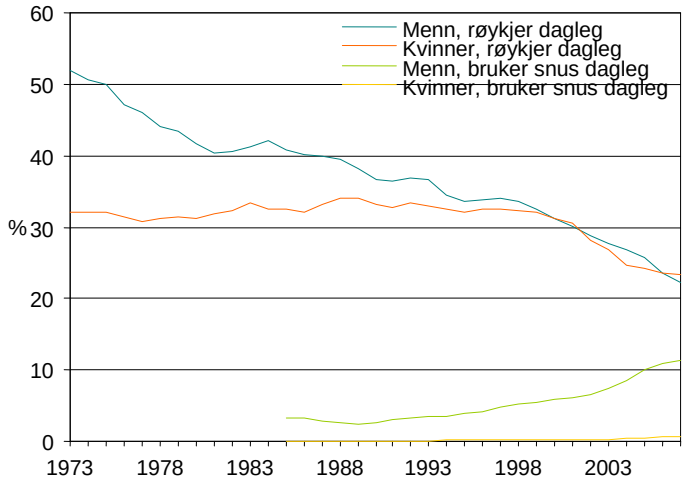
Statistics show that smoking was the cause of death in over 6 700 cases in 2003. That corresponds to 16% of all deaths, 19% of male deaths and 14% of female deaths. The number of male deaths that can be attributed to smoking was 3700, and the number of female deaths was 3000. The number of deaths caused by smoking is increasing among women, while the number of men who smoke is going down.

In 1973 over half of the male population smoked, and about 30% of the female population did the same. This difference has contributed to the differences in the smoking related illnesses and deaths between women and men. In 2007 the number of men and women who smoked daily was about the same, about 22% of each gender. No differences among the younger generation were found.

Smoking is the behavioural factor that can most easily be correlated with one's state of health. It is the best documented and is also clearly marked by differences in social class. Smoking is much more prevalent in groups with lower education, lower income and manual labour as a profession. In recent years however, all socio-economic groups have seen a decline in the numbers of smokers. Among men the decline has generally been large and even. Among women there has been more variation.

With regard to the use of snuff, there are great differences between men and women. The daily use of snuff has increased among men from 3% in 1985 to 11%, while the percentage of women using snuff has never been more than 1%. This increase has been explosive among younger men. In the age group 16-34, the percentage of men using snuff has increased from 3% in 1985 to nearly 20% in 2007. Use of snuff in this age group has become almost as common as smoking. It is also in this group that there has been the greatest decline in those who smoke. These two statistics may easily be linked. Among women, the percentage of smokers has gone down without any corresponding increase in the use of snuff.

Figure 6.11 The development of the percentage of women and men in the age range 16-74 who smoke or use snuff daily, 1973 -2007
Source: Central Statistics Bureau



Menn, røykjer dagleg: men who smoke each day

Kvinner, røkjer: women who smoke each day

Menn, bruker snus: men who use snuff each day

Kvinner, bruker snus: women who use snuff each day

The National Strategy for the Prevention of the Use of Tobacco in Norway 2006-2010 has a multifaceted perspective, looking at social inequality, gender and cultural background as it pertains to smoking habits. All of these perspectives are taken into account when the measures in the plan are conceived and implemented. Supervision of the plan, surveys and evaluations will also take these perspectives into account.

6.4.4 Boys and men – sexuality and sexual habits

Sexual habits are connected to gender and gender-based differences in the understanding and experience of sexuality. Cultural gender-based differences have historically influenced the sexual habits of both women and men. In the Gender Equality Survey both men and women were asked if they viewed their sex life as good or not. About half of both women and men rated their sex life as good or very good. There were more women than men who thought of their sex life as good, but there were also more women than men who were very dissatisfied with their sex life. Younger women and men were somewhat more satisfied than older people.

The sexual habits of men and women have grown more alike since the 1960's. Surveys indicate that it is generally women who have changed their behavioural pattern. Some factors that have been put forth to explain this phenomenon is: the work towards gender equality; an evening out of earlier differences in education, and easier access to contraceptives. It is important to have enough understanding of the sexual habits of a population in order to

understand, predict and prevent the spread of sexually transmitted diseases such as HIV/Aids, Chlamydia, and herpes. Having a firm knowledge base may also help prevent unwanted pregnancies. Institute of Health has therefore examined the sexual habits of the Norwegian population with five years in between each survey, the first one being in 1987.

The great majority among women and men over 18 years of age report that they have sexual experience. Only 5% of women and 8% of men over 18 years said in 2002 that they had not had any sexual experience. In 2002 the average age of sexual debut for boys was 17.5 for boys, 17.1 for girls. The age of sexual debut for girls has not changed much since 1987 (the first year of the investigation) but has become 0.7 years lower for boys. One of five boys has had their sexual debut before the legal age of sexual consent (16 years). One of four girls has had their sexual debut at less than 16 years of age.

A good sex life is looked at by many as one of several very important criteria for quality of life, according to the Gender Equality Survey. Studies also show that many people are sexually active until quite late in life, although the percentage of people who are sexually active declines with age. In the oldest groups we find large gender differences. While 40% of men between 75 and 85 years of age reported being sexually active, the number was just 17% for women of that age. At the same time, just as many men as women reported that pain or other bodily problems hindered them from being sexually active.

More men than women report having had many sexual partners (more than ten). Among men however there seems to be a change towards having fewer sexual partners. In 2002 more men than women reported having many partners, but these gender differences are still markedly reduced from what they were in 1987.

There are changes that have happened with respect to sexual experience with a member of the same gender. In 1987, around 4% of men answered that they had such an experience, while around 11% of men in 2002 responded that they had had a sexual experience with another man. The average age for first sexual contact with another man was 15, both in 1992 and 2002. It is primarily in the younger age groups that this change regarding homosexual experience has happened. In the age group 18-24 years, the percentage of men who reported a homosexual experience was as follows: 5.8% in 1987, 14.1% in 2002. If we look at men in the age group 45-59, 2.8% responded that they had had a homosexual experience in 1987 and 4.5 % in 2002.

Table 6.3 Percentage men and women who have had sexual intercourse with a partner of the same gender

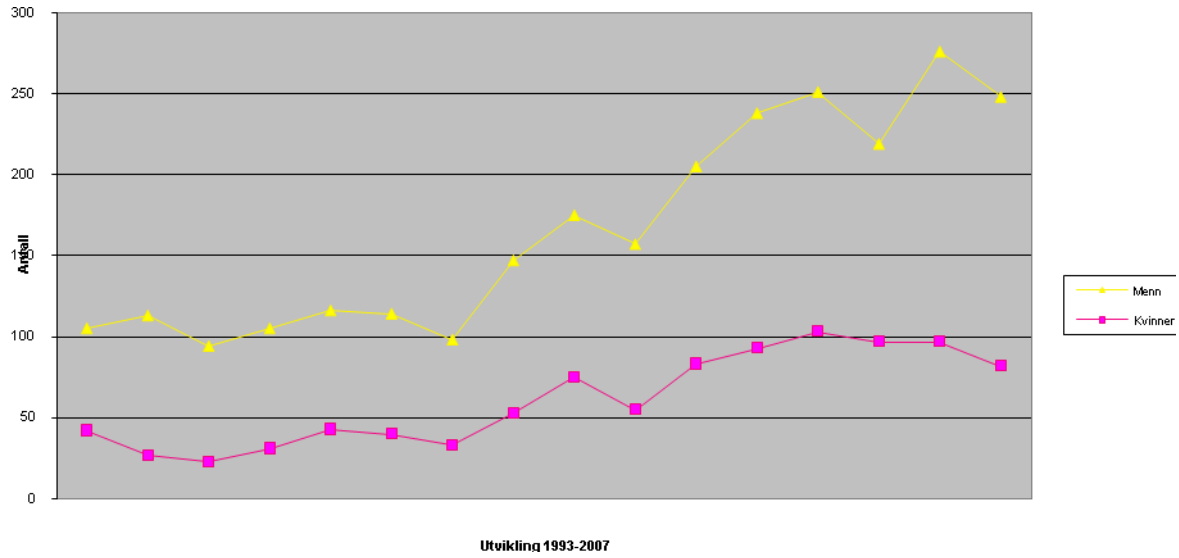
	Menn	**Kvinner**
1987	3,6	3,3
1992	4,8	3,7
1997	5,1	6,4
2002	10,7	11,7

The Sexual Habits Surveys from 1987 – 2002 underscore that having sexual experience with a person of the same gender is by no means synonymous with being homosexual, lesbian or of bisexual orientation. A clear majority of those who reported having a homosexual experience also reported to having a heterosexual orientation (61%).

In 2002, 13% of Norwegian men reported that they at one or another time in their life had paid for sex. That represents an increase from 2% of those who responded in 1992. The percentage of women who say they have paid for sex is low at all survey times.

6.4.5 Sexually transmitted diseases

There are clear gender differences regarding the statistics about sexually transmitted diseases. From the time that cases of HIV and AIDS began to be officially registered in the early 1990's, we see that 2 of 3 persons registered with the disease have been boys or men. In the group of boys/men, persons with homosexual experience are over-represented. In figure 6.12 the number of cases is distributed by gender for the period 1993—2007.



Figur 6.12 Årlege tilfelle av hiv blant kvinner og menn

Figure 6.12 Yearly cases of HIV among women and men

Utvikling: Development

We see the same gender pattern for the occurrence of gonorrhoea as for HIV, and the scope is about the same. Hepatitis C can also be transmitted through sexual contact, but there are more variations in the way in which Hepatitis C is transmitted. Regardless, Hepatitis C is more rampant among boys and men than among women. In 2007 there were 69 registered cases among women and 127 among men.

Genital Chlamydia is the sexually transmitted infection that has the widest spreading now, with 23 000 registered cases in 2007. Women are over-represented both among those that go to take the tests and those that actually have the infection. There may be some hidden statistics in this case and it is doubtful that the available statistics give a full picture of the situation.

There is little doubt that gender differences in sexual habits and practice influence the frequency and occurrence of infection.

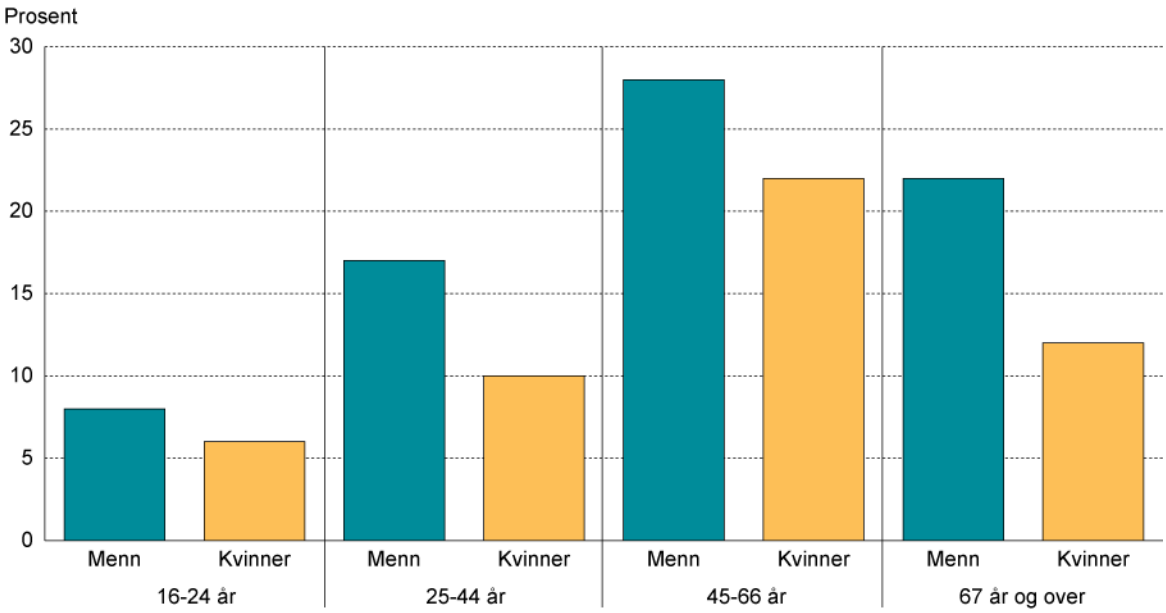
6.4.6 Alkohol and Narcotics

Men drink substantially more alcohol than women. They drink more each time they drink and they often drink to get drunk, although in the past 10-15 years the habits of girls and women begin to be more similar to those of boys and men. Still, the estimated yearly alcohol consumption of men is 2.5 times higher than women. Researches have estimated that there are probably six times more men than women who abuse alcohol. However, there are only twice as many men as women in alcohol rehabilitation centres. It seems that men also in this area resist asking for help for their problems. It is claimed that men to a greater extent than women mask both sorrow and depression with intoxication and that many men self-medicate themselves with alcohol when they have psychological difficulties.

Regarding narcotics use, 13% of the 15-20-year olds in the Surveys of Youth say that they have used hashish. Boys make up a large portion of these. However, there are no essential differences between boys and girls when it comes to experimenting with mind-altering substances in the teenage years. When it comes to serious and long-term abuse the gender differences are more obvious. Studies of addicts at rehab centres and needle exchanges show that there are more than twice as many men as women among these serious addicts. Most of those who try narcotics in their teenage years try them out in a limited way and for a short period of time, then quit and move on. But some develop a stronger addiction and the risk of becoming an addict seems to be higher for men than for women.

Use and abuse of drugs can lead to health problems and social problems directly related to the drugs, both acute and chronic problems that are consequences of long-term and heavy use. High alcohol consumption over a long period of time increases the risk of developing alcoholic liver disease, for example fatty liver, hepatitis and liver failure. 10-30% of those who have a high and long-term abuse of alcohol develop liver disease related to alcoholism. The extent of hospital admissions and deaths, related to alcoholic liver disease, is twice as high for men as for women. This is actually surprisingly low, given the fact that the average alcohol consumption for men is to three times higher than for women. The statistical anomaly may be explained by the fact that those women who do drink a lot have a much higher propensity to develop alcoholic liver disease than men with a corresponding consumption.

Figure 6.13 Drink a lot of alcohol two or more times per week. Men and women in different age groups. Percent. 2005



Source: Central Statistics Bureau

Each year there are about 200-300 deaths by overdose as a result of too high a consumption of opiates such as heroin. The number of overdose deaths varies from year to year, and it has gone down the last few years. In Oslo there are about 1400-1500 ambulance calls in connection with overdoses. Women comprise about 20% of these cases, both with regards to deaths by overdose and ambulance calls. Men comprise therefore 80% of the cases. Death by overdose occurs most often among relatively young adults and makes up a large part of the deaths in the age group 20-50 years. On the national level, overdoses make for 12% of deaths in this age group and in Oslo the percentage is around 25%.

6.4.7 Accidents

Accident statistics reflect the consequences of traditional masculinity, including the expectation that boys and men are more active, aggressive, brave and daring than girls and women. Even from the earliest years of childhood, boys are much more prone to accidents and injury. Accidents make up a large portion of the risk of death for children. In the age group 0-17, 42% of all deaths had external causes, while 58% are caused by illness. Boys dominate the accident statistics. Boys are also more injury prone than girls. In 2003 for example, the number of broken bone injuries in the age group 0-17 was 464 per 100 000 for boys and only 240 for girls.

Such differences between the sexes last the whole life span. More men than women die of accidents. In 2004 1165 men died from accidents, compared to 815 women, and more men than women die in accidents in all age groups and all types of accidents except one: More women than men in the age group over 80 die as a result of a fall (358 women and 225 men).

Road accidents make up a large part of all accidents. There are about 12 000 traffic accidents yearly in Norway that cause injury, and around 200 people die in traffic accidents every year. More men than women are injured and killed in traffic; in 2005, 220 people were killed; of these, 154 were men and 66 were women. The same year, 6553 men and 4661women were injured in traffic. The numbers are especially high for young adults. With respect to car

crashes, it is noteworthy that there are more injured drivers that are men, while among injured passengers we find more women. Young men are the most prone to be injured and killed in traffic. This may be because they tend to drive aggressively and fast.

Researcher Rossow separates out the traffic accidents that can be classified as drug-related injuries. Narcotics and alcohol use is one of the most prevalent risk factors for traffic accidents. Between 20-40% of drivers, in accidents resulting in death in Norway, have been under the influence of alcohol. In traffic accidents where the driver is under the influence, we also find that injuries tend to be more serious than in accidents where alcohol has not been involved. The police in Norway register about 5000 cases of driving under the influence of alcohol yearly and 4000 cases of driving under the influence of narcotics or sedatives. It is usually men who get behind the wheel when they are intoxicated and men make up 85% of the intoxicated drivers caught by the police.

6.5 Strategies to reduce gender differences in health -- the use of preventive health services among boys and men

Gender differences are clear when we look at both the reporting of illness and the use of health services. There is about a five-year difference in life expectancy between women and men and the causes of death vary somewhat along gender lines. A long-term goal would be to reduce and even out the gender differences, but since the actual causes of the differences are so complex, it may not be possible to set binding goals for the future based on the knowledge of today. These gender differences are not only biological. Lifestyle, cultural attitudes, attitudes towards one's own body, and variations in accessing health and care services are all factors that influence the differences we see. Social differences also lead to health consequences for men and women.

It is not known how much weight to give these and the many other factors that may play a role in gender inequality with regards to health. The life expectancy in Norway for both genders is on the rise and the differences between the life expectancy of men and women on the decline. The reduced risk of infant death has surely contributed to the lengthening of life expectancy. Better public health and preventive measures against illness play a large role in extending life, while the development of pharmaceutical medicine plays a smaller role.

Awareness of gender differences in health and use of health services can help better the general public health and improve the quality of the health and care services. Central elements in this work are:

- reaching out with health information to both genders
- making the school health service and public health centres for teenagers more attractive as an alternative for boys
- an integrated gender perspective in the health and care services and in research on health
- an increase in knowledge about gender differences in the use of health services
- goal-oriented measures to reduce the occurrence of sexually transmitted disease

6.5.1 Dissemination of health information

The authorities today use extensive resources towards the dissemination of health information to the population. Public authorities take direct responsibility for the spreading of information and other institutions also do their part, institutions like research foundations, volunteer groups and consumer groups. The information gets spread in the form of publications, via Internet and in other ways. Communication is used today as a common initiative on par with legislation, financial arrangements and structural conditions.

Information is important both in order to prevent illness in the population and as an aid to anyone who has identifiable or unidentified ailments. To inform the population on both risk factors and preventive factors with regard to illness promotes better public health and fewer deaths. Changes in lifestyle have led to an increase in the quality of life and life expectancy for women and men. When information needs to go out it is important that gender issues do not hinder an unbiased communication flow.

The government believes that is important to ensure that health information reaches both women and men. The information should target men and women in different ways, in the same way as other background variables are taken into consideration when communication is being developed. Health professionals must learn how to best communicate with both genders and with people from different backgrounds. In certain cases it is obvious which gender is the target of the message, for which gender the information is most relevant (for example regular scrotum examination for men and warnings against narcotics use during pregnancy for women). Information must adapt itself to different social groups as well. Income and education draw important lines between people as often as gender does. Social background is a stronger factor than gender with respect to predicting life expectancy even though gender also contributes to the perceived differences.

The sex life of an individual plays a role in general health and quality of life. Section 6.4.4 has data from the Sexual Habits Surveys. In the Gender Equality Survey, a majority of both men and women said they were satisfied with their sex life. But at the same time, sex is a sensitive topic for many. The work towards gender equality, for example working towards counteracting negative stereotypes, necessitates that more information about sexuality and perceptions about sexuality is spread.

In public health campaigns we need to evaluate gender as a variable to be considered when communication strategies are developed. How this best can be done will vary from initiative to initiative. In some cases, health information that is specifically adapted to a particular gender is what is needed.

The preventive work in the area of lifestyles is rooted in the Action Plan for a better National Diet (2007-2011), the Action Plan for Physical Activity (2005- 2009), The National Strategy for the Prevention of Tobacco-related Damage (2006- 2007) and the escalation of plans to prevent drug abuse.

The gender influence is central in the preventive work within the fields of nutrition, physical activity, and use of tobacco, drugs and alcohol. All of the current strategies and plans contain mention of gender differences and emphasise a gender perspective when developing interventions. There has not been found large gender differences regarding the onset of smoking, quitting smoking, motives and motivation for quitting smoking or how much knowledge women and men have about smoking. However, men and women can still to a certain degree have varying motives for smoking and different was of communicating which should have an influence on how stop smoking programs are developed. Men are less likely to seek help, for example to go to a course. But despite these differences 2007 saw for the

first time more men than women (51% to 49%) take contact with the Smoke hot line, which is a free advice service where one can get help to stop smoking and/or using snuff.

Several mass media campaigns about smoking have been conducted in recent years. Campaigns can be adapted to target different audiences in the way they are designed, which channels are used, which actors are used and the way the message is conveyed. In Norway the most common way of doing a campaign is to choose something gender-neutral in order to reach out equally to women and men. The results from the evaluation of the Stop Smoking campaigns in 2003 and 2006 did not show any systematic gender differences. However, since it is mainly men who use snuff, the information material on snuff has had a more"masculine" design. Unfortunately, self-help brochures usually don't have much effect. If one is to reach young men with information about snuff, it may be more important to actively use arenas such as secondary schools and the military.

Several research reports show that women generally have better results from treatment interventions than men when it comes to drug and alcohol problems. The documentation is clear that gender-sensitive treatment gives better results than gender-neutral treatment. It is also probable that the gender dimension has an impact when it comes to communicating about preventing drug and alcohol abuse. Alcohol consumption does not mean the same thing for girls and boys, and girls and boys experience risk and safeguards in different ways. The problem of alcohol and drug abuse seems to have different types of consequences for girls and boys. So when it comes to working preventively, a gender perspective is essential.

The Bergen Clinics (Stiftelsen Bergensklinikkene), one of the seven regional competency centres in Norway for questions about drug and alcohol abuse, has the theme of gender and intoxication as its specialty area. The competency centre holds courses in the region and nationally that shed some light on the problems that exist in dealing with boys and drug abuse from a prevention and risk perspective. The Bergen Clinics published a collection of articles in 2007 called"(Gender) Beauty and the beast" (Kjønnheten og Udyret) where prevention of drug abuse, early intervention and treatment with a gender perspective are themes. National Competency Centres offer separate courses on men and drug and alcohol abuse and women and drug and alcohol abuse. They are also helping municipalities to develop action plans to combat drug and alcohol abuse. In order to do this it is important to map out the general status of the drug and alcohol consumption use in each area. In doing this, gender patterns may be revealed and specific preventive measures can be initiated.

In the three-year project to be carried out in cooperation between the Workplace Committee against Alcoholism and Drug Abuse (AKAN) and Bergen Clinics, one of the goals is to increase understanding about the need for gender-specific preventive strategies in the workplace. On the basis of this information, an evaluation will be made whether gender-specific methods will be developed for the preventive work in the workplace. Other individual projects receiving subsidies from the Norwegian Directorate of Health are targeting arenas where the problems of boys are prevalent, for example traffic and alcohol. The same is true for work being done to improve the health of homosexuals which combines the areas of HIV, drugs and psychological health in a broad health perspective.

Norwegian Directorate of Health is working now on guidelines for early identification and intervention among those who work with at-risk children and youth. The guidelines will take up differences in behavioural patterns that can be seen in girls and boys as early warning signs of a problem with alcohol or drugs.

6.5.2 Conscious efforts on behalf of boys in the school health service in order to make it more attractive for boys to use the service

Public health centres and school health service

Public health centres and school health service from 0-20 years is a regulated municipal service that is meant to be accessible for the users. In many municipalities the service includes a public health centre specifically for juveniles. The service works to prevent psychological and physical problems and conditions in children, youth and pregnant women through guidelines, counselling, networking and health check-ups. Recent numbers from SINTEF Health show that boys use this service much less than girls.

During the ages 0-5 years the children come to the public health centres accompanied by their parents. When they start school, they can begin to seek out the service on their own. Surveys show that more girls seek out the services than boys. In order to ensure equal access to service it is important to consider all users and their needs. User participation is central. The employees in the service need to be updated on what boys are concerned about and how problems can be discussed according to their premises. Establishing separate girl and boy groups may be an effective means to create a secure environment and give information adapted to the target group.

If boys are to get their needs met, the service needs to be visible and accessible in the school environment. Several information channels may be used to make the service more easily accessible. Putting more information on the Internet may help boys to use the service more actively. The website"Klara Klok" (Klara the Wise) is an example. Text messages may be another possible information channel. School nurses that use mobile phones and text messages to send information have reported that they have had better luck getting boys to use the service. Information in the classes themselves, boys groups, newsletters, and information material directed particularly at boys may also be effective.

A public health centre service directed particularly at boys has been established in Asker municipality. The service is open 2 hours a week. Although boys have access to the regular service under the public health centre's program for youth, 50 % of boys choose to meet up at the time set off just for boys. This indicates that the boys may need a service that is tailored especially to their needs. The public health centre for boys in Asker holds a "boy conference" every year for boys in the 10th class. The theme for the conference in 2008 was "Identity and Psychological Health". In addition, the health centre arranges special theme nights for boys and for fathers. The health centre has a goal to make their target group more health conscious, better the psycho-social environment and motivate teenagers to develop a healthy style. Some of the questions that are taken up are:

- the body
- sexuality/contraception
- intoxicants
- anabolic steroids
- testing for sexually transmitted diseases
- girlfriend/boyfriend family, school, job
- first-time use of the service

The Ministry encourages all municipalities to develop the school health service in such a way as to be equally attractive to boys and girls.

6.5.3 An integrated gender perspective in the health and care services, and in health research

The Women's Health Commission (NOU 1999:13) says in its recommendation about a gender perspective on health and illness that "gender is biology, and as biology it is obviously relevant in understanding illness and health". But gender is also identity (how we experience ourselves as a man or women), cultural symbols (how we attach certain characteristics and expression to concepts of femininity and masculinity). The Commission also says, " a characteristic that is found again and again in many of the report's subtopics is how the foundation of knowledge, the regulations and the practice often builds upon an unspoken masculine norm (man as a biological gender)".

The general practitioner survey that the Cancer Society did in 2007 shows that gender influences the treatment situation. Men have a higher threshold for the expression of worry, and this in turn is partly dependent on whether the doctor is a man or woman.

Men and women have different experiences with health and illness. Therefore, a gender perspective on health and quality of life is important. A male perspective on health and quality of life will benefit gender equality and facilitate men and boys in achieving comparable living conditions and health to women.

Both research results and experiences with health care personnel suggest that men and women have a different psycho-social approach to the body. They clearly handle health and illness differently.

The number of male-specific illnesses (especially prostate and testicle cancer) is on the increase, and men have an especially high death risk as a consequence of accidents. Men are over-represented in the suicide statistics and psychological problems of men seem to be under treated. Recent research indicates that one of four parents who go through a divorce or family breakup takes a leave of absence because of illness following the breakup. This applies to many men.

The Ministry of Health and Care Service's research strategy for 2006-2011 underlines the need for more understanding of gender differences in the area of health. The programmes under the direction of Norway's Research Council which receives funds from the Ministry of Health and Care Service, also reflects this. In the programmes the council will encourage gender and gender differences in health and illness be taken up and discussed in all relevant projects. In the assignment documents sent to regional health services for 2007 and 2008 it was emphasised that the gender perspective should be integrated in a positive way.

The Committee of Ministers in the European Council passed a recommendation on January 30, 2008 that a gender perspective and work to reduce gender differences in the area of health should be integrated into national health policy. The recommendation challenges all member states to integrate a clear gender perspective in health services and to develop tailored strategies to prevent illness and treat problems especially tied to men or women. The members are encouraged to gather gender-specific health data on a regular basis and develop a clear gender perspective in health research.

The main challenges in the field of gender equality within the health and care sector are to increase the general knowledge of gender difference in health, illness and health services, and to consider these gender differences when forming initiatives for prevention and treatment. The goals of the Ministry of Health and Care Services lie along two axes. The one is to

include a gender perspective in all enterprises where that perspective is relevant. The other is to focus specially on health problems that either men or women exclusively have, or health problems that cause one of the genders specific difficulties.

The Ministry of Health and Care Services has asked the regional health enterprises and the Health Directorate to put effort into helping their health services develop a gender perspective. Generally speaking can this perspective be maintained in the ordinary work that is done to prevent and treat illness. An exception would be separate services for men and women. Special challenges connected to women's and men's health must be met with sufficient knowledge and resources in the ordinary service apparatus. The Ministry of Health and Care Services has informed all regional health enterprises in its yearly assignment document that the gender perspective must be ensured in clinical research (gender differences in illness and treatment). This can be done by carrying out analyses of all research results with an eye to gender if that is relevant.

White paper nr. 20 " A National Strategy to Even Out Social Differences (2006-2007)" shows that the relationship between social differences in health and gender is complex. If one uses life expectancy as a starting point one sees that social differences are less for women than for men. For other health aims, such as psychological health, the social differences are greater for women. Some studies show that access to health services is unequal along gender lines. The white paper underlines that all strategies and measures taken to influence health behaviour must be evaluated as to the consequences they may have for gender.

The theme of a gender perspective is followed up in documents from the Ministry of Health and Care Services:

- Ministry of Health and Care Services research strategy 2006-2011
- White Paper no.16 (2002–2003) "Prescription for a Healthier Norway"
- White Paper nr. 25 (2005-2006) " Mastery, Possibilities and Meaning, the Challenges for Care in the Future"
- Strategy Plan for Women's Health 2003–2013
- National Strategy for Cancer 2006–2009
- National Strategy for Diabetes 2006–2010
- National Strategy for the Prevention of the Use of Tobacco 2006–2010
- National Strategy for KOLS 2006–2011
- Nasjonal Strategy for Children's Enviroment and Health 2007–2016 The Children's Future
- Action Plan to Prevent Unwanted Pregnancy and Abortion 2004–2008
- Action Plan for Physical Activity 2005–2009
- Escalation Plan for the Area of Narcotics 2007–2010
- Action Plan for a Better Diet 2007–2011
- Responsibility and Consideration, Prevention of hiv and other Sexually Transmitted Infections (2002)

6.5.4 Systematic measures for reducing the occurrence of sexually transmitted disease

The Strategy Plan for prevention of HIV and sexually transmitted disease contains its a separate objective about evaluating gender questions in all plans, prioritisation and initiatives. Organisations that work with prevention of HIV and sexually transmitted diseases and that receive public subsidies, shall maintain a gender perspective in applications and project descriptions. An increase in awareness of the importance of gender must be realised through information and professional advice from central health authorities and relevant professional milieus. Special measures shall be implemented that are directed specifically towards men and others towards women. In addition, the emphasis on the importance of gender must be maintained in connection with all other objectives in the plan.

Strategies and measures in the area of sexual health are rooted in the Action Plan for Prevention of Unwanted Pregnancy and Abortion (2004-2008) and the Strategy plan for Prevention of HIV and Sexually Transmitted Infections. New plans will be set forth in both these areas in 2009.

The work being done to prevent the spread of sexually transmitted diseases and the work to better sexual health among young boys and men in general, extends to counselling, guiding and testing for sexually transmitted infections. It is an extensive task to get young boys and men to take care of their own sexual health. This includes condom use as well as sexual health in general. The measures have as a goal to help increase competency in connection with sexual choices, actions and identity. They also should increase competence and autonomy in sexual relationships. Men who have sex with men are an important target group because they are prone to sexually transmitted infections. Examples of measures to reach this target group are strengthening of low threshold testing services, guidance and counselling, identity building measures directed towards sexual identity and competence raising initiatives and guidelines for health personnel with a focus on homosexuality and sexual minority status.

Gender differences have a strong influence in working with youth and sexuality. Boys have other experiences, use other arenas for health information and benefit from other initiatives than girls. Health information in this area must therefore use a language and a form that matches with the metaphors in boy culture and be directed to the needs of boys. Surveys show that boys have generally less knowledge than girls about issues of the body and sexual health. The surveys also show that boys want more knowledge and they would like to communicate with someone who knows what boy problems are all about. There is a great lack of adult men as role models, counsellors and conversation partners in the spheres of young boys. This may be a reason why boys don't use the regular service of the health centres and school health services to the same degree as girls. Youth health centres are still a female dominant arena, both with regards to health workers and users.

Use of information, and teaching material that makes use of boy culture and techno-culture (such as problem solving computer games and short SMS messages), has shown to be successful in reaching out to boys. Health Centre on line (www. Klara-klok.no) and SUSS telephone are examples of this. Group programmes with information from boys to boys under the direction of Medical Personnel's Information about Sex and Active Choice—Red Cross Youth also has been shown to be a good information channel,