London Borough of Redbridge

Annual Public Health Report 2024/25

The Status of Men's Health in Redbridge

Contents

Foreword

From the Director of Public Health

I am very pleased to present our Annual Public Health Report for Redbridge on the important subject of men's health. When we look at health and wellbeing through the lens of gender or sex, we can see disproportionalities in experiences, health outcomes, and use of services for either men and women. At population level, sex or gender can sometimes be a health asset and can sometimes be a risk factor for different diseases and health conditions. This report explores how masculinity impacts on health and wellbeing for men in Redbridge.

We have looked in detail across a wide range of health and wellbeing topics and identified those areas where there are significant differences in health-positive behaviours, outcomes and service access between men and women, and where there are differences between different male populations and communities. This examination of differences between men is very important for us with the wide diversity in our population in Redbridge. We know as a health and care system that there is more for us to do to understand these differences through increasing our knowledge about these differences and this report is a starting point for building this understanding. I present here our key recommendations which reflect this and also seek to build a systems approach to addressing the disproportionalities.

I wish to offer thanks to my team and other colleagues from across the Council and its partners for their support and input in producing this report.

Gladys Xavier

Director of Public Health

Foreword

From the Chair and Vice Chair of the Health and Wellbeing Board

Sex and gender are two of the key factors that contribute to our residents' opportunities for good health and risks of disease. We welcome this report from the Director of Public Health which seeks to illuminate how aspects of masculinity might affect the healthy life expectancy of people in Redbridge. Wherever we can identify health inequalities, our health and care partnerships in Redbridge are driven to address them and we are pleased to see the recommendations set out in this Annual Public Health Report.

We can see that at a broad level, men's health outcomes are generally worse than that of women and we know this is down to both biological and social factors. We know that in our borough these differences are significant with men living around two years fewer than women in good health. Additionally, men in Redbridge spend around five years fewer of life in good health than men in similar boroughs across the country, and there a marked differences in outcomes for men of different ethnicities. It is vital that we consider these inequalities when we design our systems for care and our disease prevention strategies. We look forward to working across our partnership to help address the challenges raised in this report.

Cllr Mark Santos

Chair of the Health and Wellbeing Board

Dr Anil Mehta

Vice-Chair of the Health and Wellbeing Board

Executive Summary

There is clear evidence that for both men and women, health inequalities are experienced for which the main driver of disproportionality is a person's sex. At a population level, men's health is generally worse than women's due to both biological and social reasons. Genetics affects how men's bodies function differently to women's, leading to an increased risk of conditions like heart disease. Societal expectations for men to be self-reliant, brave, and risk-taking also contribute to poorer health outcomes for men.

In Redbridge, these differences are quite stark. Men in Redbridge live on average 4.3 years fewer than women and have 2 fewer years in a healthy life. They also spend around 5 fewer years in good health than similar areas. More men die prematurely in Redbridge than women, and this difference is more significant than the England average.

Men of different ages face unique challenges: young men are more likely to be involved in violence or car accidents, middle-aged men are more affected by alcohol misuse and suicide, and older men suffer more from chronic illnesses and social isolation.

This report also highlights factors that negatively impact men's health. Lifestyle factors such as smoking, alcohol use, diet, and exercise; and social factors like opportunities in education and employment.

Men from different ethnic backgrounds are being impacted by these factors in varying ways. For example, men of White ethnicity groups are more likely to misuse alcohol, while men of Black ethnicity groups face higher unemployment. Men from minority ethnicities may also face specific challenges in expressing their mental health and emotional needs as influenced by cultural views on mental health.

These issues are particularly relevant in Redbridge, as we are a very diverse community. However, there is a lack of detailed data to fully understand the problems faced by different groups of men in the borough. We do not have enough information broken down by sex, ethnicity, or sexual orientation to better understand the health status and needs of individual groups, and to determine if there are significant differences in access to services.

To address these issues, it is important to apply a gender-equity lens in policymaking and service design and commissioning. We also need to improve data collection to better understand the health needs and monitor access to services of different groups of men. In addition, continuous engagement is essential to understand the cultural needs and norms of different subgroups. Lastly, service designs and health promotions should have gender norms and cultural sensitivity in mind to improve accessibility and acceptability.

Section 1 | Overview

Too many men are dying early, and they are disproportionately affected by various long-term illnesses and conditions such as heart diseases, and some cancers, and are more likely to be involved in suicide and injury.

Almost one in five men (19%) in England and Wales died before the age of 65, compared to just over one in ten in women (12%)[1]. Men contributed to 60% of deaths from heart diseases[2], 75% of suicides[3], and 60% of deaths from cancer[4]. Men are 25% more likely to have type 2 diabetes in England[5], and 125% more likely to have diabetic amputations[6].

Underlying causes of poor health outcomes for men and boys

The factors influencing the different health outcomes between men and women are multifaceted and intricate. While biology plays a significant role in shaping bodily structure and function, our health is also deeply influenced by our social environment. The difference between how men and women interact within society, as well as the broader societal dynamics, greatly contribute to their difference in health outcomes. These factors often interact with each other making the situation more complex.

Differences in biology can only explain parts of the story

Genetics are the blueprints of human bodies. The genetic disparities between men and women contribute to differences in their body structure and function, resulting in various disparities in health outcomes.

For example, boys are more affected by congenital and developmental disorders, more boys have delayed reading, attention deficit hyperactivity disorder, and autistic spectrum disorder[7,8]. These challenges can harm their educational achievements and social development.

Sex differences also play a role in adult health. For instance, women are generally less likely to develop cancer and often have better survival rates if diagnosed. However, they are more prone to autoimmune diseases such as rheumatoid arthritis, because of their more active immune system[9,10].

Female sex hormones are also protective for cardiovascular diseases[11]. The way men's bodies tend to deposit fat in their abdomen also increases the risk of diabetes and hypertension[12].

Social and cultural factors

Men's health is not solely determined by biology; it is also shaped by societal expectations of what it means to be a man, and how men perceive themselves. These societal norms, often referred to as "gender norms," dictate how individuals should behave based on their gender. Recognising and understanding these norms can shed light on differences and inequalities between men and women in society.

Traditionally, according to these rules, men and boys are expected to be 'tough' and 'strong', to appear in control and to take risks. This is closely linked to men's health and well-being[13,14,15].

This pressure to conform to traditional notions of masculinity, particularly among younger men, can lead to risk-taking behaviours and neglect of physical and emotional well-being. These men may also be reluctant to seek professional help when needed.

Additionally, societal expectations of strength and courage may encourage behaviours such as violence, speeding and excessive alcohol consumption, which can further harm their health[16,17,18].

The need for a gender-responsive approach

The influence of gender norms on men's health has been recognised and efforts to address men's health have gained momentum recently. Initiatives such as the World Health Organization (WHO) Europe's 2018 Strategy highlighted the need for a gender-responsive approach to men's health[19]. The Parliamentary Office of Science and Technology's 2023 brief further underscores the health disparity between men and women in the UK setting, emphasising the importance of addressing inequalities among different groups of men[20]. In November 2023 the UK Government announced that a men's health task and finish group will be established to focus on awareness on health needs faced by men and to improve men's engagement with health services[20].

As discussed in the documents above, the disproportionality could only be partly explained by biological differences. Social norms and gender roles contribute to differences in risk-taking behaviour, exposure to risk factors, such as alcohol, tobacco, and other substance use, and the differences in interaction with health services between men and women. The key health challenges affecting men are strongly influenced by gender norms and are often clustered with socioeconomic inequalities across the life course such as ethnicity, education, income, employment, occupation, migration status, disability and sexual orientation.

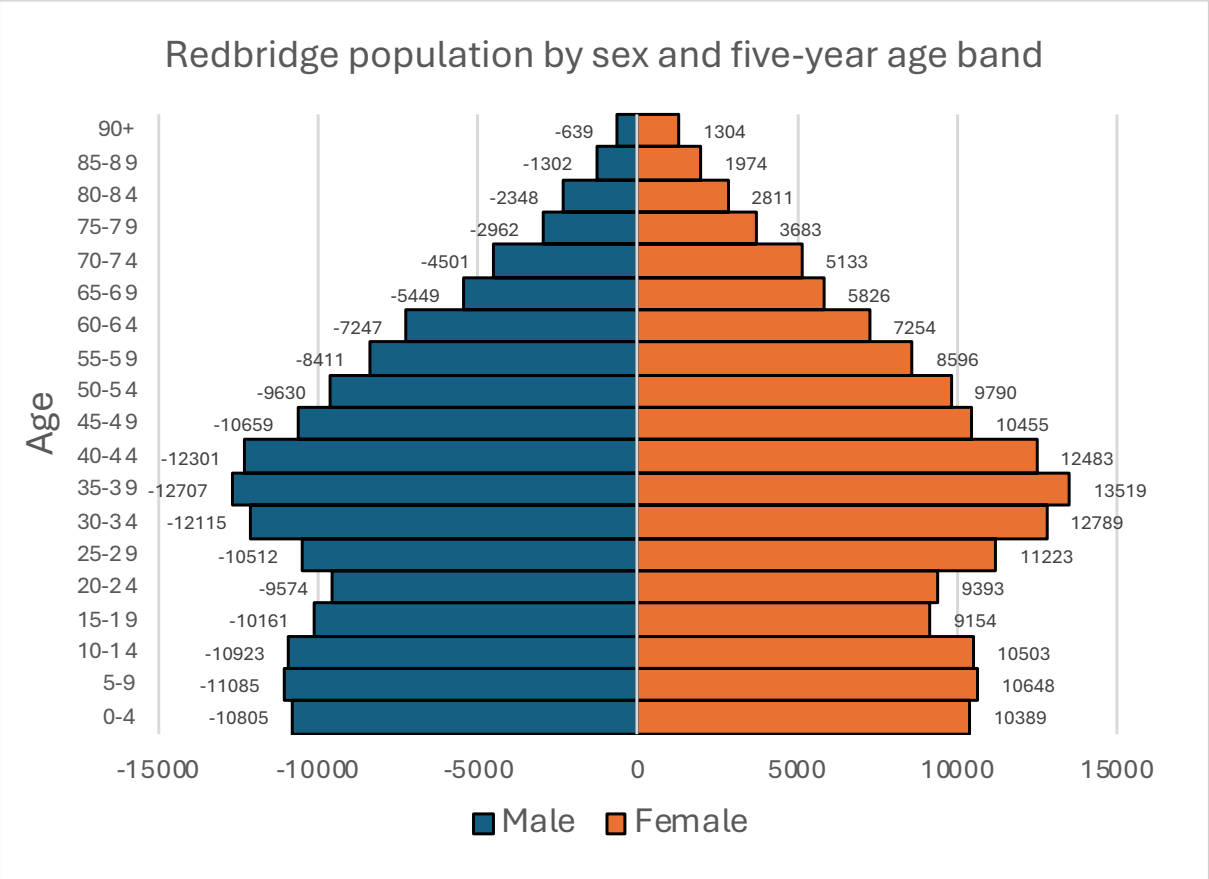
The aim of this report

This report aims to focus on the male population in Redbridge, highlight the key public health issues and challenges they are facing, and raise awareness and inform relevant decision-making.

Section 2 | Health Status of Men in Redbridge

2.1 The male population of Redbridge

At the 2021 Census, the male population of Redbridge numbered 153,331. The median age for Redbridge men is 36, one year older than for London[1].



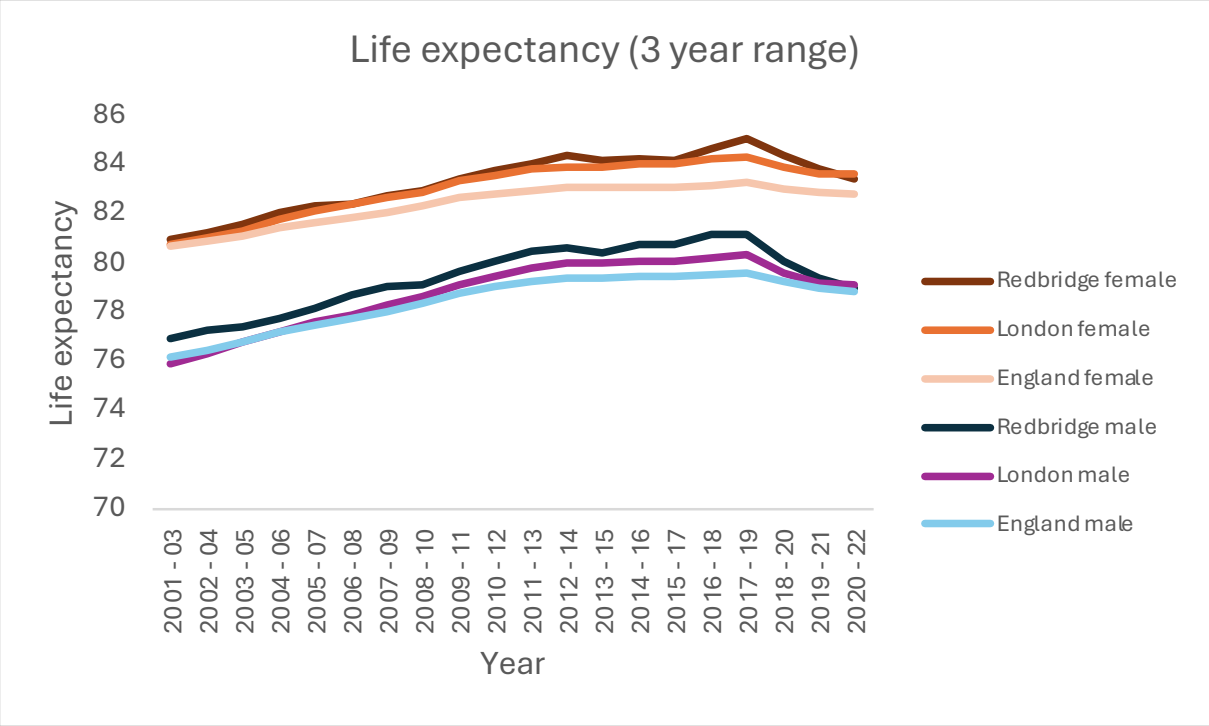
2.2 Life expectancy and healthy life expectancy

Life expectancy (the age to which half a population live) and healthy life expectancy (the age at which half a specific population are still living in good health) can be used as measures for the general health status of a population.

Life expectancy has increased steadily in the UK since the 19th century. However, this increase slowed between 2011 and 2020. Life expectancy reached 79 years for men and 82.9 years for women in 2018-20, and fell from 2019 to 2020, with a 1.3 years decrease for men and 1 year decrease for women[2].

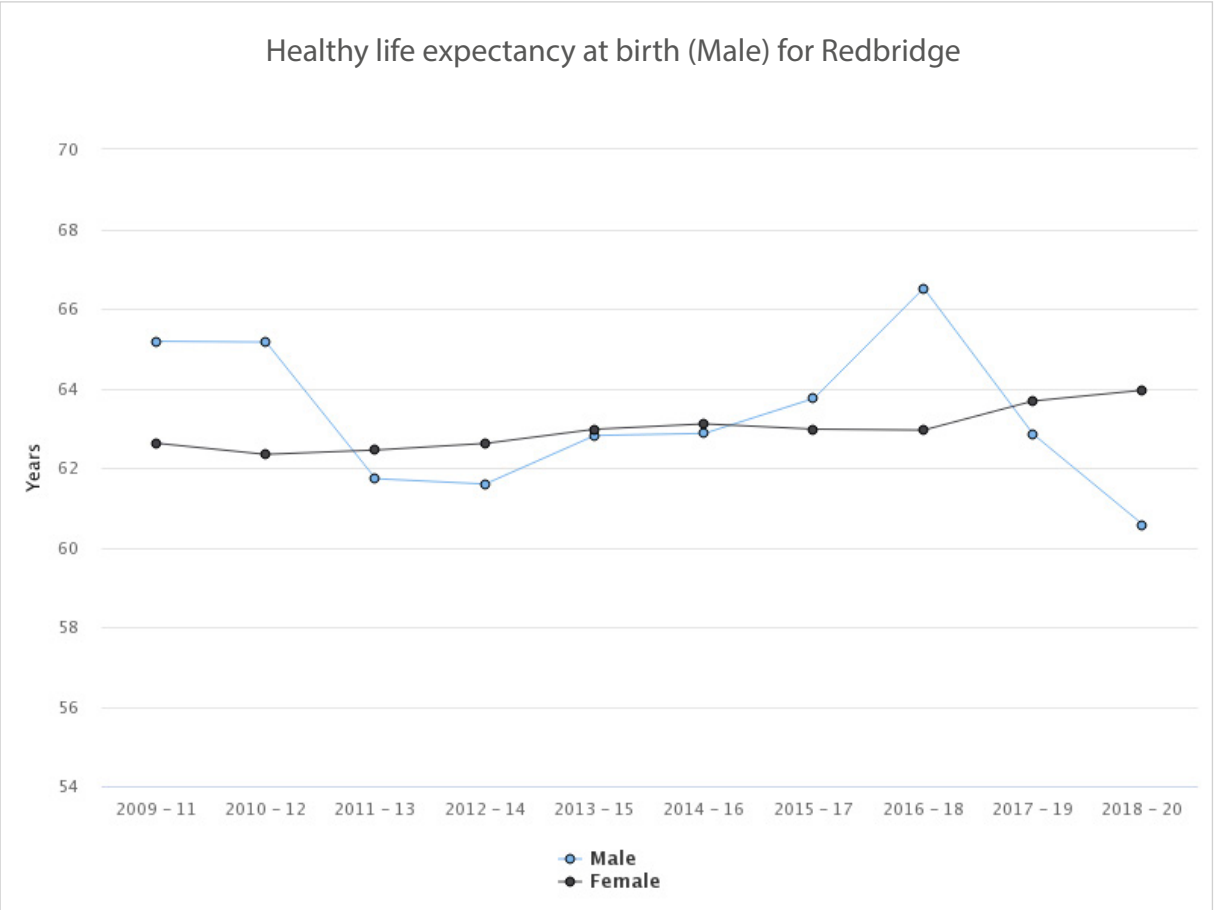
In Redbridge, men live 4.3 years fewer than women

Redbridge follows a similar trend, with an improvement in life expectancy in both men and women over the past decades, including a closing of the difference between the genders (from 4.3 years in 2004-06 to 3.3 years in 2016-18). However, the gap has been widening again since 2017 and there has been a significant drop in life expectancy in men since 2018-20. The latest data suggest that men live 4.3 fewer years than women, with a life expectancy of 78.9 years and 83.2 years respectively. The difference is smaller than the London average (4.6 years) but larger than England's (4.1 years)[3].



In Redbridge, men now have fewer years of good health than women

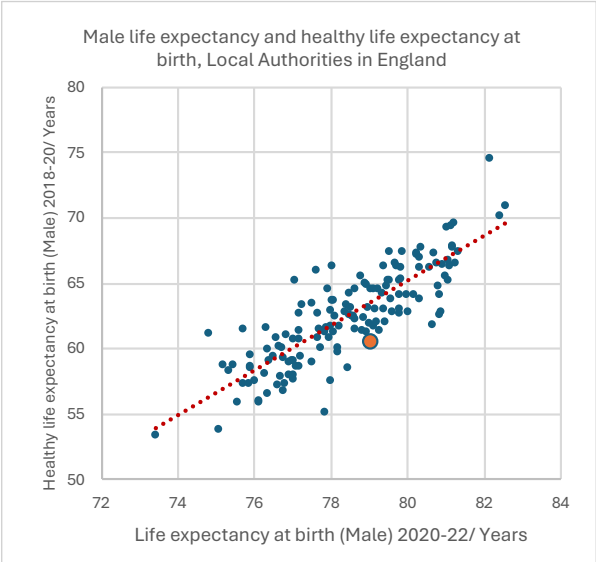
Despite dying earlier, Redbridge men used to have more healthy years in life than women. However, this has reversed since 2018-20, and Redbridge men are living 2.1 years fewer than women in healthy life, with no limiting long-term illness (disability-free life expectancy). This has not been the case in London and England, in which men still have a longer healthy life than women[4].

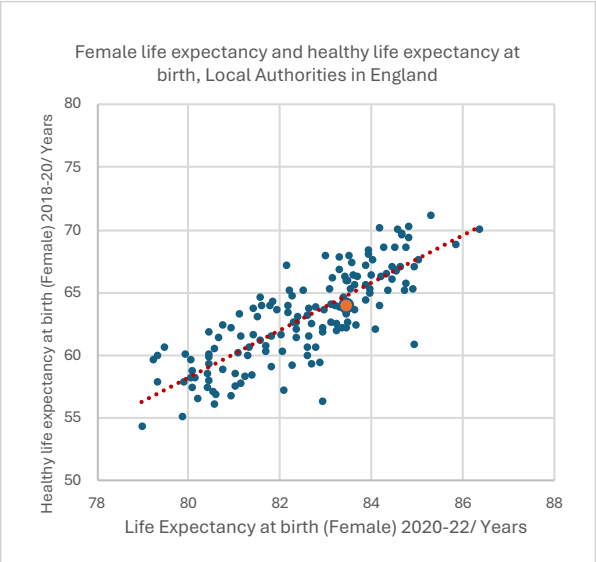


Men in Redbridge live 5 to 10 years fewer in good health than areas with similar life expectancy in men

In general, in areas where men live longer, they also experience longer healthy life expectancy. When we compare other local authorities in England which experience similar life expectancy to our borough, we find that Redbridge men live around 7 years fewer in good health than the areas with the longest healthy life expectancy and 5 years shorter than average. This doesn't apply to the Redbridge female population. Here, the healthy life expectancy is just slightly lower than the average among local authorities with similar life expectancy[4].

These findings suggest an area of concern for men's health in Redbridge.





2.3 Mortality

Premature mortality, often defined as the death of people under age 75, refers to deaths that occur at a younger age than expected. Premature deaths, especially for those of younger and middle age, are devastating to families, with potential loss of income, increased life stress and loss of a carer.

Premature mortality reflects underlying health disparities, social inequalities, and the potential gaps in the effectiveness of the health system.

In Redbridge, more men die prematurely than women, and the picture is worse than the England average

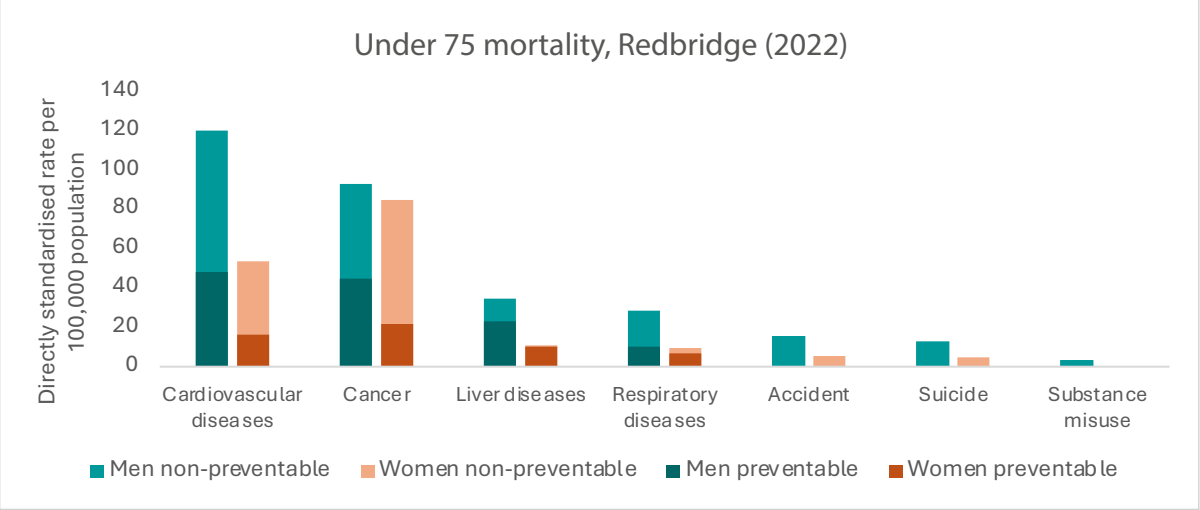
In England in 2021, between 4 and 5 out of 1,000 men died before reaching 75 years of age. This is 58% higher than that of women (about 3 out of 1,000). In London, a similar proportion of men died young, but the proportion is lower in women, resulting in a larger difference of 74%.

In Redbridge, 0.44% of men and 0.25% women died before 75 years of age each year. This difference is similar to that of London and much higher than that of England's average[5].

Causes of death

Many health conditions affect men and women in different ways, and most of them lead to more premature mortality in men than women.

In Redbridge, the top cause of death was cardiovascular disease (including heart disease and stroke), followed by cancer, and liver disease. More deaths among men are considered preventable, and the difference is most striking for cancer and cardiovascular diseases[6].

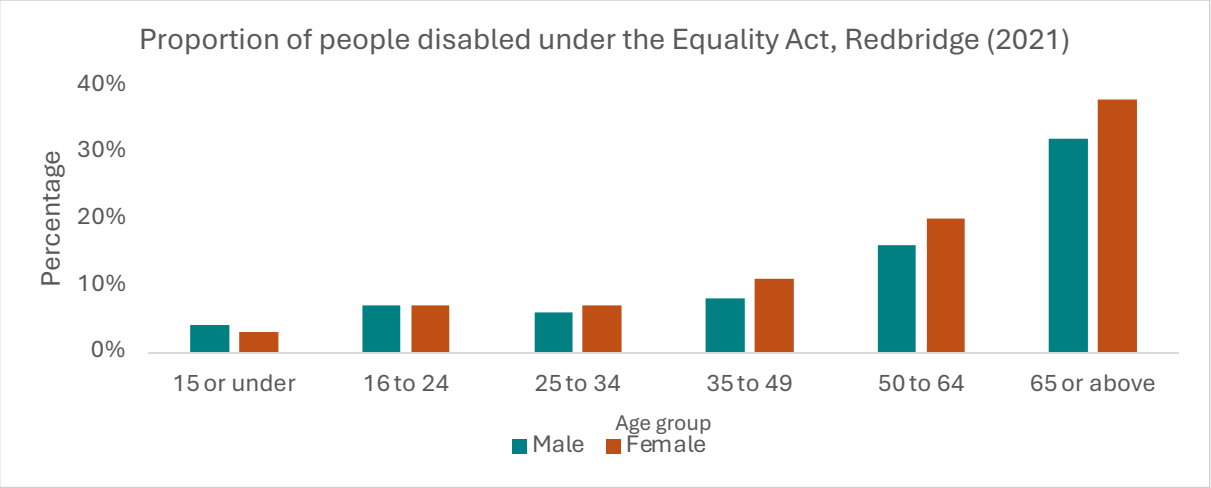


Men in Redbridge have a comparable or lower rate to that in London in most of these major causes of mortality, except for cardiovascular diseases and liver diseases[6].

2.4 Disability

Disability means having a physical or mental impairment that has a substantial and long-term negative effect on the ability to do normal daily activities[7].

In 2021, around 11% of men and 13% of women in Redbridge are disabled under the definition of the Equality Act, which is comparable to the London average of 12% and 14%. The proportion of people with a disability increases with age. More than one in four residents in Redbridge over 65 years of age are considered to have a disability[1].



2.5 Long-term conditions and cancers

Non-communicable diseases, or chronic diseases, including cardiovascular disease, diabetes, chronic respiratory disease, and cancers, are the results of a combination of genetic, physiological, behavioural, and environmental factors[8].

More men are experiencing long-term conditions

In addition to dying younger, long-term illnesses are also more common among men than women. In England, for example, there are more men than women diagnosed with diabetes (9% vs 5%) and hypertension (32% vs 29%)[9].

Men with chronic illnesses are less likely to be diagnosed or treated

Diagnosis and treatment rates are also poorer among men. For example, of every four deaths before age 75 from heart disease, three are in men, which means men are three times more likely to die early of heart disease than women[10].

Similarly, 17% of men and 14% of women are estimated to have untreated high blood pressure[9].

The rate of lower limb amputation, which serves as an indicator of poorly controlled diabetes, is over twice as high in men compared to women (10.6/10,000 vs 4.7/10,000)[11,12].

Men are also more likely to suffer from diseases like abdominal aortic aneurysm which is a potentially life-threatening disease of a large blood vessel in the abdomen. Screening is offered to men during the year they turn 65[13].

Long-term conditions in Redbridge

Redbridge has the third highest prevalence of diabetes in London (8.7%, London average 6.5%), and ranks highest among the North East London boroughs[14,15]. It is estimated that 4% of men and 3% of women with diabetes have not yet been diagnosed[9].

Among patients with diabetes in England, Redbridge has the third highest rate of major lower-limb amputations, almost double that of England's average[12].

For hypertension and coronary heart disease, Redbridge has the second highest prevalence among all North East London boroughs[14].

The higher proportion of untreated diabetes and hypertension not being diagnosed in men, and the poorer outcomes highlighted the disparity in diagnosis and treatment of chronic illnesses.

2.6 Cancers

The five most common cancers among men in England are prostate, lung, bowel, bladder, and skin melanoma, with a total number of over 86,000 men diagnosed in 2020[16].

In England, more men than women are diagnosed with cancer each year. Men have higher chances of being diagnosed with certain types of cancer compared to women:

- Men are more than twice as likely to be diagnosed with cancer of the nasal cavity, sinuses, larynx, and bladder.
- They are also twice as likely to be diagnosed with cancer of the oesophagus and urological cancer (excluding prostate cancer).
- Additionally, men are 50% more likely to be diagnosed with liver cancer, oral and pharyngeal cancer, as well as cancers of the head, neck, and stomach.

These differences could partly be due to genetics, but behaviours like smoking and alcohol consumption, which are more common among men, also play a role[17].

In addition to being more likely to develop cancer, cancers in men are often diagnosed at a later stage. In 2023, only a half (52%) of cancers in men were diagnosed at stage 1 or 2, compared to 67% in women[17]. Late diagnosis could delay treatment and reduce the chance of survival.

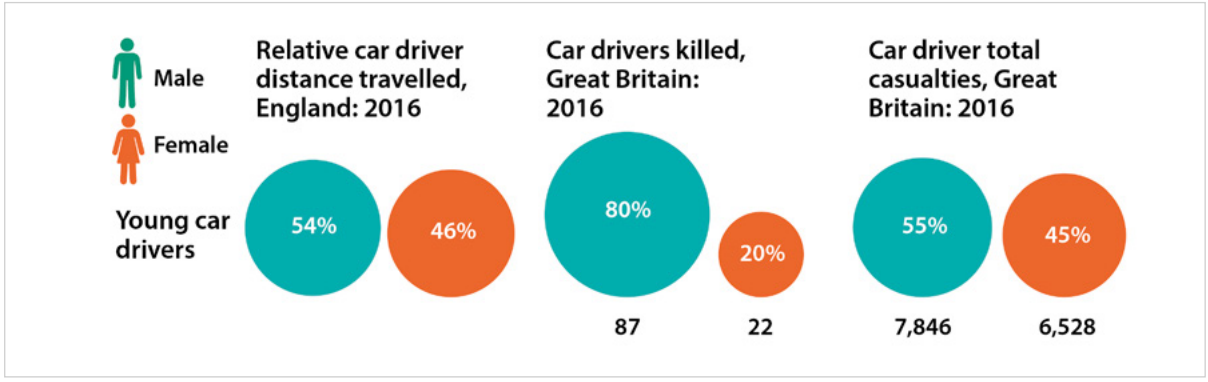
Cancers in Redbridge

Redbridge has the sixth lowest under-75 mortality rate from cancer among all local authorities in England, even with the age difference taken into account[18]. However, we do not have further data available to examine the incidence or prevalence of cancers by sex at our local authority level. While incidence and prevalence are comparably lower than in most other local authorities, the impact of cancer is experienced by many of our residents each year as a sadly common serious illness and prevention interventions such as screening programmes continue to be prioritised within our local health and care system.

2.7 Accidents

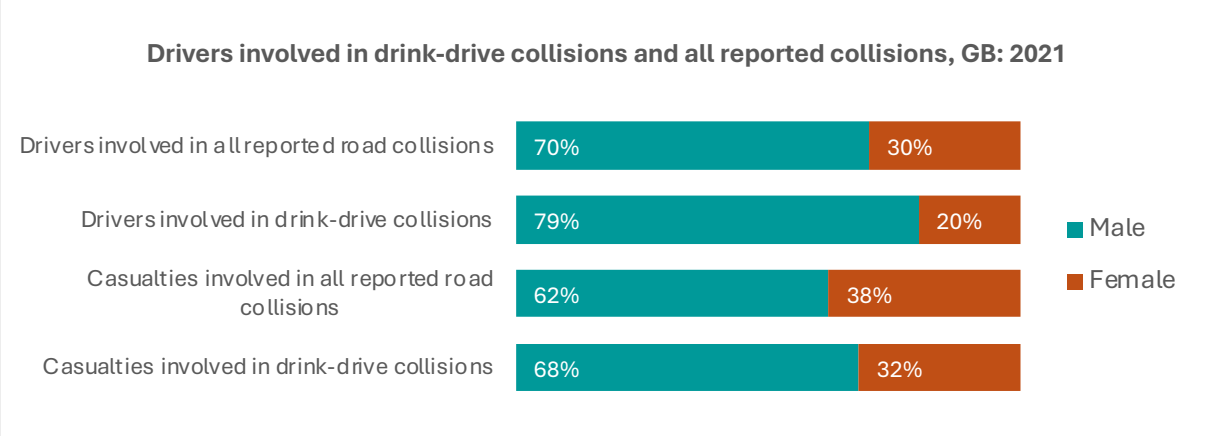
Men are more likely to be involved in accidents or to be killed at home, on the road or at work. It could be the result of a higher proportion of men working in occupations that put them at risk, such as construction, and differences in risk-taking behaviours between the sexes.

If we look at road accidents, for example, despite male car drivers covering just more than half (54%) of the distance travelled, 4 out of 5 car drivers getting killed were male[19].



Source: Written evidence submitted by the Department for Transport, National Travel Survey and DfT Stats19

Men are also much more likely to be involved in road collisions and drink-drive-related collisions[20]. Young male drivers are particularly at risk, they are 4 times as likely to be killed or seriously injured from collisions with all car drivers aged 25 or above[21].



2.8 Mental health

One in six adults (17%) living in England experienced symptoms of anxiety or depression in the seven days prior to being surveyed and met the criteria for a common mental health disorder[22].

Although men are less likely to report symptoms of both common and severe mental health conditions, one in eight men reported having a common mental health condition, and 1 in 17 men reported severe mental health symptoms[23].

Mental health in Redbridge

18% of the Redbridge population experiences symptoms of anxiety or depression. This means that more than 40,000 people in Redbridge live with a mental health condition[24].

The proportion of the population of Redbridge with depression is lower than the London and England averages but has increased from 6.3% in 2019-2020 to 7% in 2020-2021[25]. These figures may underestimate the true nature of depression in the borough where some communities are less likely to seek support due to mental health stigma.

No breakdown data in Redbridge is available.

Suicide

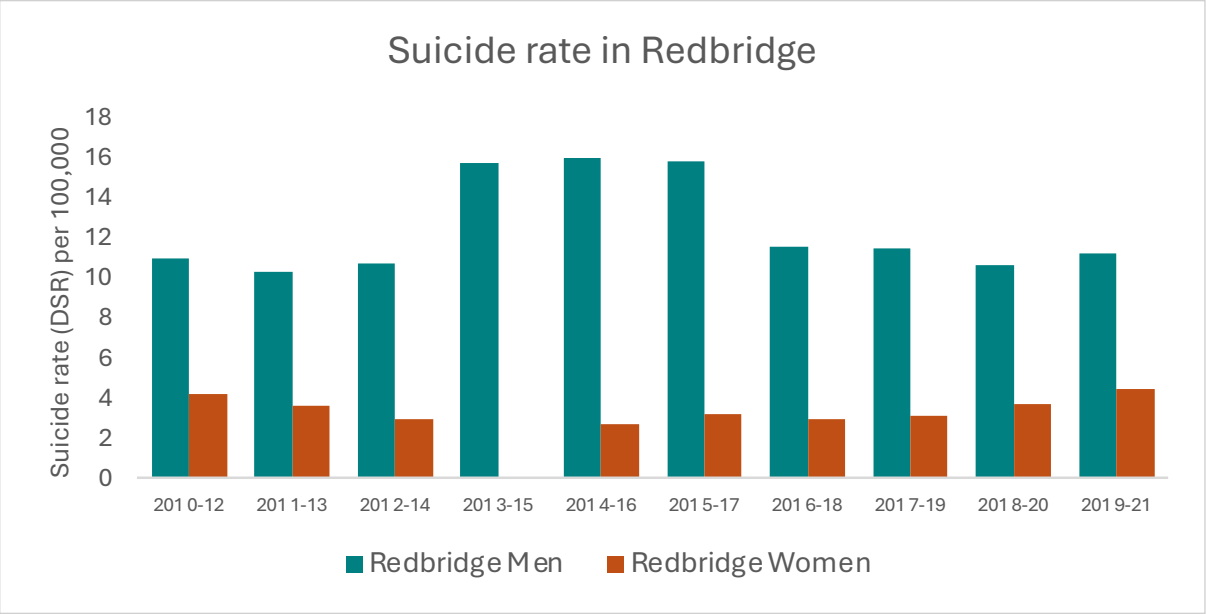
Suicide and injury or poisoning of undetermined intent is the leading cause of death for males aged 20 to 49 in the UK[26].

Suicide is more common in men, with three times as many men dying by suicide than women. In 2022, the rate of suicide among men was 16.4 deaths per 100,000 in England and Wales. The risk of suicide peaks between 45 and 64 years old among men[27].

Suicide in Redbridge

Between 2001 and 2021, 356 people died by suicide in Redbridge[28]. The suicide rate of men in Redbridge remains two to four times that of women in the past ten years[29].

The latest suicide rate of men in Redbridge in 2019-21 was 11.2 per 100,000, which is lower than the London and England average at 16.0 per 100,000.



2.9 Interpersonal violence

Interpersonal violence

In Redbridge, men's hospital admissions for violent crime are 56.4 per 100,000 annually, below London's 69.7 and England's 65.3 averages. Yet, this equates to one man admitted every four days. This is four times higher than for women at 11.2[30].

Unintentional injuries and domestic violence

Boys and younger men in Redbridge exhibit higher rates of hospital admissions for both unintentional and deliberate injuries compared to London and England averages. In the 0-14 age group, the rate is 60.2 per 10,000, lower than London's 73.2 and England's 87.6, but still higher than that of women in Redbridge at 44.6. For younger men, Redbridge's rate is 57.9 per 10,000, lower than London's 90.9, but higher than that of women in Redbridge at 48.5[31].

Although overall women are more likely to be victims of domestic abuse, one-third of victims of domestic abuse are men[32]. Men can feel stigmatised when disclosing their situation and fear they might not be believed because of their gender.

Men's experiences as victims of violence and abuse can also be shaped significantly by gender norms. Expectations of masculinity can present difficulties for men and boys to accept or recognise such experiences, take them seriously, and report them[33,34].

Fear of not being believed might prevent disclosure

Victims experiencing more subtle forms of domestic abuse often fear that they might not be believed if they reported their perpetrator. This is also often the case when the abuser is a well-respected member of society.

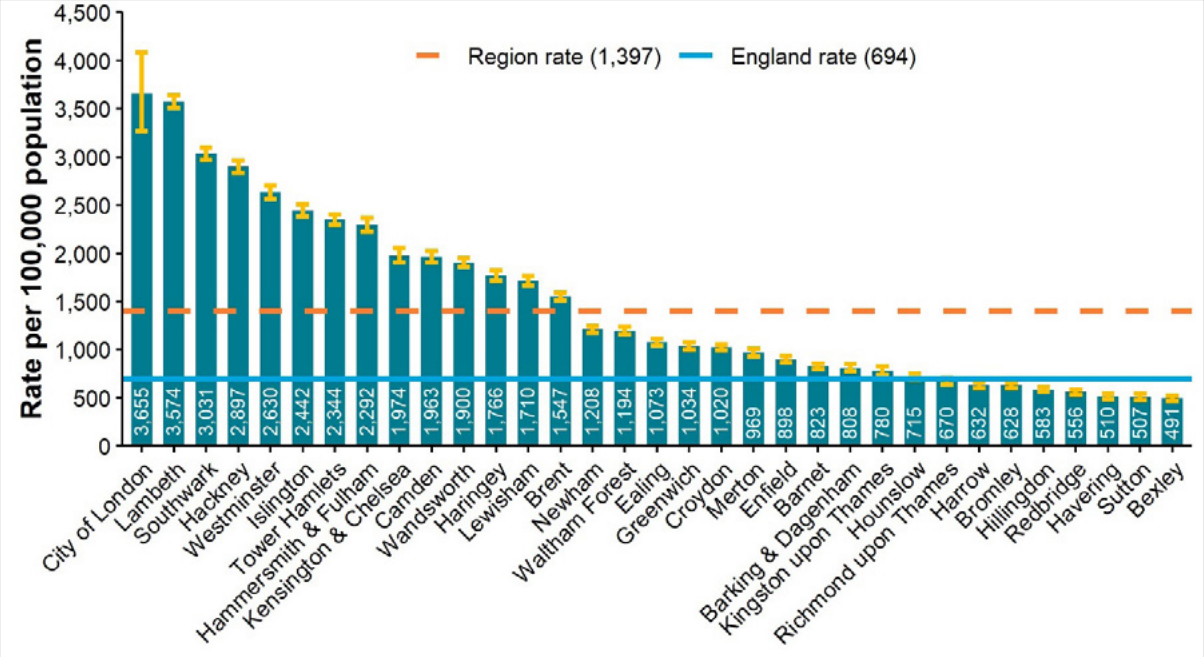
2.10 Sexual health

Nationally, the detection rate of new sexually transmitted infections (STI) is more common in men than women. STIs like gonorrhoea, syphilis, and HIV are more common among specific groups of men, including gay, bisexual, and other men who have sex with men (GBMSM), young men aged 15-24, and certain Black ethnic groups[35].

Sexually transmitted infection in Redbridge

Despite London having 17 of the top 20 local authorities with the highest rates of new STIs[36], Redbridge has the fourth lowest new STI diagnosis rate among all London local authorities and is lower than England's average[37].

Chart: Rate of new STI diagnoses per 100,000 population by local authority of residence, London residents, 2022 (Data sources: GUMCAD, CTAD)



There is no STI data broken down by sex at Redbridge level.

2.11 Self-assessment of health

Self-rated health is a reliable predictor of morbidity and mortality and is used extensively in public health research[38]. Although men typically experience earlier mortality and are more prone to chronic diseases, they are less inclined to rate their overall health as poor.

In England, only 5.1% of men described their health as bad or very bad, compared to 5.5% of women. In Redbridge, the figures were 4% for men and 5% for women. Men in Redbridge rate their health similarly to their peers in London[39].

The disparity between self-rated health and morbidity and mortality highlights the distinct perspectives that men and women have regarding their health. This can influence their lifestyle choices and their willingness to seek help when needed.

Section 3 | Behaviours affecting men's health

Behavioural factors like tobacco and alcohol use, poor diet, unsafe sex, and lack of exercise contributed to around 40% of male deaths in the United Kingdom in 2019[1].

The presence of these factors can be strongly influenced by gender norms and how these are fashioned by the society and culture around us[2].

3.1 Smoking

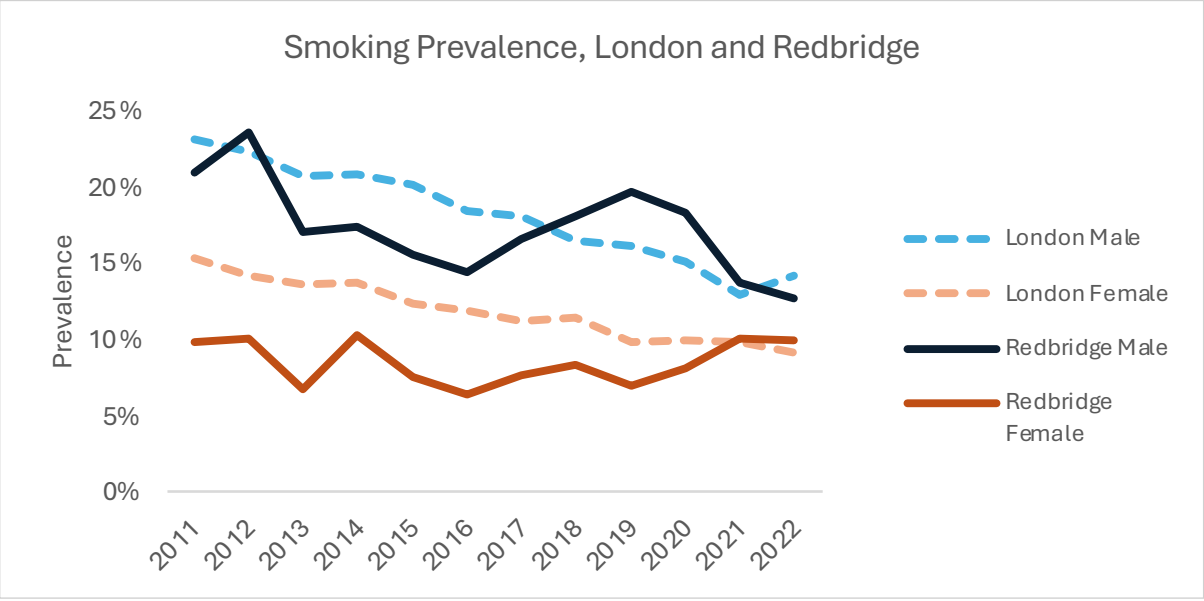
Smoking kills more people than any other factors

Smoking is the leading cause of preventable illness and premature death in England. Smoking is a major contributor to health inequalities, and is responsible for half of the life expectancy gap between the highest and lowest income groups[2,3]. It is estimated to contribute to 21% of all admissions for respiratory diseases, 14% of all admissions for circulatory diseases, and 9% of all admissions for cancers[4].

There is a notable difference between men and women in hospital admissions that are attributable to smoking. For men, 5% of all admissions and 29% of admissions for smoking-related conditions are attributable to smoking, whereas for women, the figures are 3% and 21%, respectively[5].

One in eight men in Redbridge are smokers

In Redbridge, 12.7% of men smoke regularly or occasionally, while this figure is only 10% for women However, in comparison to the overall London level, Redbridge has a lower smoking prevalence among men[6].



3.2 Alcohol and drug misuse

Alcohol is known to cause more than 200 different diseases and injuries. Excessive alcohol use contributes to at least 13% of deaths in people aged 20-39 years. It can also contribute to social problems such as unemployment, divorce, domestic abuse, and homelessness[7,8.]

In the UK, two out of three people who died as a direct consequence of alcohol are men. Most of these deaths relate to liver disease, mental ill health, and alcohol poisoning[9].

In Redbridge, men are three times as likely as women to be dependent on alcohol (6% compared to 2%), twice as likely to take drugs, twice as likely to die due to a condition caused by alcohol, and three times as likely to die from drug misuse[10,11,12,13].

Alcohol and drug use are not isolated issues. They reflect broader mental health and social challenges among men, as men tend to cope with mental health challenges differently to women, as they are more likely to self-medicate with alcohol and drugs to alleviate emotional distress[14].

Alcohol and drugs are killing almost two times as many men as women

In 2019/20, 280,000 admissions to hospital nationally were estimated to be attributable to alcohol, which increased by 2% from 2018/19 and 8% from 2016/17. Men contributed to 65% of the admissions[15].

In Redbridge, the male population loses around 787 years of life to alcohol-related conditions each year, whereas for women this figure is approximately 425 years. Conversely, in London, men lose 934 years compared to 355 for women[16].

In England, the rate of death from drug misuse stands at 7.3 per 100,000 for males and 2.8 per 100,000 for females. Meanwhile, in London, the rate is lower, with 5.1 per 100,000 for males and 1.9 per 100,000 for females. In Redbridge, the rate is even lower, at 2.9 per 100,000 for the years 2018-2020, female data is not provided due to the small number reported[17].

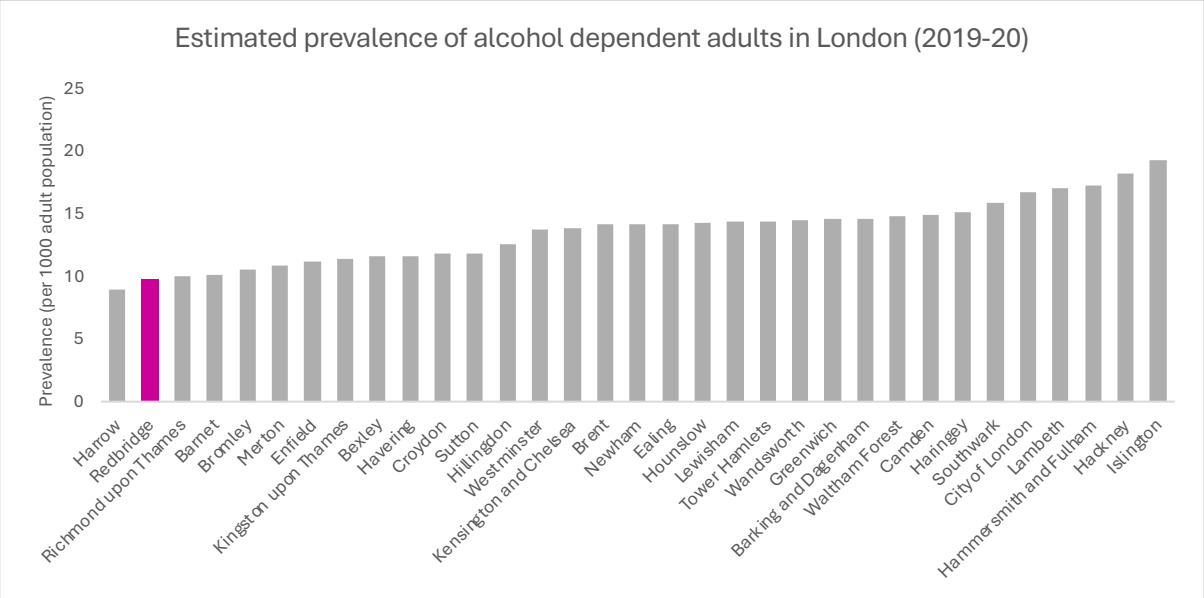
Prevalence of alcohol use

In England in 2021, 79% of people reported drinking alcohol in the past year, with 49% drinking at least once a week. Men had higher rates of alcohol consumption than women, with 82% of men and 76% of women reporting drinking in the last 12 months, and 57% of men and 43% of women drinking at least once a week. This trend of higher alcohol consumption among men was consistent across all age groups[18].

In London, 25% of men and 14% of women drank more than 14 units of alcohol per week. Men exhibit nearly double the prevalence of harmful drinking compared to women across all levels of deprivation[19].

Alcohol use in Redbridge

In 2019/20, it is estimated that Redbridge has the second lowest prevalence of alcohol dependence among adults in all London local authorities, with a rate of 9.76 per 1,000. In total, there were an estimated 1,751 males and 483 females identified as alcohol dependent in Redbridge during that period. This indicates that for every five individuals who are alcohol dependent in Redbridge, around four are male[20].



Substance misuse in Redbridge

In Redbridge, there are approximately 2,200 individuals dependent on alcohol and 1,500 users of opiates (including heroin and heroin-like drugs) and/or crack cocaine. This contributes to over a hundred preventable deaths annually. Additionally, nearly half of all thefts, burglaries, and other acquisitive crimes in the area are committed by individuals addicted to opiates and/or crack cocaine, resulting in an estimated loss of £28 million per year for residents, local businesses, and services[21].

Alcohol, substance misuse and violence

In addition to the direct health risk, alcohol plays a significant role in increasing the risk of intimate partner violence both directly, by diminishing self-control and intensifying emotional reactions, and indirectly, by exacerbating stressful circumstances like financial troubles[22].

3.3 Overweight and obesity

Obesity is a significant risk factor for various health conditions including diabetes, heart disease, stroke, liver disease, several types of cancer, injuries, arthritis, and depression. It can lead to both death and disability, making it one of the most significant long-term health challenges[23].

Currently, approximately 64% of adults in England and over half (55.9%) of adults in London, are classified as overweight or obese[24]. In London, men are 23% more likely to be overweight or obese compared to women, with 64% of men and 52% of women falling into this category[25]. The disparity emerges early in childhood, as evidenced by Year 6 statistics in London schools, where 44.3% of boys were overweight or obese, compared to 36.5% of girls[26].

In Redbridge, 61.6% of adults are overweight or obese, which ranks it as the sixth highest among the London boroughs and exceeds the London average of 55.9%. However, specific breakdown data by sex is not available[27].

3.4 Diet

Men are eating less healthily than women

In England in 2020/21, only 29.2% of men met the '5-a-day' fruit and vegetable consumption recommendations, which is almost 20% lower than that of women (35.7%). There is no local breakdown data for London and Redbridge[28.]

The level of consumption is associated with age and deprivation. Fewer than 25% of people under 44 years old have '5-a-day' while more than 40% of people aged between 65 to 84 did so. The proportion of people meeting '5-a-day' also shows a gradient by deprivation deciles, only 20% of people of the most deprived decile compares to over 35% of the people of the least deprived decile. A similar pattern reflects in employment status with the smallest proportion of people who are unemployed meeting 5-a-day[29]. Further breakdown by sex is not available.

3.5 Physical activity and sedentary behaviour

Physical inactivity contributes to 1 in 6 deaths in the UK, with a third of men and nearly half of women taking too little physical activity to protect their health[30.]

Men are more physically active than women

In England in 2022/23, 65.9% of men and 61.2% of women reported that they have at least 150 minutes of physical activity a week, reaching the WHO recommendation on physical activity[30]. At the same time, 22.5% of men and 27.0% of women engaged in less than 30 minutes of physical activity per week[31].

Redbridge men are as active/inactive as their peers across England

In Redbridge, 68.6% of men and 51.8% of women were physically active, and 22% of men and 32% of women were physically inactive[31].

Section 4 | Social and environmental factors affecting men's health

While clinical care accounts for 20% of health outcomes, evidence suggests that health behaviour accounts for around 30%. Social and environmental factors like ethnicity, income, education, employment, and housing together make up 50% or above[1,2,3].

These social, cultural, and environmental factors all interact in complex ways. In addition to their direct effect on health, they affect the lifestyles and behaviours discussed in the previous section, as well as their interaction with the health systems. These interactions happen simultaneously and on multiple levels, which can amplify the effects of systemic social inequalities[4].

Our gender norms and roles interact with factors that contribute to social exclusion and vulnerability, such as financial insecurity, discrimination and migration status, and result in the marginalisation and exclusion of some groups of men.

We all live within multiple layers of privilege and disadvantage[5]. Men's experiences and behaviours can vary a lot depending on where they stand in society[6,7]. This is particularly relevant in Redbridge, as we are among the most ethnically diverse local authority areas in the country[8].

4.1 The demography of men in Redbridge

4.1.1 Age

Age is a significant factor in men's health. The age of men is closely linked to social norms, roles in society, behaviours, and health problems.

According to Census 2021, Redbridge has a large young to middle-aged male population, with 22% of men being aged 15 or younger, 66% aged 16 to 64, and 12% aged 65 or over. However, there is significant geographical variation. Certain wards, such as Monkhams and Wanstead Village, have a higher proportion of older men, while others, like Loxford and Ilford Town, have a younger demographic. These demographic variations result in different challenges and health service needs across various local areas.

Younger men

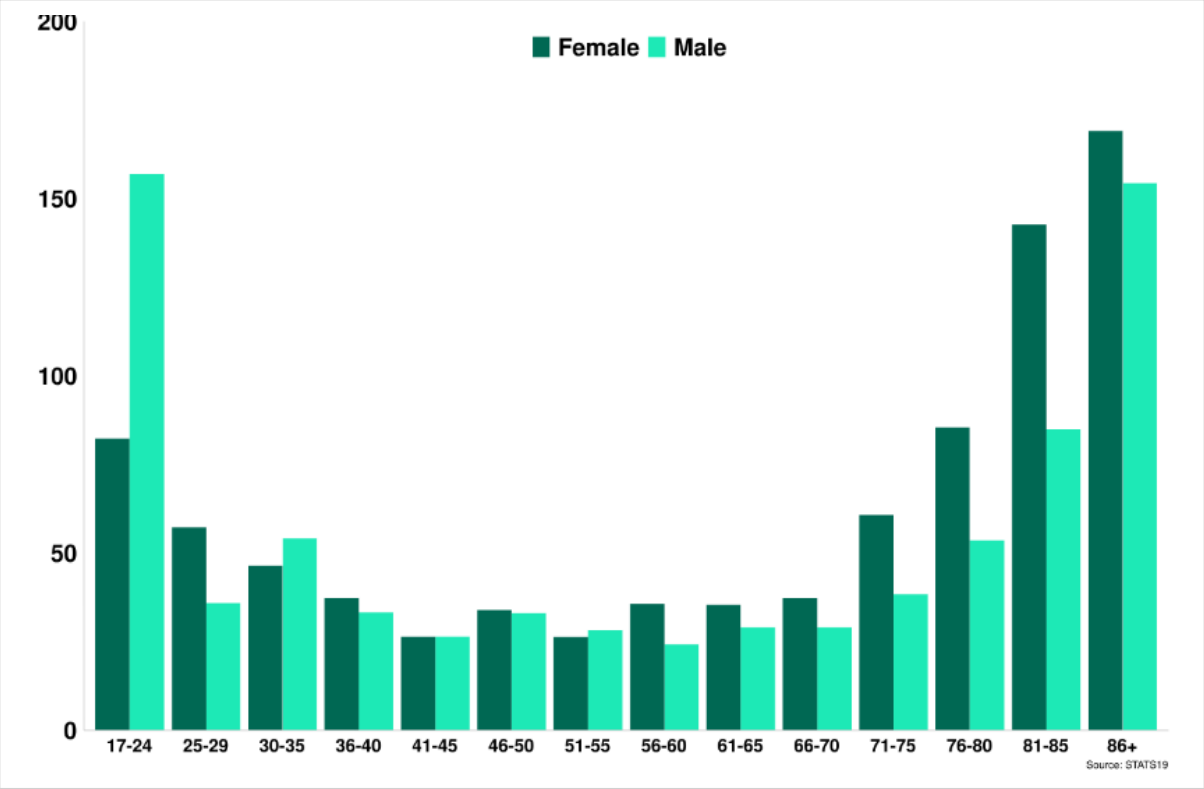
The expectation of being 'tough' and 'strong' and encouragement in risk-taking is closely linked to young men's health.

Accidents

Younger men's propensity for risk-taking behaviour is evident in road accidents. Risk driving, such as speeding, drink and drug driving, and mobile phone use, which are more common among young drivers, is shown to be strongly linked to road traffic accidents[9,10,11].

Young men aged 17 to 24 are among the highest-risk groups of drivers, with their casualty rates almost highest of all age groups and nearly double that of female drivers of the same age.

KSI car driver casualties per billion miles driven, by age and sex, Great Britain: 2022



Source: Reported road casualties in Great Britain: younger driver factsheet, 2022

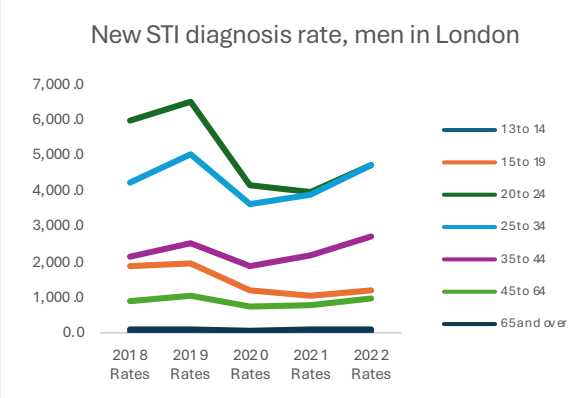
In London, men were 77% more likely to be injured or die on the road than women, with just less than 4 in 1,000 men killed, seriously or slightly injured in a collision (men 3.78/1,000; women 2.13/1,000). Men also have more than double the risk of being killed or seriously injured than women in a collision (baseline KSI rate by sex: men 0.53/1000, women 0.22/1000). In addition to more frequent propensity to risk-take in men, this might also be partly explained by the different role and is further complicated by the level of deprivation[12].

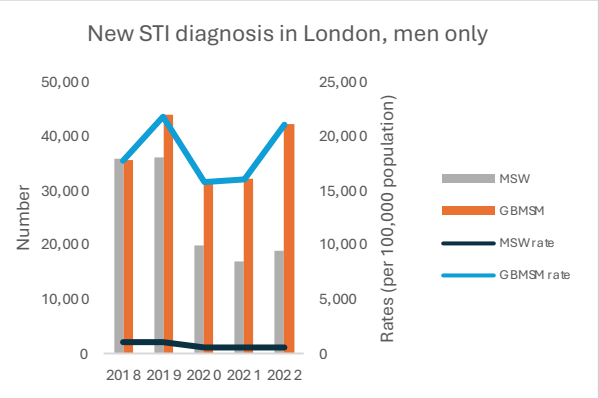
No borough-level breakdown data was identified.

Sexually transmitted infections

Young men are particularly at risk of contracting sexually transmitted infections (STI), with the peak at 20 to 34 years old, almost double that of other ages.

STIs like gonorrhoea, syphilis, and HIV are more common among specific groups of men, including gay, bisexual, and other men who have sex with men (GBMSM), young men aged 15-24, and certain Black ethnicity[13].





Middle age

Men aged between 30 to 60 years are suggested to be caught between models of their older, more traditional, strong, silent, austere fathers and those of their younger, more progressive, individualistic sons. They are also more likely to live alone without social or emotional support, while facing increased economic pressures[14].

As discussed earlier, men often cope with mental health difficulties differently to women, demonstrating an increased tendency to self-medicate with alcohol and drugs to alleviate emotional distress[15]. For example, they may express more externalising behaviours such as alcohol consumption, irritability, and aggressive behaviours while underreporting other symptoms[15]. This is particularly prominent in the middle-aged groups.

Alcohol use

Middle-aged men have the highest level of harmful drinking among all age groups. The proportions of men who usually drank more than 14 units in a week peaked at 36% at the age of 55 to 64. The proportions then declined as they got older. Across all age groups, men were more likely than women to drink at increasing or higher risk levels[16].

Suicide

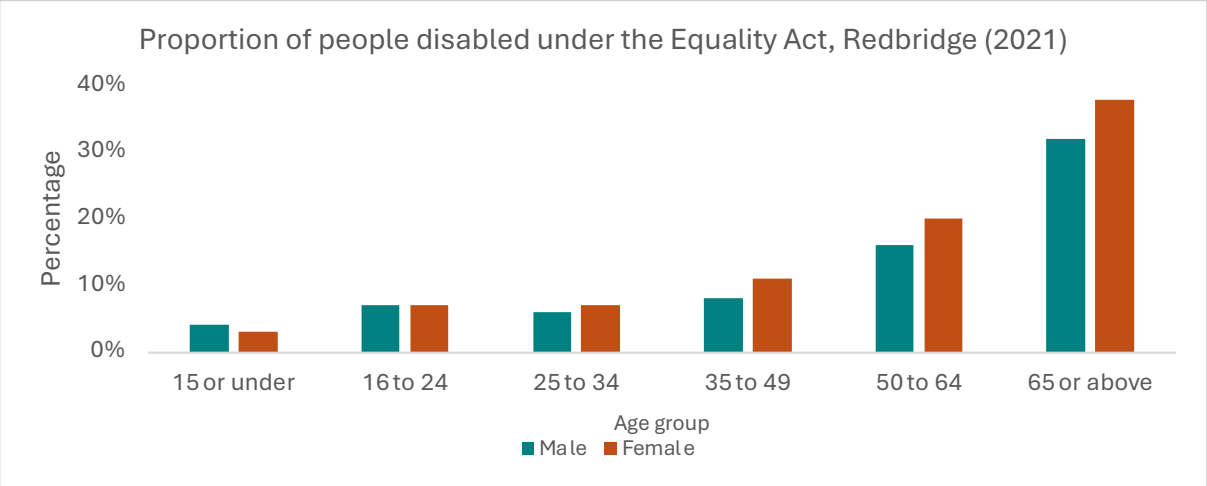
Middle-aged men also have the highest prevalence of suicide among all ages and sex. The risk of suicide peaks between 45 and 64 years old among men[17].

Older men

Among older men, there is a wide range of experiences, with some enjoying affluent retirements while others continue working past retirement age in low-paying jobs. Certain groups of older men, such as those living alone or without partners, are at risk of feeling lonely and socially isolated[18,19,20].

Long-term illnesses and disability

With the accumulation of exposure to behavioural and environmental risks, older men are inevitably more prone to being affected by long-term illnesses and disability. For example, the Census in 2021 showed more than one in four residents in Redbridge over 65 years of age are considered to have a disability[21.]



Loneliness/ social isolation

Loneliness and social isolation are linked to increased health risk. For example, it is associated with a 50% increased risk of dementia. Older people, especially widowed older homeowners living alone with long-term health conditions are more likely to report loneliness and are at risk of social isolation[22,23].

4.1.2 Ethnicity

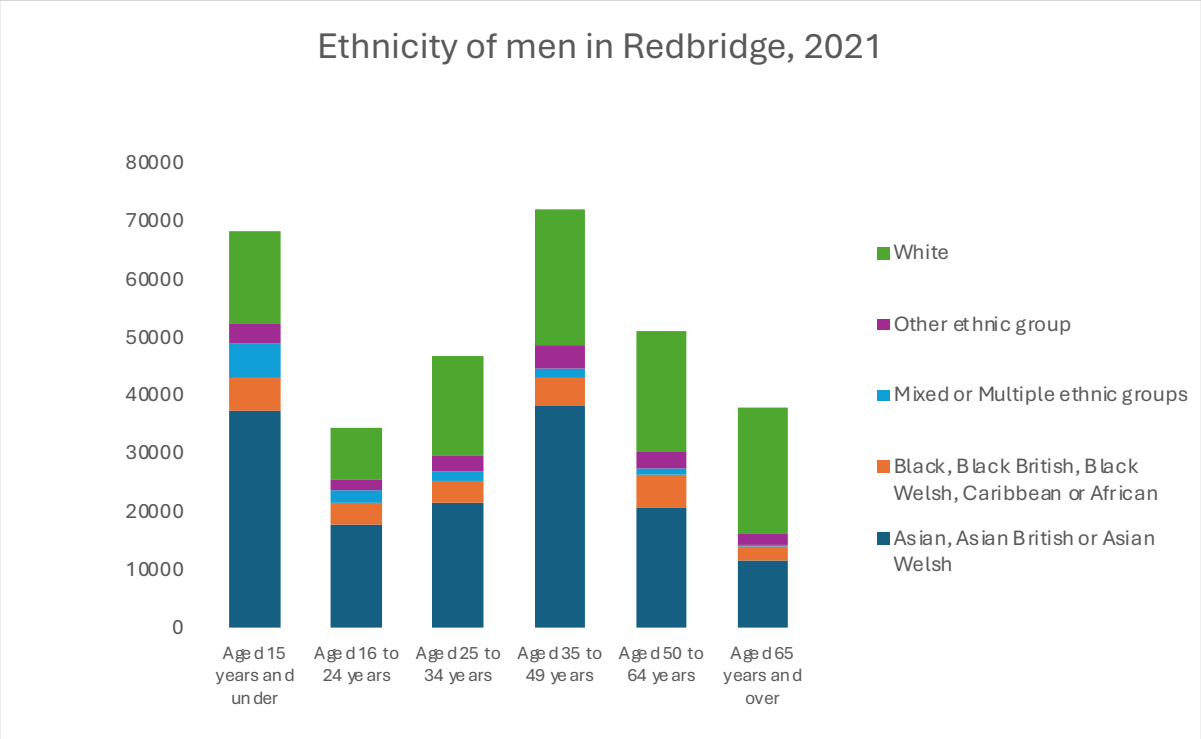
When ethnicity interacts with biological, environmental, economic, and behavioural factors, and with social norms, it has a complex effect on health outcomes. There are significant differences in lifestyle, behaviour, disease prevalence, healthcare access and health outcomes between different ethnic groups[24,25].

In addition, ethnicity is closely linked to important influencers of health such as education and employment, which we will discuss later in this chapter.

Redbridge is the third most diverse local authority in England

Redbridge is the third most diverse local authority in England and Wales, with 42% of men identified as South Asian, 34% White, 7% Black, African or Caribbean[26].

Levels of ethnic diversity differ among different age groups. Among the younger age groups, most men are of Asian ethnicity. In the population over 65, the majority are white. There is significant geographical variation in these demographics.



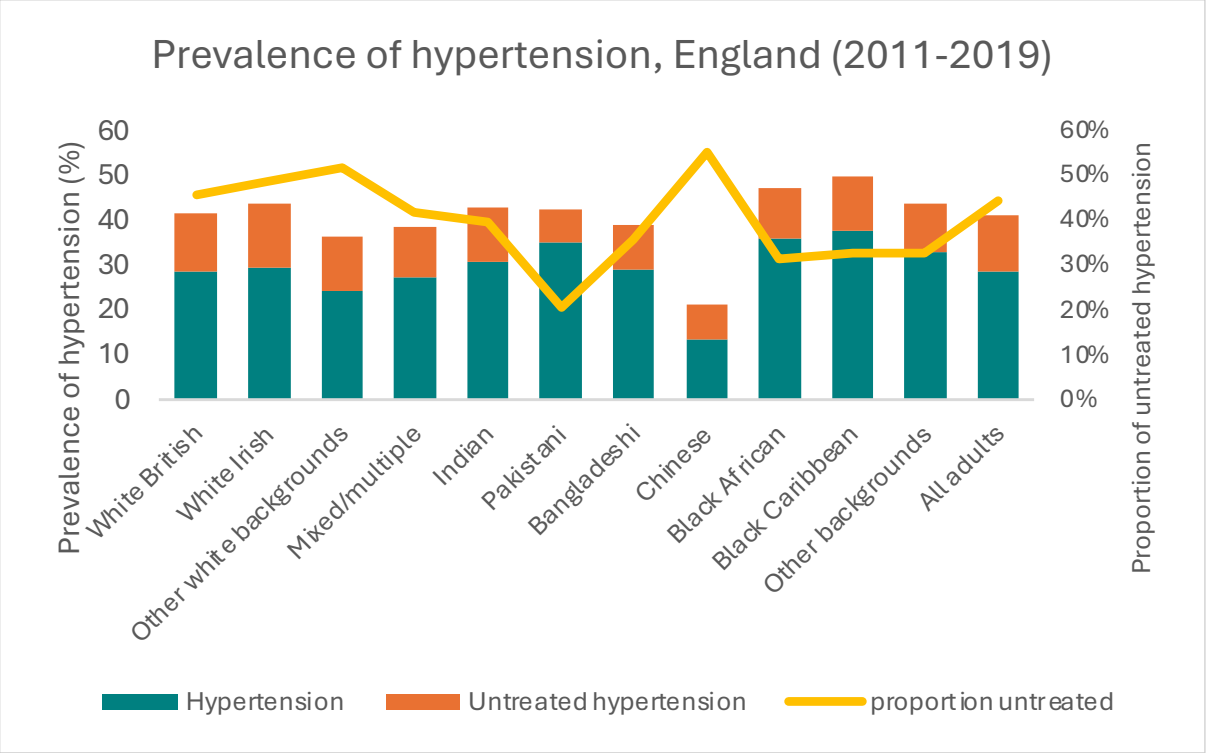
Due to the ethnic composition of Redbridge, the health needs of the population are likely to be different from the other parts of England, and this difference should be considered upon adapting national priorities and strategies. The potential difference in social norms among different ethnicities might also mean a need for varying approaches in communications and health promotion among different parts of Redbridge.

Furthermore, 4% of men in Redbridge – higher than the London average of 3.3% – face challenges with English or cannot speak English. This creates additional barriers to accessing information, employment opportunities, and health and care services. Notably, there is considerable geographical variation within the borough, with the highest proportions of men struggling with English found in Clementswood (6.6%), Loxford (6.2%), Seven Kings (5.9%), Goodmayes (5.8%), Ilford Town (5.8%), and Valentines (5.0%)[21].

Long-term illnesses and cancers

Ethnicity is closely linked to risks of long-term illnesses and cancers. It could be a combination of the effects of genetic makeup, varying socioeconomic factors, cultural and behavioural differences, differences in how closely-knitted their community is, hence the support people have, and the difference in access to health services. Some examples of varying relationships among ethnic groups and illnesses are illustrated as follows[24,27]:

- People with South Asian ethnicity have a six times higher risk of developing diabetes than people with White ethnicity.
- The Black ethnicity population has a three times higher prevalence of diabetes than the White ethnicity population, and they have a higher mortality from diabetes.
- Black African and Black Caribbean men have the highest prevalence of hypertension, while men of Chinese ethnicity have the highest proportion of untreated hypertension.



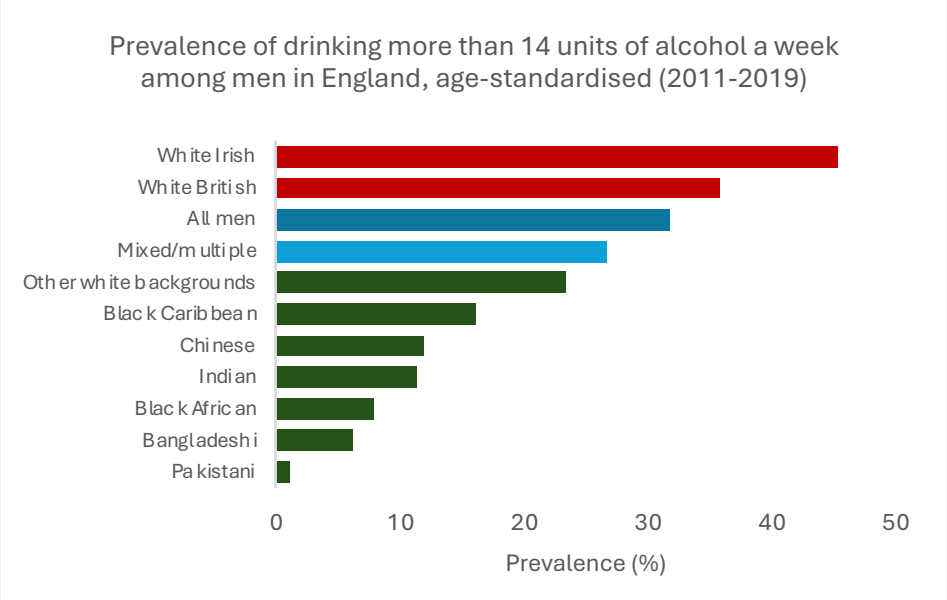
- Men of Black African or Black Caribbean ethnicity are three times more likely than men of White ethnicity to experience prostate cancer and have the highest mortality from this disease.
- White British men have a higher risk of lung and colorectal cancer compared to men of Asian or Black ethnicity.

Behavioural factors

Ethnicity is also closely linked to social norms and behavioural factors, like alcohol use, smoking, physical activity, and attitude towards sex.

Alcohol use

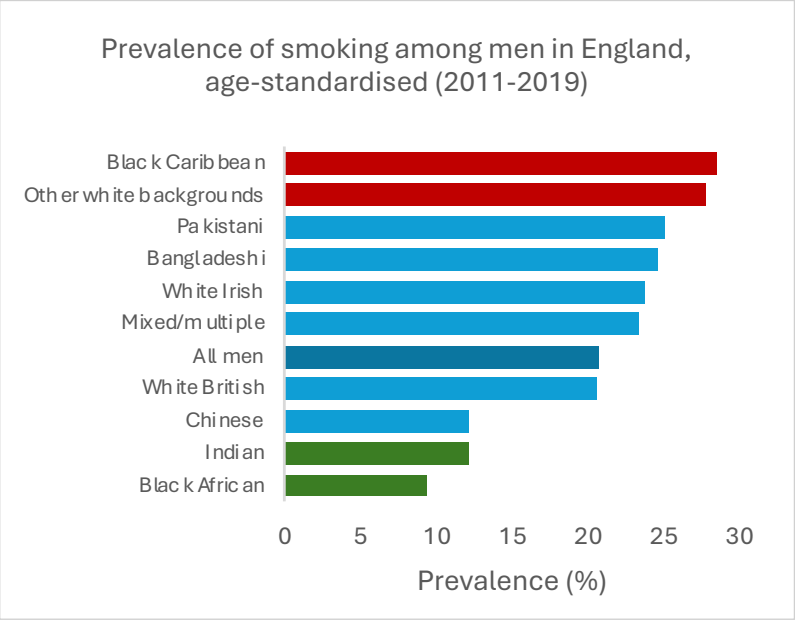
Alcohol drinking is more prevalent among White British and White Irish men than among Black and Asian men, and Muslim men are far less likely to associate masculinity with alcohol use[28]. This is particularly relevant to Redbridge due to the geographical variability of ethnic composition.



Smoking

Nationally, Black Caribbean and other White ethnicity group have a higher prevalence of tobacco smoking[27]. There's a disparity in smoking rates between genders based on ethnicity, notably among individuals of Asian heritage, where men are significantly more likely to smoke than women, with estimates suggesting a 4- to 10-fold higher smoking rate[29].

- Black Caribbean men and men of White Other ethnicity have significantly higher smoking prevalence.
- Asian and Black African men have the lowest smoking prevalence.



It is worth noting that some ethnic groups, often grouped together, such as Black African and Black Caribbean or Pakistani, Bangladeshi, and Indian, show marked differences in smoking prevalence. Unfortunately, we do not have data at this level of granularity for Redbridge.

Sexual attitude and behaviours

The third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) demonstrated potential variations of sexual behaviour and lifestyle among men of different ethnicity groups. For example, when compared to men of White ethnicity groups, men of Black ethnicity have a significantly higher number of partners in the past five years. The other factors such as having concurrent partners or paying for sex also displayed variation among different ethnic groups, but the statistical significance was limited by the small sample size[30].

Physical activity

The level of physical activity also varies with ethnicity, with 31% of men with Asian ethnicity being inactive and only 21% of White men being inactive[31].

Mental health

Attitudes towards mental health conditions vary widely across different cultures and communities. Numerous studies showed people from ethnic minority communities often perceived mental health conditions as something to be kept private and not openly discussed[32]. Mental health conditions were often hidden to prevent community gossip, which was felt as highly threatening to both the person living with the condition and their close family[32]. This is particularly relevant as the population of Redbridge is predominantly Asian[33].

Service utilisation and detention rates also vary among different ethnicity groups. Men from African and Caribbean backgrounds are disproportionately represented among users of mental health services[34,35]. Detention rates under the Mental Health Act were 2.2 times higher for people of African origin and 4.2 times higher for those of Caribbean origin compared to the average. Additionally, Black Caribbean men spent more than twice as many days in psychiatric hospitals compared to people of White British origin, according to a survey of median hospital admission periods[36].

Suicide

Suicidal thoughts are highest among men of White Other ethnicity. However, suicide attempts are most frequent in Black and Black British men[37] (26). The suicide mortality rate for men was highest in White (14.9 per 100,000 men) and Mixed/Multiple Ethnicity groups (14.7 per 100,000 men) individuals[38].

This is especially important as Redbridge is highly diverse and multicultural[26].

Racism, stereotyping, stigma and discrimination

Men of minority ethnicities also contend with a range of issues including racism, discrimination, and social and educational disadvantages. The impact of these experiences can differ significantly among various ethnic groups. A recent report from the UK Government Equalities Office on masculinity made the following findings[20:]

- Portrayals of masculinity in UK print media often include racial and class stereotypes[39].
- Certain ethnic minority groups may be unfairly blamed for issues related to masculine norms, such as child abuse, leading to their further marginalization[40].
- 28% of Black Caribbean and 31% of African respondents to a survey reported experiencing racism within mental health services[41].
- For African and Caribbean men, accessing services often involves interactions with the police and criminal justice system, where they are more likely to face controlling responses[36].

A Race and mental health report done by Mind, including a survey, interviews and focus groups, also reflected people from ethnic minority communities sharing their experience of direct and indirect discrimination within mental health services. Combining with stigmas within some communities, only 30% of ethnic minority communities feel comfortable talking about their thoughts and feelings[42].

These trends interact with other factors including higher rates of poverty, housing instability, and homelessness, as well as challenges in education leading to limited opportunities[35,43]. Experience of racism can have a significant impact on the mental health of Black boys and young men. Negative media portrayals and racist assumptions can erode their resilience as they grow up. These stereotypes may be influenced by gendered perceptions about Black men and boys[43].

4.1.3 Sexual orientation and gender identification

Traditional gender norms often assume heterosexuality as default and fit into traditional gender roles, that is, either a male or a female. This can create challenges for people who are lesbian, gay, bisexual, transgender or any combination of those. They may feel excluded or treated differently as they don't match with these rules[20,44].

Increased risk in sexual health, mental health, and increased risk of smoking, alcohol, and drug abuse are often associated with the LGBTQ+ community[45].

Sexual health

As discussed earlier, STIs like gonorrhoea, syphilis, and HIV are more common among gay, bisexual, and other men who have sex with men (GBMSM).

Mental health

Individuals who identify as LGBTQ+ are 2 to 3 times more likely to experience a mental health disorder compared to those who identify as heterosexual. Half of LGBTQ+ individuals reported living with depression over the past year, and 3 in 5 said they experienced anxiety[46].

A YouGov survey commissioned by a charity for LGBTQ+ people in 2017, which included more than 5,000 participants including over 750 identified as trans, showed that almost half of transgender individuals considered taking their own life in the last year, as did 1 in 3 individuals who identify as lesbian, gay, or bisexual but are not transgender. This percentage is significantly higher compared to the general population, where the number estimated is 1 in 20[47].

Interpersonal violence/ Abuse

Interpersonal violence can be more common in male same-sex relationships compared to heterosexual relationships, with studies suggesting that 34-45% of men in such relationships experience intimate partner violence. Men experiencing this violence have an increased risk of mental health issues, substance abuse, and sexually transmitted infections[48].

Interactions with other factors

Gay, bisexual and trans (GBT) men have diverse experiences of gender norms, shaped by their positions in society. For example, young, mainly middle-class students in England were more likely to hold pro-gay attitudes and have openly gay friends[20,49].

Sexual orientation and gender identification in Redbridge

The majority of Redbridge's population, at 88.6%, identified as heterosexual. The remaining identified as follows: gay or lesbian (0.85%), bisexual (0.94%), pansexual (0.35%), asexual (0.03%), queer (0.01%), another sexual orientation (0.04%), and 9.72% chose not to answer[21].

Most of Redbridge's population, 90.6%, identified with a gender that matched their sex registered at birth. The remaining identified as follows: those with a gender different from their sex registered at birth but no specific identity given (0.6%), as a trans woman (0.17%), as a trans man (0.19%), non-binary (0.03%), another gender identity (0.03%), and 8.41% chose not to answer.

London Borough of Redbridge does not hold any breakdown data on sexual orientation or gender identification in Redbridge.

4.1.4 Men with disabilities

Research has found that men with disabilities often struggle to conform to ideals of masculinity centred around physical strength and performance, feeling pressure always to be strong and tough[20,50,51]. Additionally, if disabled men face exclusion or marginalization in labour markets, health care, and education systems, they may struggle to meet societal expectations of being breadwinners and career-focused individuals[52].

Despite legal changes aimed at combating discrimination against disabled individuals, negative stereotypes persist[53,54]. Attitudes towards those with less visible disabilities, like mental health conditions or learning disabilities, tend to be more negative compared to those with more apparent disabilities like physical or sensory impairments[20].

For instance, research has shown that men with learning disabilities are often portrayed negatively in culture and media[20,55,56]. Similarly, recent studies regarding men with Duchenne muscular dystrophy have highlighted how they may be denied an adult identity and infantilized due to assumptions about their cognitive and physical capabilities[52].

In Redbridge, as discussed earlier, the proportion of men with disability increased with age and has the largest proportion in the oldest age group.

4.2 Social Determinants

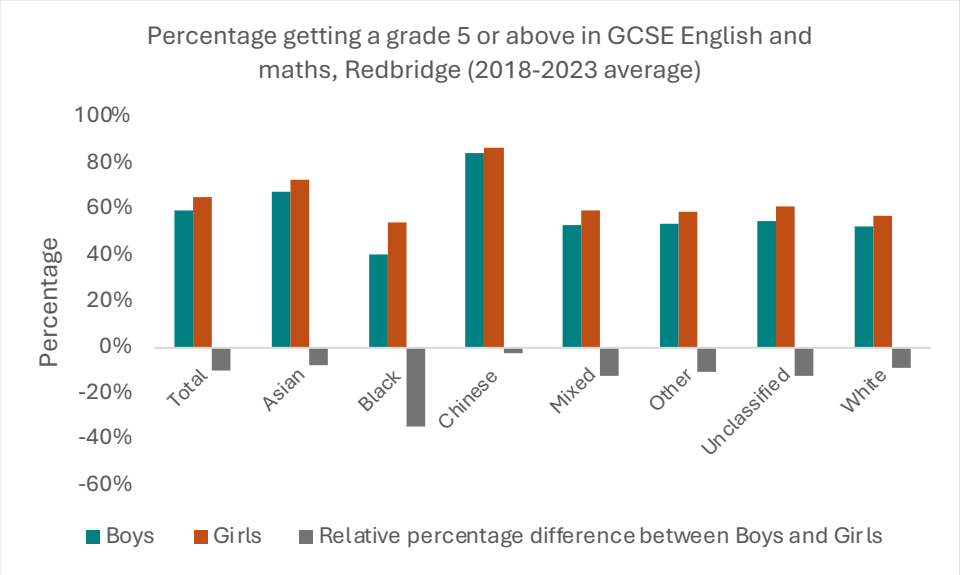
4.2.1 Education

Education plays a crucial role in determining our health. It enables individuals to build strong social networks, secure meaningful employment, develop essential skills for lifelong learning and problem-solving, and foster a sense of worth. These factors collectively contribute to improved opportunities, a higher quality of life, and better overall health. Research suggests that by the age of 30, individuals with higher levels of education can expect to live four years longer than those with lower levels of education[57,58,59].

In England, the percentage of boys getting a grade 5 or above in GCSE English and maths is lower than girls (47.0% vs 52.7%).

The difference exists among all ethnic groups, but there are significant disparities between them. The largest gap between boys and girls was seen in the black Caribbean, Gypsy/Roma, and Irish Traveller ethnic groups. For every 10 girls who achieved a grade 5 or above, only 6 or 7 boys managed to do the same. In contrast, ethnicities like Indian, Chinese, and White had 9 boys achieving the same level[60].

In Redbridge, the disparity is less pronounced, with 62% of boys and 65% of girls achieving a grade 5 or above in GCSE English and maths, reflecting a mere 3% absolute difference. However, notable differences exist between ethnic groups, with the smallest relative difference in Chinese (2%) and the largest relative difference of 35% between boys and girls of the Black ethnicities[61].



4.2.2 Housing and Homelessness

Housing is a crucial determinant of health. Houses provide shelter to families, protect personal possessions, and provide spaces to socialise with friends. In England, 1 in 5 dwellings doesn't meet decent standards[62].

In the GLA's 2024 rough sleeping survey, approximately 90 people were observed sleeping rough in Redbridge, and around 90% were male[63].

Living alone is an important risk factor for social isolation[64] and is linked to poor health outcomes including increased mortality[65], increased risk of depression and anxiety[76].

In Redbridge, about 10% of men (about 10,000) aged over 15 live alone, but this number doubles to 21% for men aged over 65. Nearly 60% of men living alone are men of White ethnicity. The proportion of men living alone varies greatly by location. For instance, in Clayhall, it's 4%, while in South Woodford and Wanstead Village, it's 14% and 16%, respectively. Among men over 65, Wanstead Village has the highest rate at 35%, followed by Ilford Town at 37%[21].

4.2.3 Employment

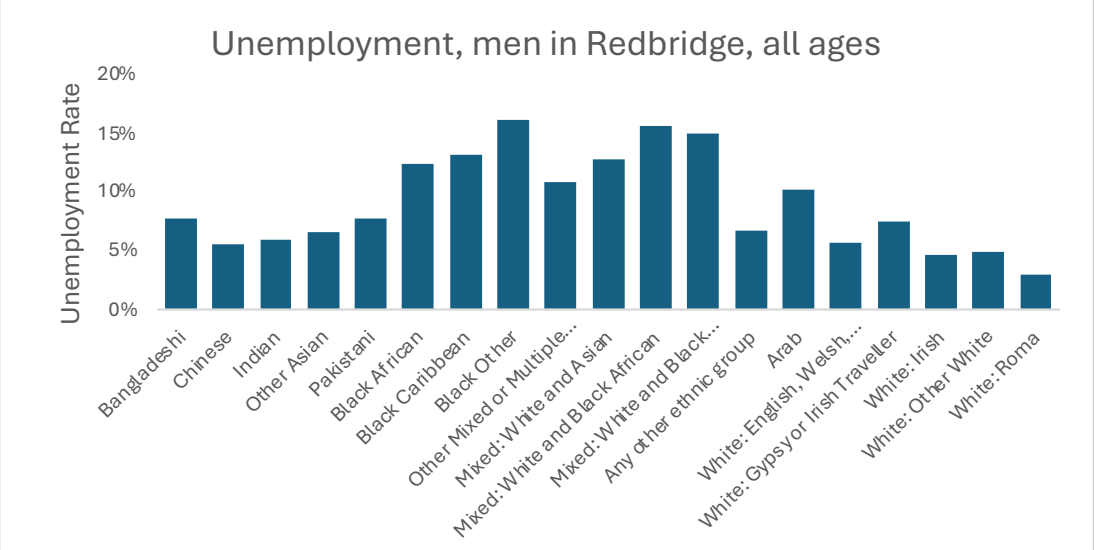
Employment has been considered the most important factor affecting people's health[67]. Individuals experiencing prolonged unemployment have a shorter life expectancy and poorer health compared to their employed counterparts[68]. The effects extend beyond the individuals. Children raised in unemployed households are nearly twice as likely to fail at all stages of education, including key stage 1 (Year 1 to 2), key stage 2 (year 3 to 6) and key stage 4 (GCSE) of the national curriculum, compared to those from working families[69].

Additionally, young people categorised as NEET (Not in Education, Employment, or Training) are at heightened risk of experiencing adverse physical and mental health outcomes, unemployment, and obtaining low-quality, low-paying jobs in the future[70].

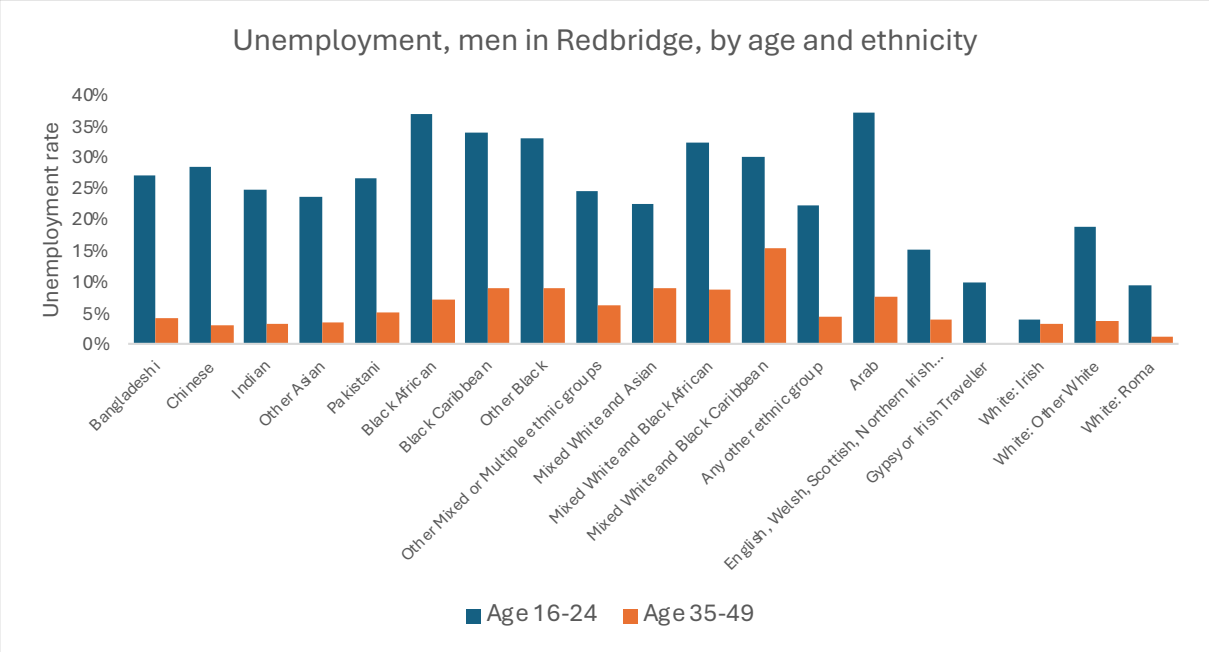
In Redbridge, calculated from the Census data, the overall unemployment rate for men is 7%. Notably, unemployment is more pronounced among younger men, reaching 24% for those aged 16 to 24, and 7% for those aged 25 to 34. These numbers are similar to the London's average[67].

Employment, age and ethnicity

There exists significant variation in unemployment rate across ethnicities, the lowest among South Asian and Chinese men between 6-8%, and highest among the Black and mixed ethnic groups between 12-16%.



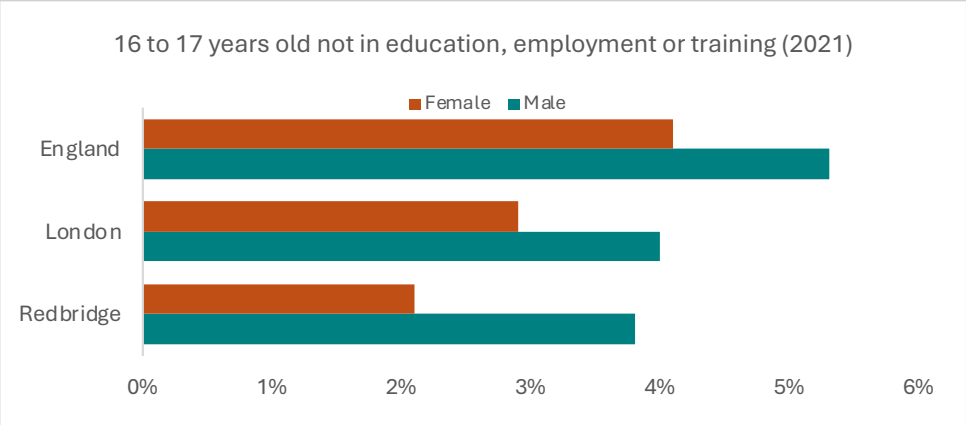
The trend remains consistent when considering both age and ethnicity: within each ethnic group, men aged 16-24 are disproportionately affected by unemployment. Among ethnicities, the lowest unemployment rates are observed among White British/Irish men (15%), while men of Black ethnicity have the highest rates (30% to 37%) and South Asian/Chinese men fall within the range of 24-29%[75]. If we look at age 35 to 49, the age group with the lowest overall unemployment rate, significant inequality exists among different ethnic groups, with the lowest among most Asian and White ethnicity groups at about 3-4%, to between 9-15% among most Black ethnic groups*.



*The percentage for men of Arab ethnicity is affected by there being a small number of individuals of this ethnicity in the borough.

Teenagers not in education, employment, or training (NEET)

The percentage of young individuals aged 16 to 17 years who are not in education, employment, or training (NEET) is lower than the England average. However, there is a notably higher proportion of males within this category compared to females[71].



Employment and other risk factors

Employment is closely linked to other health issues or behaviours such as diet, physical activity, smoking and suicide. This will be discussed in the later part of this chapter.

4.2.4 Poverty

Poverty often restricts the range of health impacting options available to individuals, be it healthy food, decent housing, or time for exercise. Poverty also results in stress and poor living conditions. All these lead to poor health. People frequently live a shorter life and develop disability earlier when they have lower incomes[58].

In Redbridge, 5.2% of men (5,300) are claiming unemployment-related benefits, compared to 4.9% of women. The percentage of male claimants is lower than that of London (5.6%) but higher than that of the national average (4.3%)[72].

4.2.5 Social isolation and loneliness

Men are at higher risk of social isolation and loneliness, they are less likely to communicate with friends and family by meeting up in person, speaking on phones or exchanging text or instant messages. Additionally, men in general, have lower access to support networks than women[73]. This puts men's health at risk, as positive relationships and community cohesion can build resilience and reduce the effects of factors like deprivation, while social isolation increases the risk of premature death of all causes[64, 74].

4.3 Interactions between factors

Employment and Smoking

Smoking prevalence varies significantly across occupations, with routine and manual workers in Redbridge having the highest rate at 17.2%, followed by individuals who have never worked or are long-term unemployed at 14.5%[75]. In comparison, London has rates of 20.2% and 11.7% for these groups, respectively[75].

Employment, Education, and Physical Activity

Deprivation, employment and education are closely linked to the level of physical activity. People in the most deprived group are more likely to be physically inactive compared to those in the least deprived group. About 35% of the most deprived group are inactive, while only 16% of the least deprived group are inactive.

This trend also applies to employment and education: 35% of unemployed individuals are inactive, while only 18% of working individuals are inactive; similarly, 47% of people with no qualifications are inactive, compared to only 15% of those with a level 4 qualification or higher[76].

Poverty, employment, and mental health

Mental health is closely linked to poverty and a person's economic status. Suicidal thoughts, attempts and self-harm are highest in people who are economically inactive, followed by those who are unemployed, while the lowest proportion is in those who are employed[77]. This is relevant to Redbridge, as only 66% of working-age residents are in employment compared to 75% in London. In addition, 27% of working-age Redbridge residents are economically inactive, compared to 21% in London[78].

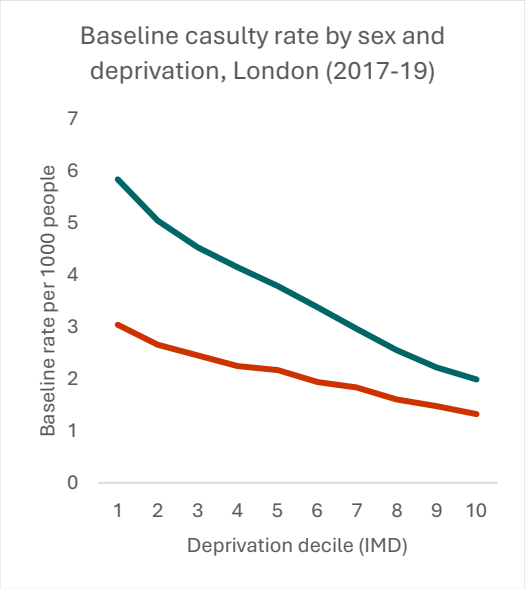
There is also a gap of 66% between the employment rate of people who are in contact with secondary mental health services in Redbridge, and those who are not[79].

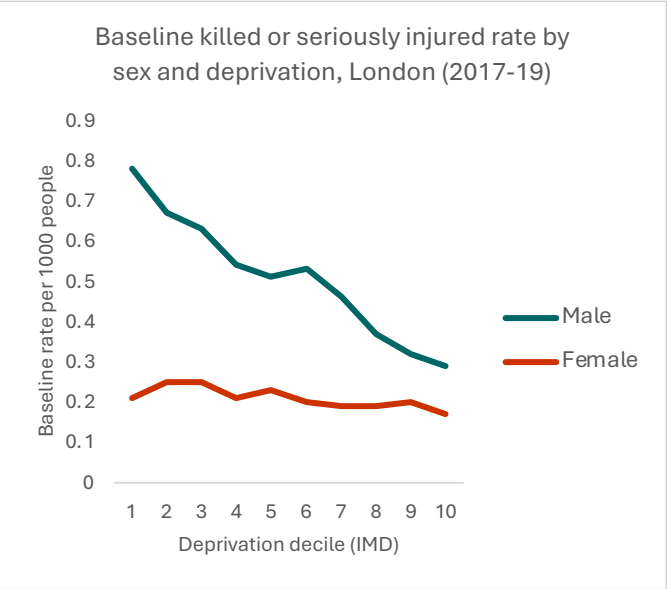
The rate of suicide in the lowest social class in the most deprived areas has been found to be approximately 10 times higher than those in the highest social class in the least deprived areas[80].

Deprivation and road accidents

Deprivation is also closely linked to injury and death on roads, and the effect is more profound among men. The report, *Inequalities in road danger in London (2017-2021)* illustrated that the more deprived the home postcode, the higher the casualty rate for men. Men living in the most deprived 30% of London have double the mortality and injury rate of men living in the least deprived 30% (0.66 vs 0.34 killed or seriously injured per 1,000 men)

For both men and women, the more deprived the home postcode, the higher the casualty rate. This trend is more pronounced for men than it is for women[81].





Section 5 | Accessing Health Services

Men tend to avoid seeking medical assistance

Men's tendency to avoid seeking medical assistance is a well-documented trend backed by various studies. Compared to women, men often express more embarrassment during medical appointments and may wait longer before seeking help, particularly if their symptoms aren't visibly affecting them physically[1].

The main obstacles to seeking help include reluctance to talk about emotions or health concerns, feelings of embarrassment, anxiety and fear, and difficulties in communication with healthcare professionals. This reluctance can lead to serious health issues when symptoms are ignored, ultimately causing worse health outcomes for men and placing additional strain on the healthcare system[2].

5.1 General practices and outpatient services

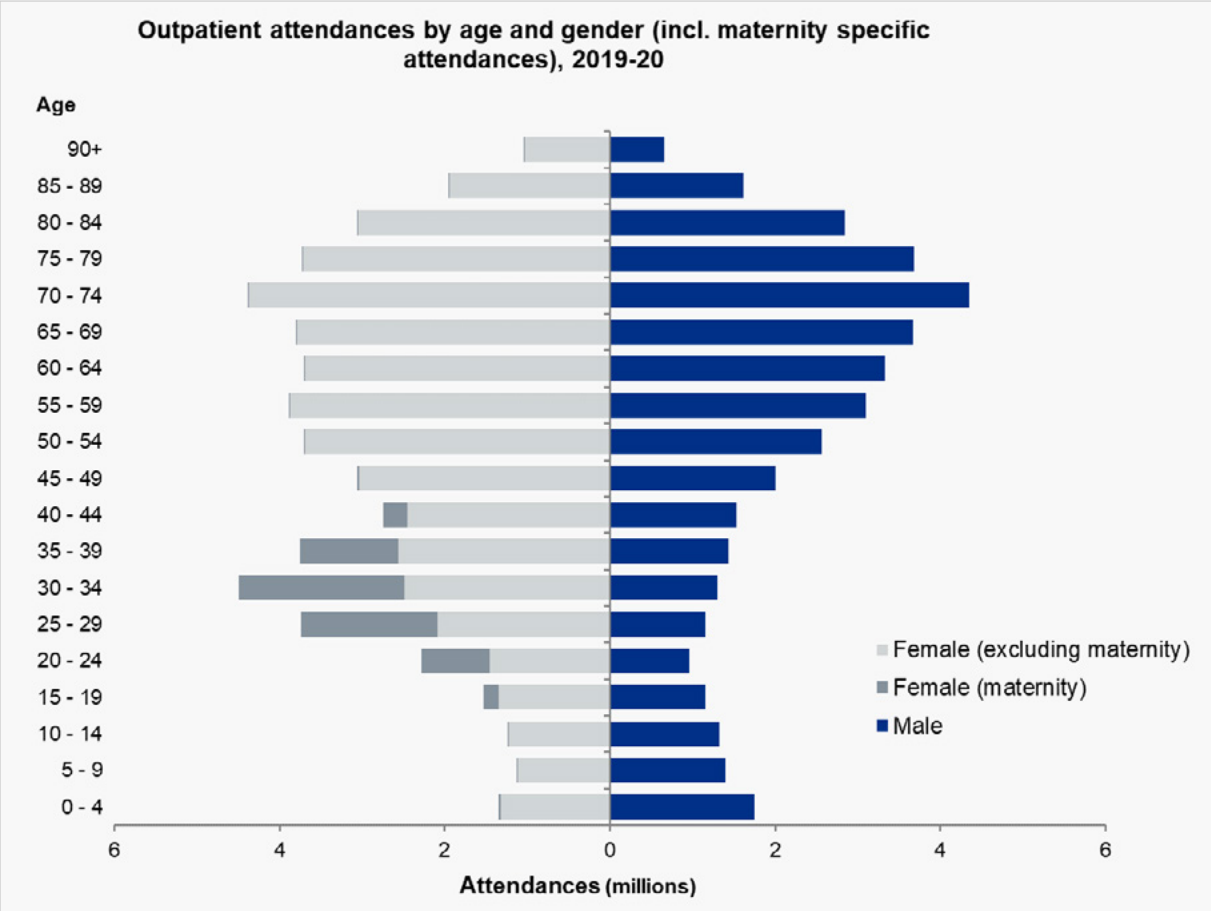
General practices

This tendency is evident in the UK, where research on general practices shows that men visit their GP only two-thirds as often as women. On average, men see their GP about three times a year, while women go approximately 4.6 times a year[3].

The biggest gap is seen between ages 21 and 39, where men visit their GP less than half as often as women. In this age group, men have around 1.7 visits per year, while women have about 4.2 visits per year[3]. The consultation rates between men and women over age 58 are quite similar. In addition, there were no significant differences in consultation rates between men with different levels of deprivation[3]. It has also been identified that for men and women with similar medical conditions, such as heart disease and depression, the rate of receiving medication was similar[3].

Outpatient attendances

Outpatient attendance reflects a similar trend. In 2019-20, men only comprised 42.1% of hospital outpatient activities in England, the difference is still significant excluding visits for maternity services[4].



5.2 Screening

The data from England indicates that the uptake of bowel cancer screening is consistently lower in men compared to women and there are noticeable social disparities in participation rates[5]. Additionally, for abdominal aortic aneurysm screening, only 55% of men have taken up the offer[6]. This suggests there may be challenges in engaging men in uptake of screening, which could potentially contribute to poorer health outcomes.

5.3 Mental health services

Similar to the situation in general practice, compared to women, men are less likely to seek help for mental health difficulties and hold more negative attitudes toward the use of mental health services[7].

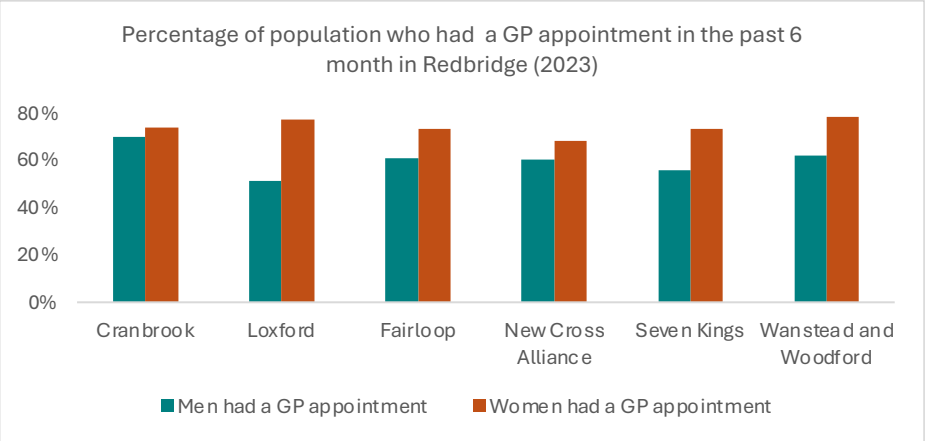
In the UK, women are 1.58 times more likely than men to receive medication or psychological therapy even when differences in prevalence are taken into account[8].

Traditional masculine gender roles are thought to be deterring men from engaging with mental health services, as traits associated with traditional masculinity include stereotypes of stoicism, invulnerability and self-reliance, and negative emotions are perceived as a sign of weakness. Failure to adhere to these stereotypes could result in self-stigmatisation and further discourage them from seeking help[7].

5.4 Redbridge data

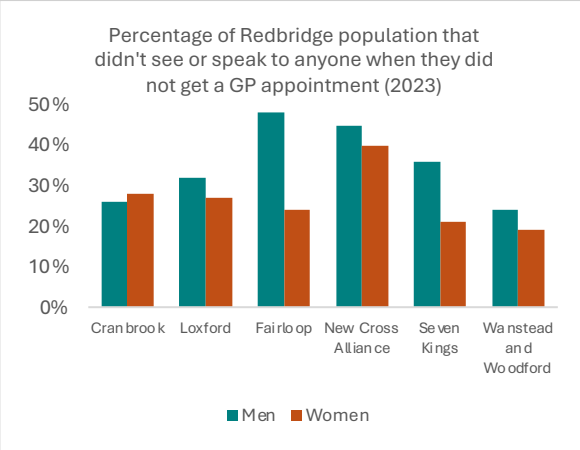
5.4.1 General practices

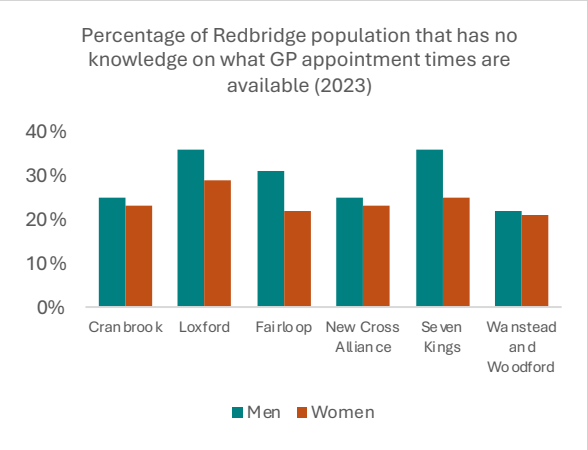
Redbridge data show that men visit their GP less frequently than women, although there are some apparent variations across the six primary care networks[9].



In general, the difference in GP visit frequency between men and women is larger in younger age groups. However, there is significant geographical variation (Appendix 1).

In all primary care networks (PCNs), when unable to secure a GP appointment, more men than women did not see or speak to anyone. This may indicate the important role of GP visits among men, as well as men's reluctance to seek help.





Across all PCNs, more men than women are unaware of available general practice appointment times. There are significant variations among different age groups in individual PCNs (Appendix 2).

The NHS GP Survey only provides a snapshot of the situation, the results are limited by the small number of responses from each PCN, and it doesn't offer statistical analysis. However, these results indicate potential inequality in GP access between genders. There are also marked geographic variations, which may be influenced by individual PCN practices or demographic differences, indicating potential room for improvement.

Data on screening uptake differences between genders is not available at the local authority level.

5.4.2 Smoking cessation service

The Redbridge Tobacco Control Plan (2023-2028) highlights that despite improvements in smoking rates over time, there has been a notable decline in successful quit rates since 2016. Specifically, Redbridge reports a very low 4-week quit rate of 303 per 100,000, significantly below the London average of 1,665 per 100,000[10]. Reductions in quit rates can be predicted as the prevalence of smoking reduces as the proportion of smokers who find it difficult or undesirable to quit increases in the smoker population.

In the first two quarters of the service year 2023/24, smoking cessation services were provided for 133 men and 63 women respectively. This ratio is roughly proportional to that of the local smoking prevalence.

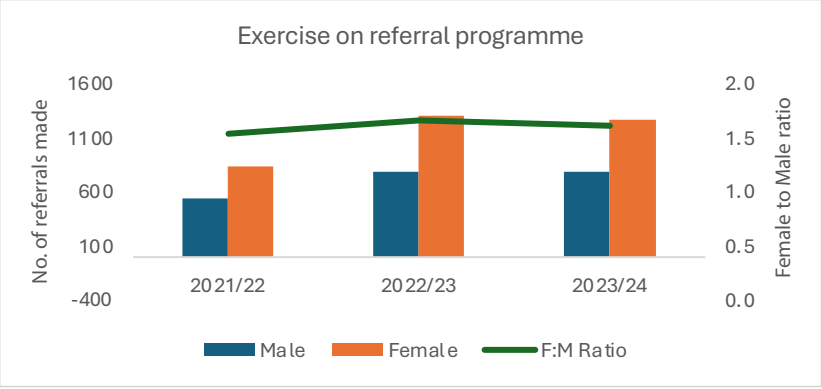
5.4.3 Drug and alcohol services

The service use data for Redbridge in 2020/21 reveals that a total of 562 residents were in drug treatment, with the majority (two-thirds) seeking treatment for opiate use. The most cited substances in addition to opiates are crack cocaine, alcohol, and cannabis. The gender distribution shows a split of 75% male to 25% female, slightly deviating from the national ratio of 71% male to 29% female.

There is no publicly available data on the gender distribution of local alcohol services.

5.4.4 Weight management

The Exercise on Referral program in Redbridge allows doctors or health professionals to refer individuals who could benefit from physical activity to help manage their medical conditions. It's open to Redbridge residents aged 16 and above who are not active and wish to boost their physical activity levels. Qualified instructors guide participants with medical conditions to reach their fitness goals. By proportion, more women were referred to the exercise on referral programme in Redbridge, with a ratio of 1:1.6.



Section 6 | Conclusion and Recommendations

This report is the first attempt to profile men's health status in the London Borough of Redbridge in an Annual Public Health Report. The completion of this report has not been straightforward, as data on many of the health outcomes and behavioural factors were either not segregated by sex and other demographic factors, or not of high quality due to small sample sizes, at the local level. As a result, the profile is by no means comprehensive.

Nonetheless, this piece of work provided some insights into the disproportionality faced by men living in Redbridge, and highlighted some unique challenges in our borough.

Men in Redbridge are disproportionately affected by cardiovascular disease, cancer, diagnosis and treatment of hypertension and diabetes. Unhealthy behaviour, such as eating less than 5-a-day, smoking and harmful alcohol drinking are also more common among men.

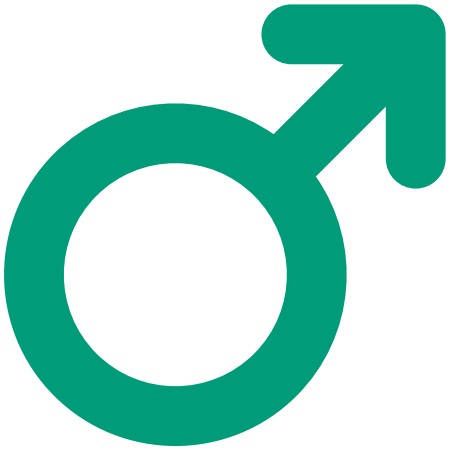
There are significant differences in health risks and behaviour between men of different ages, and ethnicities. The age of men and where they live in the borough are also linked to the disproportionality of health outcomes, mortality, and engagement with health services.

This report also highlighted how men's health is closely related to culture and social norms, and other factors including education, poverty, employment, and housing.

We require a better understanding of the root cause of these differences to improve men's health in Redbridge through a gender-responsive and culture-sensitive approach.

Tackling the root causes of disproportionality between the two genders and among different groups of men, and improving men's resources and social skills to handle life's difficulties is not a task that could be achieved by one agency alone and requires close collaboration across all partners within the system.

To bring it forward, priorities and key areas for action have been identified with reference to the WHO-EURO Men's Health Strategy taking into account the local situation.



Recommendations

1 Strengthen governance structure and work across sectors

Men's health and behaviour are closely related to upbringing, education, and cultural and socioeconomic background. Redbridge should adopt a health-in-all-policy approach which considers the difference in gender in all policies,

- Establish support to ensure health policies address gender differences in exposure to risk and experience of health outcomes.
- Ensure gender health equity is on the agenda of the Place-based Partnership Board and the Health and Wellbeing Board, such that policymakers and service providers may consider the effect on people of different genders upon policy-making, service commissioning, and service provision.

2 Establish intelligence support and build a strong local evidence base through research and evaluation

Given Redbridge's diverse population, it is important to gain a deeper understanding of the male population, particularly the differences among various subgroups defined by ethnicity, age, sociodemographic difference and geographic distribution. Comprehensive analysis of community profiles, research and engagement are necessary to explore how cultural backgrounds and social norms influence men's behaviours and interactions with local systems. The following efforts could support the identification of the focus and priorities of health needs among different cohorts of men in Redbridge:

- Collaborative work between Redbridge partners and the North East London ICS Intelligence Team to further develop segmentation tools and products which allow for greater depth of analysis of health risk factors across different male cohorts in our borough.
- Ensure best practice around equality assessment is followed in the evaluation of all services and policies, in terms of service access and health outcomes between genders and within relevant gender sub-populations, considering the disproportionality in health needs.
- Consider the development of further equity audits for service areas focusing on the interaction between ethnicity factors, cultural factors, and gender.

3 Strengthen participation and leave no one behind

A participatory approach that recognises the importance of engaging men from various communities should be adopted in the development and implementation of health strategies to achieve sustainable results.

- The Redbridge Place-based Partnership to consider engagement work with specific male cohorts for specific health conditions in its engagement prioritisation processes.
- Reviews of health equity and service access equity should consider measures of levels of exclusion for key male risk groups including men who are unemployed, homeless, migrants, of different ethnic origins, gay, bisexual and trans men, or who are living with mental illnesses or disability.

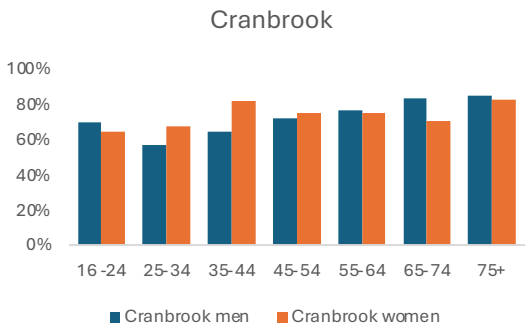
4 Make the system gender responsive

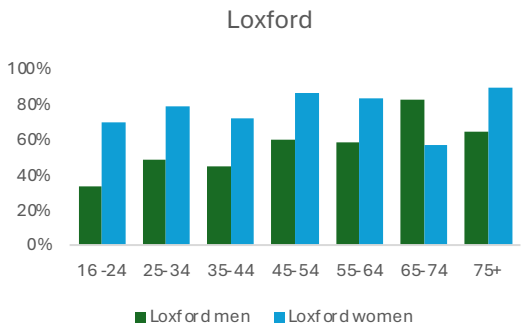
The WHO-EURO men's health strategy advocates for a gender-responsive approach that considers gender norms, roles, relations, and inequalities. Similarly, the government's gender norm report highlights the importance of designing policies, programs, and campaigns that promote gender equality and avoid perpetuating harmful norms and stereotypes:

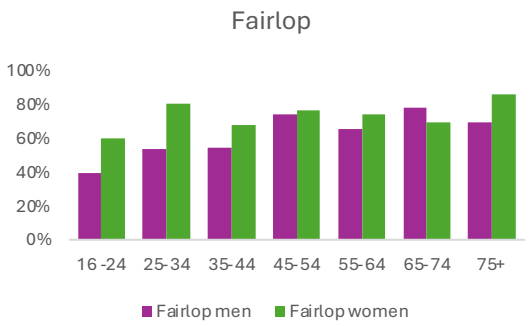
- Acknowledge men's health needs, their help-seeking behaviour and interactions with the health system and ensure a model of care that makes health services more accessible to men and boys, taking into account gender norms, roles and other factors affecting men such as ethnicity, education and employment status.
- Take a gender perspective into health promotion initiatives, aiming at improving health outcomes across the life course and developing more equitable gender roles, by redefining harmful gender norms, and challenging gender stereotypes.

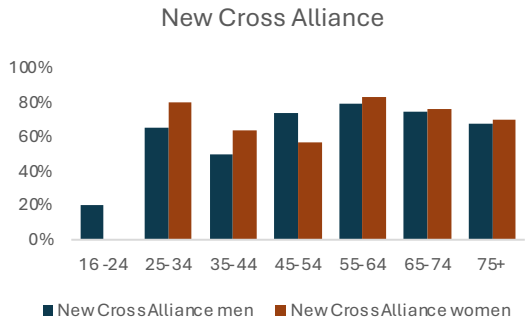
Appendix

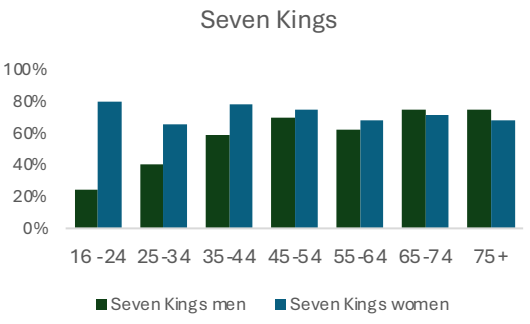
Appendix 1 **Percentage of the population who had a GP appointment in the past six months**





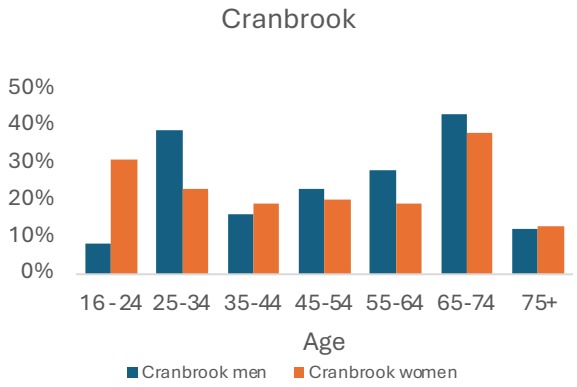


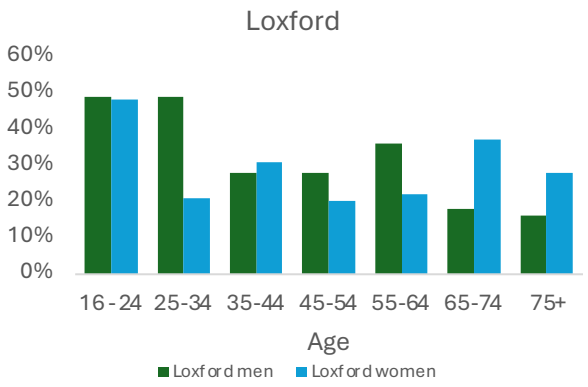


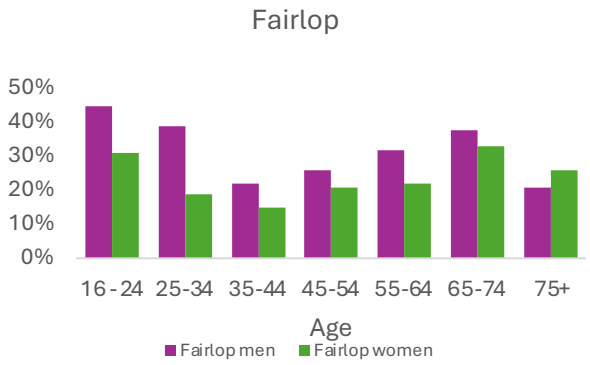


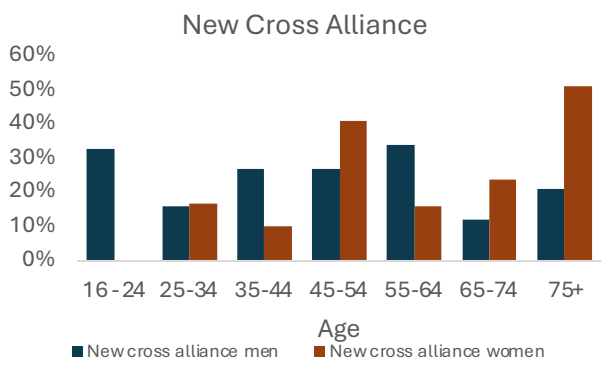
Source: NHS GP Survey

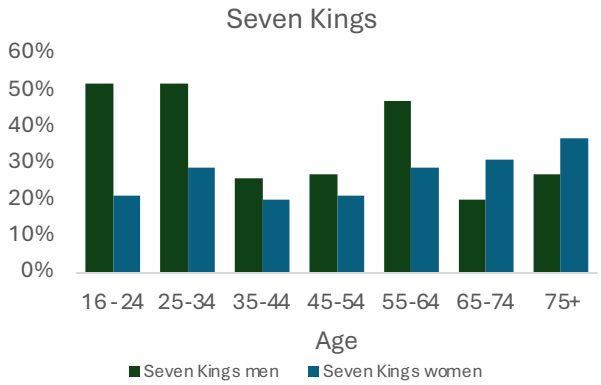
Appendix 2 **Percentage of the population that did not see or speak to anyone when they did not get a GP appointment**











Source: NHS GP Survey

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Section 5

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