MINISTRY OF HEALTH
MALAYSIA

NATIONAL MEN'S HEALTH PLAN OF ACTION MALAYSIA 2018 - 2023

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TABLE OF CONTENT

FOREWORD by the Minister of Health Malaysia

The catalyst for a developed and safe nation stems from a healthy society and harmonious family institutions. The health of a family depends on the health of every member in the family; hence male and female health are equally important. It is established that men have poorer health than women and are exposed to a variety of health risks. This is a growing concern globally and locally. In Malaysia, the life expectancy of males is shorter than women by five to six years, while premature deaths among men between the ages of 15-65 years is twice that of women. The major contributors to premature deaths of men in Malaysia include chronic cardiovascular illnesses such as heart disease and stroke; road traffic accidents; diseases related to the lungs such as bronchitis, pneumonia and asthma; and cancers whereby colorectal cancer is the main cancer that affects men, followed by lung and prostate cancers.

Men's health behaviour differ from their female counterparts, influenced by socio-cultural differences on expectations and roles. This issue is projected by the low attendances for health screening among males. It is clear that in order to address men's health issues, ongoing efforts should be undertaken by all parties and agencies. Hence, it is timely to focus on men's health in order to improve their physical, mental and social well-being for the benefit of the family and future generations. It is timely that the development of National Men's Health Action Plan took place, as comprehensive services need to be introduced to tackle issues regarding men's health. The main objective in developing this Plan of Action is to promote gender equity through measures that target the health and quality of life of Malaysian men.

It is anticipated that the promotion and management of health on men's health will be carried out more proactively and effectively at the community level. Ideally, it is necessary to establish a friendly health service to men's health to facilitate and provide a place of reference and consultation for specific male health. It is hoped that this National Men's Health Action Plan will help the Ministry of Health and other relevant agencies plan health services for men and empower them to be more proactive in maintaining their own health. I am convinced that all agencies and ministries are able to implement health elements within the jurisdiction and task of each ministry and agency involved.

It is with great importance for me to note here, that striving towards a vertex health status in our nation depends on our current and forthcoming efforts. Hence, I envision that the strategies outlined in this National Men's Health Action Plan will be successfully executed.

YB Datuk Seri Dr Dzulkefly Ahmad
Minister of Health Malaysia

PREFACE by the Director General of Health Malaysia

In the past decade, Malaysia has witnessed unprecedented multi-sectoral commitment in setting and implementing imperative agendas for the health of its citizens. The Ministry of Health looks seriously upon the male health gap or "men's health gap". In line with the "Sustainable Development Goals" to improve health for all ages and genders, the Ministry of Health is taking a step to focus on male health, so that the gap in health can be tackled. However, while gender approaches are being introduced to reduce this gender disparity, and every step taken to improve men's health, the equally important health of women will not be ignored.

Although men are provided with the same exposures and opportunities as women in terms of healthcare and access to health services or advice, analyses have shown that men faced certain barriers in terms of their perceptions, behaviours and beliefs around their health needs, which require more serious attention. Male attributes like independence, assertiveness, risk-taking, sense of invulnerability and withstanding of pain may have contributed to their increased exposure to various health and disease risk factors such as hypertension, diabetes and smoking. Despite this, health screening uptake among men is low, records from health clinics showing that only 3.3% of men were screened in 2015 as compared to the 4.1% in women. Hence, it is time for us to see the needs of men in healthcare in order to improve the quality of their health and subsequently enable them to be healthier social leaders.

The Ministry of Health has always emphasised fair and universal service. Acknowledging the need to address challenges associated with men's healthcare, the National Men's Health Action Plan (NMHAP) is prepared as a male-friendly framework to drive a more structured service delivery policy. This action plan aims to ensure equality in the utilization of health services by men. It integrates the "life-course health" (service to all ages) approach that was enacted in the Seventh Malaysia Plan to enhance primary health services. This is so that the scope of provision of health promotion, prevention, treatment and rehabilitation services targeted for men could be further expanded within healthcare facilities and the community.

Last but not least, we would like to acknowledge the key government and institutional experts and community representatives for their tremendous contribution to the preparation of the NMHAP. We would like to especially thank the Adult Health Sector for their relentless effort in coordinating and drafting this important document.

YBhg. Datuk Dr. Noor Hisham bin Abdullah
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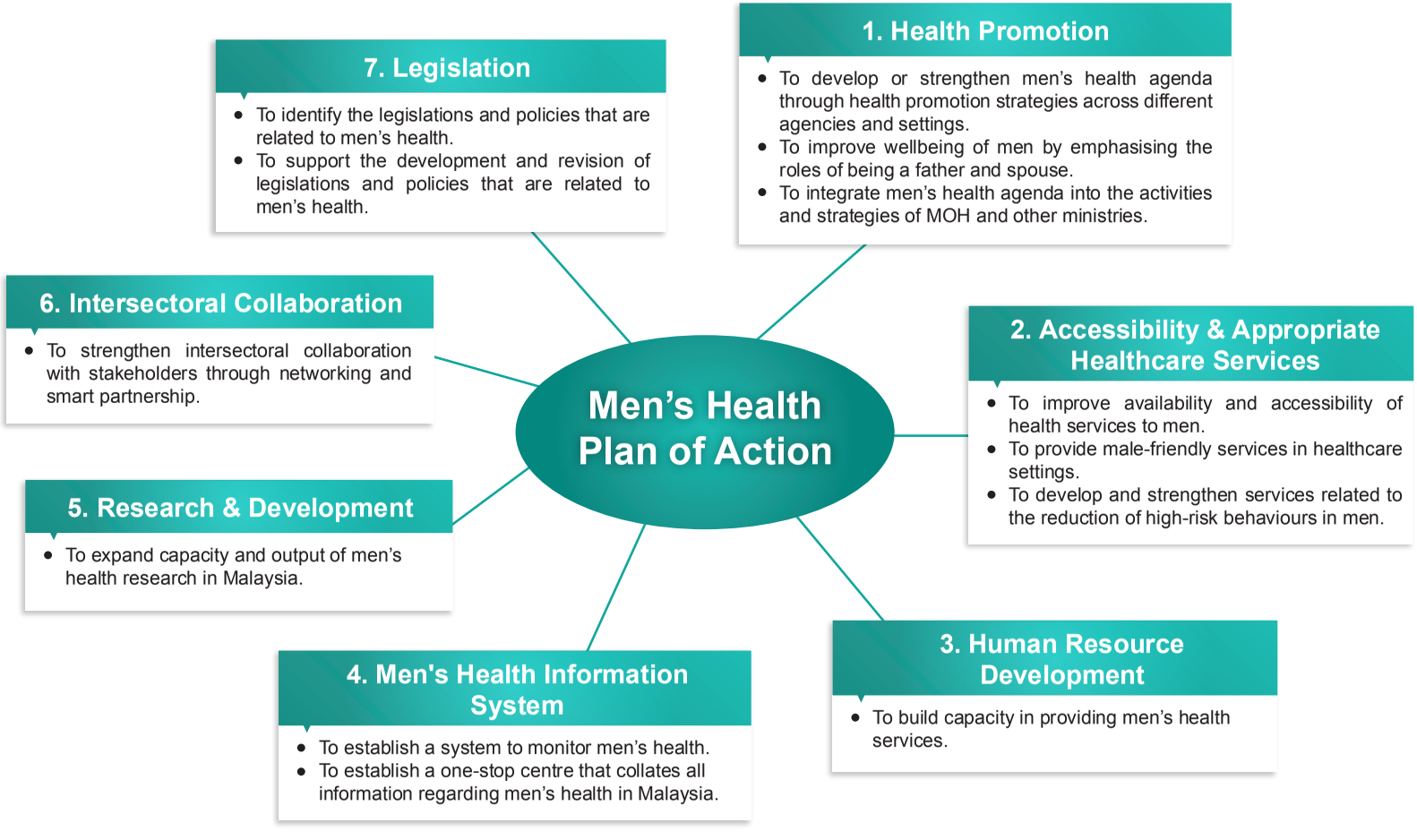
Men's Health Plan of Action
1. Health Promotion
To develop or strengthen men's health agenda through health promotion strategies across different agencies and settings.
To improve wellbeing of men by emphasising the roles of being a father and spouse.
To integrate men's health agenda into the activities and strategies of MOH and other ministries.
2. Accessibility & Appropriate Healthcare Services
To improve availability and accessibility of health services to men.
To provide male-friendly services in healthcare settings.
To develop and strengthen services related to the reduction of high-risk behaviours in men.
3. Human Resource Development
To build capacity in providing men's health services.
4. Men's Health Information System
To establish a system to monitor men's health.
To establish a one-stop centre that collates all information regarding men's health in Malaysia.
5. Research & Development
To expand capacity and output of men's health research in Malaysia.
6. Intersectoral Collaboration
To strengthen intersectoral collaboration with stakeholders through networking and smart partnership.
7. Legislation
To identify the legislations and policies that are related to men's health.
To support the development and revision of legislations and policies that are related to men's health.

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ABBREVIATIONS AND ACRONYMS

AADK	*Agensi Anti Dadah Kebangsaan (National Anti-Drugs Agency, Ministry of Home Affairs)*
AG	*Attorney General*
BPH	*Benign Prostatic Hyperplasia*
BSSK	*Borang Saringan Status Kesihatan (Health Status Screening Form)*
CVD	*Cardiovascular Diseases*
DALYs	*Disability Adjusted Life Years*
DM	*Diabetes Mellitus*
DOSH	*Department of Occupational Safety and Health Malaysia*
ED	*Erectile Dysfunction*
FFPAM	*Federation of Family Planning Malaysia*
FOMCA	*Federation of Malaysian Consumers Associations*
FSW	*Female Sex Workers*
HIV	*Human Immunodeficiency Virus*
HCV	*Hepatitis C Virus*
HPT	*Hypertension*
Hyperchol	*Hypercholesterolaemia*
ISM	*Institut Sosial Malaysia*
IBBS	*Integrated Bio-Behavioural Survey*
JAKIM	*Jabatan Kemajuan Islam Malaysia*
JKM	*Jabatan Kebajikan Masyarakat (Department Of Islamic Development Malaysia)*
JPJ	*Jabatan Pengangkutan Jalan (Road Transport Department Malaysia)*
JPM	*Jabatan Perdana Menteri (Prime Minister's Office)*
KOSPEN	*Komuniti Sihat Pembina Negara*
KPKT	*Kementerian Perumahan dan Kerajaan Tempatan (Ministry of Housing and Local Government)*
KPWKM	*Kementerian Pembangunan Wanita, Keluarga dan Masyarakat (Ministry of Women, Family and Community Development)*
LPPKN	*Lembaga Penduduk dan Pembangunan Keluarga Negara*
LUTS	*Lower Urinary Tract Symptoms*
MAC	*Malaysian AIDS Council*
MARP	*Most-At-Risk Populations*
MASO	*Malaysian Association for the Study of Obesity*
MCMH	*Malaysian Clearinghouse For Men's Health*
MDA	*Malaysian Dietitians' Association*
MDG	*Millennium Development Goal*
MESTECC	*Ministry of Energy, Science, Technology, Environment & Climate Change*
MIA	*Malaysian Institute of Accountants*
MINDEF	*Ministry of Defence*
MINDEF-RSAT	*Ministry of Defence – Rumah Sakit Angkatan Tentera (Armed Forces Hospital)*
MIROS	*Malaysian Institute of Road Safety Research*
MMA	*Malaysian Medical Association*
MOE	*Ministry of Education*
MOF	*Ministry of Finance*
MOH	*Ministry of Health*
MOHA	*Ministry of Home Affairs*
MOHE	*Ministry of Higher Education*

MOHR	*Ministry of Human Resources*
MOT	*Ministry of Transport*
MOTAC	*Ministry of Tourism, Arts and Culture*
MOWFCD	*Ministry of Women, Family and Community Development*
MSASAM	*Malaysian Society of Andrology and the Study of the Aging Male*
MSM	*Men Who Have Sex With Men*
NCD	*Non-Communicable Diseases*
NGO	*Non-Governmental Organization*
NSEP	*The Needle Syringe Exchange Programme*
NSM	*Nutrition Society of Malaysia*
NSPEA 2016-2030	*Malaysia's National Strategic Plan For Ending AIDS 2016-2030*
NSP-NCD	*The National Strategic Plan For Non-Communicable Diseases*
PBSM	*Persatuan Bulan Sabit Merah Malaysia (The Malaysian Red Crescent)*
PDRM	*Polis DiRaja Malaysia (Royal Malaysia Police)*
PIBG	*Persatuan Ibu Bapa & Guru*
PS The Children	*Protect and Save The Children Association of Selangor and Kuala Lumpur*
PWID	*People Who Inject Drugs*
SOCSO	*Social Security Organisation*
SRH	*Sexual & Reproductive Health*
TG	*Transgender People*
UN	*United Nations*
WCC	*Women's Centre for Change*

INTRODUCTION

Men's Health can be defined as a discipline that promotes the physical, mental and social well-being of men throughout their life cycle (from boyhood to manhood) and addresses health problems related to men[1]. In keeping with the World Health Organization's globally recognised definition of health[2], a healthy man is one who is 'empowered to experience optimum physical, mental and social well-being and who experiences health as a resource for everyday living'.

The status of men's health lags behind that of women; men have a shorter life expectancy and higher morbidity and mortality rates compared to women globally. The gap in life expectancy between the sexes was 4.5 years in 1990 and had remained almost the same by 2015 (4.6)[3]. These figures are quite similar to Malaysia. According to the Malaysian Statistics Department [4], a male child born in 2017 can be expected to live up to 72.7 years of age, while a female child, up to 77.4 years of age. These figures have improved continuously over the years with an increase of 0.6 years for both males and females since 2011. Apart from that, there is a higher death rate in men aged 15 to 65 compared to women of the same age, the death rate among men being twice that of women[4].

Traditionally, men are considered as the leader of a household. Even in modern times where both husbands and wives go to work, the men will make most of the major decisions while the women look after the children and the house. This scenario is still prevalent even in Malaysia. Naturally, these roles tend to carry over into health and wellbeing. A woman is expected to look after her own health as well as that of her children and husband. Unfortunately, many men insist on being the leader of their own health thus posing some 'resistance' to healthcare.

It is important to recognise that men's health status is more than simply a consequence of biological, physiological or genetic functioning, but that it is also affected by the wider social, cultural and environmental factors. It is also important that policy planners and implementers deviate from conventional definitions that focus on diseases of the male reproductive organs, as this inevitably resulted in a narrow, disease-centred approach to men's health. The need to move beyond this approach is now well documented and is especially apparent when one considers that male specific diseases only account for a relatively small proportion of the overall male mortality.

To date, only four countries – Australia, Brazil, Ireland and Iran – have attempted to address men's burden of ill health through the adoption of nationwide, male-centred strategies. A national healthcare delivery policy that considers the needs of Malaysian males and that identifies specific ways to promote optimal health outcomes for them is much needed. The planning, management and implementation of such policy should take into account the best available evidence and all baseline data on men's health in Malaysia.

A. WHY MEN'S HEALTH?

Compared to that of women, the health of men has been a relatively neglected subject. A clear manifestation of this is the target groups that are captured in the Family Health Development Programme of the Ministry of Health Malaysia. The forerunner of this programme, "Maternal and Child Health (MCH)" emphasises (almost exclusively) on health coverage for women. Today, even after much expansion to meet newer and current concerns, the programme (based on the life course perspective) captures everyone in the family except men.

Women's health , particularly sexual and reproductive health (SRH), has gained importance for obvious biological, political and social reasons. The biological events of pregnancy and childbirth are fraught with dangers, including the loss of life. This has led to the concept of women, especially those of childbearing age, being a vulnerable group. The incidence of maternal deaths also have important political implications, as maternal mortality is one of the universal indicators used to assess the health status of communities and nations. More recently, the social aspect has been woven into this complex fabric of maternal and women's health. The importance of women's health is accorded to issues related to gender, which unlike the biological construct of sex, is a social construct. Thus the biological vulnerability and the socially disadvantaged position of women become a constant theme in health policies all over the world. Men on the other hand, has never been perceived as being vulnerable or disadvantaged.

Gender perceptions also have a crucial bearing on men's health. How men perceive themselves as 'masculine' impacts on the value they place on their health and their health seeking behaviour. Generally, men like to be seen as masculine and tough so they will ignore small but vital signs of an underlying disease. They will seek medical attention only when it is too late, such as when they experience a heart attack or stroke. The reasons for poor health seeking behaviour among men could be due to the prevailing culture, as well as factors related to masculinity and education. Men's attitude and behaviour also contribute in no small measures to their indifference and neglect towards their health.

Besides, the societal construct of the male being in charge, able to cope and omnipotent has led to their reluctance to seek early care or to talk about their problems. The society's lukewarm attitude towards men's health needs is worsened by men being mainly accounted for problems faced by women, such as gender-based insensitivity, discrimination, violence and crimes. The challenge is therefore to reduce the negative impact that was brought by the image of maleness, and to encourage men to modify their attitudes and behaviours towards themselves and others.

At the World Conference on Primary Health Care (PHC) in 1978, during which PHC was endorsed as the vehicle to achieve "health for all", men's health was not listed as a component in the 8 essential health services[5]. This is reflective of the priorities and realities at that point in time, but the situation today is certainly different. Besides that, the International Conference on Population and Development (ICPD) in Cairo, 1994[6], drew attention to:

- the importance of men's role in women's reproductive health and the importance of men's own reproductive health
- the need for all countries to provide men, as well as women, with reproductive health care that is "accessible, affordable, acceptable and convenient"
- the need for reproductive health care programmes to move away from considering men and women separately and to adopt a more holistic approach that includes men and focuses on couples
- the unfairness inherent in many gender roles, calling for men to take more responsibility for household work and child-rearing

The 1995 United Nations Fourth World Conference on Women in Beijing also encouraged men to take steps toward achieving gender equality and better reproductive health[7].

Another manifestation of this neglect in men's health is the comparative development of clinical and public health disciplines. The discipline of obstetrics and gynaecology is well established, so as the MCH component of basic health service which has been accorded the highest priority in health systems of all countries. While andrology is now gaining attention, it is as yet not an established specialisation in medicine.

Fortunately, the interest in men's health has reached a level that is high enough for newer paradigms to be pursued. It has become clear that while "male medical arrogance" does exist, it does not mean men are not worried or do not care for their own health or the health of others. However, issues that are widely recognized in men's health are not necessarily broad enough in scope; the most frequently addressed are sexuality issues such as erectile dysfunction and chronic diseases especially cardiovascular disease, and to a lesser extent mental problems such as depression. Self-inflicted harm especially suicide is also a matter of concern among men.

B. INITIATIVES BY THE MINISTRY OF HEALTH (MOH)

The Malaysian Ministry of Health started to show a keen interest in Men's Health since 2002, but avid discussions to establish a National Plan of Action and outline various activities concerning this discipline only came about in April 2015. The MOH's initiatives can be attributed to the many health reports that documented discrepancies of health status between men and women. The following general principles should underlie the policies, programmes and initiatives that are put in place for men's health:

i. Health is a basic human right for all individuals regardless on sex or other variables; health being a state of complete physical, social and mental well-being, not merely the absence of disease or infirmity.

ii. Those whose needs are greater will be provided with more services based on the concept of equity. In the past, women of reproductive age were considered vulnerable and services were specially designed for them, now this is to be extended to men.

iii. Everyone should have access to a basic package of essential health care, linked effectively to higher levels of care. The principles of PHC, i.e. basic service package, appropriate technologies, community participation and inter-sectoral collaboration, are relevant and important.

iv. Health should be optimized at every stage of a person's life based on the life course perspective, such that there will be opportunities to prevent or slow the progression of morbidities.

v. Shift of the health paradigm from illness to wellness, paying more attention to health promotion and disease prevention.

vi. Practice of evidence-based medicine. The most blatant claims are usually in the area of anti-ageing for both men and women, involving not only pharmaceutical products but also "nutraceuticals" and "cosmetological" interventions.

vii. "Softer" components of care, such as caring and compassionate services that motivate men to access care, are just as important as the "hard" components of care such as technical quality.

viii. Societal and cultural contexts are important determinants of attitudes and behaviour. This should be taken into account when considering the problems faced by men in accessing healthcare.

ix. Cumulative knowledge gathered over time should be applied to avoid "reinventing the wheel". Much of this knowledge may be sought from other programmes and initiatives such as reproductive health, non-communicable disease prevention and control, sexually-transmitted infection (STI) prevention and control, ageing and health etc.

Efforts to develop the Malaysian Men's Health National Plan of Action began in April 2015 with the first meeting involving multiple agencies. Ministry of Health (MOH), Ministry of Education (MOE), Ministry of Women, Family and Community Development (KPWKM), Department Of Islamic Development Malaysia (JAKIM), Social Security Organisation (SOCSO), Ministry of Finance (MOF), Ministry of Human Resources (MOHR), Ministry of Youth and Sports (KBS), and several Non-Governmental Organizations (NGOs) were among the agencies involved. The main aim in developing this plan of action is to promote gender equity and improve the quality of life and health of men. The rationale behind this objective revolves around the well-founded statistics of gender inequality in healthcare and concerns about the socio-economic implications of such inequalities.

This National Plan of Action is prepared for adult men, i.e. age 18 and above. The following main strategies are suggested:

- Health promotion
- Accessible and appropriate health care services
- Human Resource Development
- Health Information System
- Inter-sectoral Collaboration
- Research and Development
- Legislation

The objectives of this action plan are:

- To extend men's life expectancy by reducing premature deaths of men and boys.
- To improve men's health by empowering them to live responsibly and through provision of timely and appropriate healthcare services.
- To promote men's responsibility and active participation in the field of sexual and reproductive health.
- To provide men, women and children with equal opportunities to improve their health.

The National Men's Health Plan of Action aims not only at providing a short term relief from the socio-economic implications of health inequalities; but a long term solution as well. Hence, all the activities discussed in this Plan of Action has been further classified into short term and long term with regards to their implementation. This Plan of Action will focus on six priority areas:

- Motor vehicle accident / trauma
- Mental health
- Benign prostatic hyperplasia
- Prostate cancer,
- Erectile dysfunction (ED)
- Risk Factors for cardiovascular diseases [Diabetes Mellitus (DM), Hypertension (HPT), obesity, hypercholesterolemia]

There is no doubt that concerted global action to reduce the burden of morbidity and mortality in men could have a transformative social, health and economic impact. Hence, as Malaysia becomes the fifth country in the world to develop a national policy addressing men's health, it is hoped that the policy will aid in closing the health gap between men, women and children.

References:

1. *Asian Men's Health Report Malaysian Men's Health Initiative, Kuala Lumpur (2013)*
2. *Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948.*
3. *Global Health Observatory (GHO) data. Accessed on 19.4.2018 at http://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/*
4. *Abridged Life Tables, Malaysia, 2015-2017. Department of Statistics Malaysia*
5. *Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*
6. *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. United Nations. New York, 1995*
7. *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995. United Nations · New York, 1996*

SITUATIONAL ANALYSIS OF MEN'S HEALTH IN MALAYSIA

There has been an increasing awareness of men's health in Malaysia over the past decade. This is in line with global recognition of the discrepancy in mortality and morbidity rates between the genders. This section provides an overview of the key topics of men's health in Malaysia and highlights the gaps and opportunities for improvement within these areas. This overview informs the development of the Action Plan that follows.

A. Non-Communicable Diseases in Men

Non-communicable diseases (NCD) are rising globally; the United Nations (UN) Sustainable Development Goal 3 on health and well–being has set the target to reduce premature mortality from NCD by one third[1]. Although NCD affect both genders, males are more likely than females to die prematurely (under 70 years) from NCDs in most countries. In some countries, the proportion of premature NCD deaths in males is twice or more than that in females[2]. In Malaysia, the NCD burden has reached an epidemic level. According to the National Health Morbidity Survey 2015, the prevalence of diabetes, hypertension and hypercholesterolaemia in men were 16.7%, 30.8% and 43.5% respectively. Of these, more than half were undiagnosed (diabetes 7.6%; hypertension 12.2% ; hypercholesterolaemia 8.5%)[3].

The major risk factors for NCD include unhealthy diets, tobacco use and excessive alcohol intake. Men do worse than women with respect to all of these. Data from the Global Burden of Disease Study 2010 showed that, in that year, 55% of deaths attributed to dietary risk factors were male, as were 72% of deaths from tobacco smoking and 65% of deaths from alcohol. In Malaysia, almost half of adult males are either overweight (31.6%) or obese (15.0%) while 41.4% smoke and only 5.6% eat adequate fruits or vegetables daily (>5 servings daily)[4].

Despite the high prevalence of NCD and cardiovascular risk factors, many men do not participate in preventive activities and tend to delay seeking help for their health until complications arise. For instance, the age at first onset of acute myocardial infarction is getting younger and occurs more commonly in men[5]. This may be related to men's risk-taking behaviours and underutilization of health services. In rural India, for example, men's use of tobacco is closely linked to their perception that a "real man" should be daring, courageous and confident, and smoking is seen to portray such image[6]. A study of men in Russia suggested that heavy drinking of strong spirits "elevates or maintains a man's status in working–class social groups by facilitating access to power associated with the hegemonic ideal of the real working man"[7]. In addition, men tend to be less knowledgeable than women about specific diseases, risk factors and health in general. A recent study of weight, diet, physical activity and nutritional knowledge among university students in the USA found that men were more likely to be overweight or obese, more likely to consume red meat, fast food, sugar–sweetened beverages, wine and beer, and less likely to be knowledgeable about nutrition[8].

In response to this NCD crisis, the Malaysian Ministry of Health implemented the National Strategic Plan for Non-Communicable Diseases (NSP-NCD) 2010-2014 and the NCD Prevention 1Malaysia (NCDP-1M) programme[9]. However, the impact of these strategies remains to be evaluated and they did not take into consideration gender differences in terms of health awareness, health-seeking behaviour and health practices. Nevertheless, effective interventions have been used to improve men's lifestyle. For example, the Football Fans in Training programmes in Scotland, now extended into other European countries as EuroFIT,

shows that professional sport can be an effective medium for engaging men in lifestyle improvement programmes[10]. Public health clinics, where 80% of Malaysia n patients with chronic diseases are managed, serve as the ideal setting where effective lifestyle interventions can be implemented to tackle NCD[11]. They are equipped with trained healthcare professionals, facilities and care pathways to prevent and manage NCD. However, to tackle the 'epidemic' of NCD, primary care services need to undergo further innovation to adequately address patients' behaviours. Making the healthcare service more male-friendly can be one such strategy. It has been found that many health clinics are more women- and child-friendly, and do not operate beyond office hours. This creates barriers to the proper management of NCD in working men, many of whom require regular follow-ups.

Therefore, tackling NCD using a gender-based approach should be considered as one of the effective solutions in the overall NCD strategic planning. NCD management, in particular, involves long-term behavioural modification and continuity of care. To be successful, such strategies often demand for sensitivity to individual needs by healthcare providers and services. Recognising that male patients' behaviours are different from those of female patients is crucial to developing effective personalised interventions for managing NCD.

References:

1. *Department of Economic and Social Affairs, United Nations. Sustainable Development Knowledge Platform. Sustainable Development Goal 3: ensure healthy lives and promote well-being for all at all ages. Retrieved from https://sustainabledevelopment.un.org/sdg3*
2. *World Health Organization. Chapter 1: Burden: mortality, morbidity and risk factors. Non-communicable diseases country profiles 2011. WHO global report.*
3. *Institute for Public Health, Ministry of Health Malaysia. Volume 2: Non-communicable diseases, risk factors and other health problems. National Health and Morbidity Survey 2015.*
4. *GBD 2013 Mortality and Causes of Death Collaborators. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet. 2015;385:117-71. Medline:25530442 doi:10.1016/S0140-6736(14)61682-2*
5. *White A, editor. The State of Men's Health in Europe. Extended Report. Brussels: European Commission; 2011.*
6. *Barik A, Rai RK, Gorain A, Majumdar S, Chowdhury A. Socio-economic disparities in tobacco consumption in rural India: evidence from a health and demographic surveillance system. Perspect Public Health. 2016;136: 278-87. Medline:26475772 doi:10.1177/1757913915609947*
7. *Hinote BP, Webber GR. Drinking toward manhood: masculinity and alcohol in the former USSR. Men Masculinities. 2012;15:292-310. doi:10.1177/1097184X12448466*
8. *Yahia N, Wang D, Rapley M, Dey R. Assessment of weight status, dietary habits and beliefs, physical activity, and nutritional knowledge among university students. Perspect Public Health. 2016;136:231-44. Medline:26475773 doi:10.1177/1757913915609945*
9. *Feisul Idzwan Mustapha, Zainal Ariffin Omar, Omar Mihat, et al. Addressing non-communicable diseases in Malaysia: an integrative process of systems and community. BMC Public Health, 2014; 14(Suppl 2):S4.*
10. *Hunt K, Wyke S, Gray CM, Anderson AA, Brady A, Bunn C, et al. A gender-sensitised weight loss and healthy living programme for overweight and obese men delivered by Scottish Premier League football clubs (FFIT): a pragmatic randomised controlled trial. Lancet. 2014;383:1211-21. Medline:24457205 doi:10.1016/S0140-6736(13)62420-4*
11. *Ruby A, Knight A, Perel P, Blanchet K, Roberts B (2015) The Effectiveness of Interventions for Non-Communicable Diseases in Humanitarian Crises: A Systematic Review. PLoS ONE 10(9): e0138303. doi:10.1371/journal.pone. 0138303*

B. Sexual Health in Men – Erectile Dysfunction

Erectile dysfunction (ED) is often under-diagnosed as doctors do not routinely enquire about this problem. The prevalence reported by patients varies from the prevalence detected by doctors. The age-adjusted prevalence of moderate or complete ED was 34% in Japan, 22% in Malaysia, 17% in Italy, and 15% in Brazil. The overall age-specific prevalence of moderate or complete ED was 9% for men aged 40 to 44 years, 12% for 45 to 49 years, 18% for 50 to 54 years, 29% for 55 to 59 years, 38% for 60 to 64 years, and 54% for 65 to 70 years[1]. However, there are many different data given by different studies and the prevalence of ED in Malaysia varies between 26.8% to as high as 69%[2].

The prevalence of ED among men with co-morbid medical conditions and risk factors, including cardiovascular disease, hypertension, dyslipidemia, and depression were reported to be high[3]. It has also been reported that ED precedes coronary artery disease by 2-3 years in a majority of patients[4]. Available data in Malaysia has also shown that the prevalence of ED among those with diabetics or heart disease was the highest (89.2%) followed by hypertensives (80.4%) and hypercholesterolaemia (78.9%), while men in their 50s (OR = 2.0) and 60s (OR = 13.5) had higher odds in ED[5]. Hence, it may be postulated that any increase in prevalence of cardio-metabolic factors in the future will likewise cause an increase in the prevalence of ED in Malaysia.

Currently in Malaysia, there are no specific health services that cater for men's sexual issues. Sporadic men's health centres have been set up but these are mainly in the private sector. In addition, there is no specific training locally for medical or healthcare providers. Sexual health may have been taught within undergraduate and postgraduate courses albeit not in a structured manner.

References:

1. *Alfredo Nicolosi, Edson D Moreira Jr, Masafumi Shirai, Mohd Ismail Bin Mohd Tambi, Dale B Glasser. Epidemiology of erectile dysfunction in four countries: cross-national study of the prevalence and correlates of erectile dysfunction. Urology 2003;61:201-206*
2. *Christopher CK Ho, Praveen Singam, Goh Eng Hong, and Zulkifli Md Zainuddin Male sexual dysfunction in Asia. Asian J Androl. 2011 Jul; 13(4): 537–542.*
3. *Rosen RC, Fisher WA, Eardley I, et al. The multinational men's attitudes to life events and sexuality (MALES) study: I. Prevalence of erectile dysfunction and related health concerns in the general population. Cur Med Res Opin. 2004;20(5):607–617*
4. *K L Billups. Erectile dysfunction as an early sign of cardiovascular disease. International Journal of Impotence Research (2005) 17, S19–S24.*
5. *Asnida Anjang, Ab Rahman, Nabilla Al-Sadat, WahYun Low. Prevalence of erectile dysfunction in primary care setting, Malaysia. Journal of Men's Health Volume 8, Supplement 1, April 2011, Pages S50-S53.*

C. Urological Health in Men – Lower Urinary Tract Symptoms (LUTS) and Benign Prostatic Hyperplasia (BPH)

The prevalence of moderate to severe LUTS in Malaysia is relatively high in men, reaching 42.7% in a local study[1] and this prevalence increases with age. In Malaysia, the percentage of population that is 65 and above is estimated to reach 7.2% in 2020 and 14.5% by 2040[2]. In view of this, we expect the prevalence of LUTS and BPH to rise significantly. In men above 40 years of age, LUTS is related to health issues like obesity, metabolic syndrome and smoking[3]. The Academy of Medicine of Malaysia has produced a clinical guideline on BPH in 1998[4]. Updates of this guideline based on the current best evidence is necessary to guide healthcare professionals in their management of this common condition in men.

References:

1. *Christopher Ho, CK and Praveen, S and Goh, EH and Tan, GH and Badrulhisham, B and Zulkifli, MZ and Khoo, HW and Su, XV and Ng, JY and Chong, LL and Lim, DW and Chen, ES and Teoh, SY (2011) Prevalence and awareness of lower urinary tract symptoms among males in the Outpatient Clinics of Universiti Kebangsaan Malaysia Medical Centre. Medicine & Health, 6 (2). pp. 98-106.*
2. *Population Projection (Revised) Malaysia, 2010-2040. The Office of Chief Statistician Malaysia, Department of Statistics Malaysia. 4 November 2016.*
3. *Coyne KS et.al. Risk factors and comorbid conditions associated with lower urinary tract symptoms: EpiLUTS. BJU International. 103, Supplement 3, 24–32. 2009*
4. *Consensus on Management of Benign Prostatic Hyperplasia. Ministry of Health, Malaysia; Academy of Medicine of Malaysia. 1998*

D. HIV Infection in Men

Human Immunodeficiency Virus (HIV) infection is a worldwide public health problem, with more than 70 million people infected and about 35 million deaths from HIV[1]. In Malaysia, since the first reported case of HIV infection, there have been more than 100,000 HIV cases notified by 2015. In the last two decades, there has been a shift in HIV epidemiological patterns in Malaysia. Firstly, reported cases among males, which accounted for 90% of the cases at the beginning of the epidemic, have been decreasing, as shown by the male-to- female ratio of 10:1 in 2002 and 4:1 in 2013[2]. Secondly, injecting drug use, which has initially dominated the HIV/AIDS scene in Malaysia, have seen a decline from 80% out of all HIV cases in the 1990s to below 20% in 2015. On the other hand, there has been a proportionate ascent in HIV infection via sexual transmission between heterosexual partners and among key high-risk populations such as female sex workers (FSW), transgender people (TG) and men who have sex with men (MSM)[3].

In Malaysia, men are at risk of HIV infections in three ways: (i) being the predominant gender among drug users; (ii) engagement in sexual relationships with other men (sometime referred to as men-sex-men or MSM) and (iii) being clients to female sex workers. Men who practice unsafe sex with men were found to have nearly 20-times greater chance of being infected with HIV than the general population[4]. As HIV cases among MSM are increasing in many regions globally[5], a similar trend is seen in Malaysia. The proportions of new HIV infection among MSM (reported under the category of homosexuals in the notification system) have increased from 3.9% in 2009 to 7.1% in 2012 and 8.9% in 2014[3]. This at risk population is quite large but concentrated. According to a national survey in 2016, there were around 170,000 men who have sex with men (MSM) in Malaysia. HIV prevalence among MSM and TG was highest in the year 2014 and in Kuala Lumpur, where 22% of MSM and 19.3% of TG were found to have HIV (up from the

10.2% and 4.8% in 2012, respectively). The state of Johor came second, with 15.7% of MSM and 10.6% of TG infected with HIV. While the practice of safer sex has improved slightly among FSWs and TGs, condom use behaviour was not getting any better in the MSM population[3].

The Integrated Bio-Behavioural Survey (IBBS) from 2012-2014 (IBBS 2012-2014) showed that 56.7% of men reported using a condom the last time they had sex with a male partner. This survey also revealed that among people who inject drugs (PWID), the percentage of those who had received a HIV test in the past 12 months and know their HIV status was still low, at 37.8%. Even though statistics revealed a significant decline of HIV prevalence among PWID, it is still a male predominant group with almost 95% of PWID being men[6], The IBBS 2014 revealed that lack of persistent condom use is still a major problem among key populations especially MSM, while more than half of them not knowing their status and treatment coverage has not reached the national target[3].

Malaysia has reported accomplishments in HIV treatment support and coverage. While harm reduction programmes which target drug users (such as the Needle Syringe Exchange Programme (NSEP)) remain the foundation of the Malaysian government's HIV prevention strategy, prevention programmes targeting sexually transmitted HIV infections have been scaled up as well. In order to address the ascent of sexual transmission of HIV, the Malaysian AIDS Council (MAC), together with its partner organisations, escalated its efforts in providing appropriate reproductive and sexual health services and education to the marginalised most-at-risk populations (MARP), specifically FSW, MSM and TG.

Many MSM do not disclose their HIV status due to the double stigma of being gay and having HIV. This limits the number of MSM seeking for HIV treatment, a situation which is similarly reported in Vietnam[7]. In Malaysia, homosexuality is illegal; whilst gender identification and discrimination is also an issue. HIV prevention programmes including HIV testing among MARP in Malaysia are fundamentally initiated by a few non-governmental organisations (NGO) with extremely constrained resources. Compared to the other high risk groups, MSM is much harder to reach out to as homosexuality is culturally hidden. This makes designing HIV interventions for MSM challenging[8]. Most successful HIV programmes for MSM sought to empower this group and actively involve them in a community setting. In order to support targeted HIV prevention, testing and treatment programmes, more funding is required[9].

The new Malaysia National Strategic Plan for Ending AIDS 2016-2030 (NSPEA 2016-2030) has already been in placed to end the scourge of AIDS in the country. Although Malaysia has achieved the Millennium Development Goal (MDG) of reducing new HIV cases by 50%, there is still a huge gap in HIV treatment, care and prevention coverage for some key populations. Targeting MSM with high risk perception must be strategized to gain maximum benefits among them in Malaysia[10]. The country acknowledges the increasing trend of HIV infections acquired through sexual exposures. There is certainly a need for innovative and effective ways to mitigate sexual transmission of HIV, focusing on behaviour modification and its deliverables.

References:

1. *WHO. Global Health Observatory (GHO) data. 2016 [Online] [Accessed 30 Oct 2017], Available from http://www.who.int/gho/hiv/en/.*
2. *Ngadiman S. Ending AIDS in Malaysia. Myth or Reality? Putrajaya: Ministry Health Malaysia 2015.*
3. *MOH. Global AIDS Response Report. Malaysia 2016 Country Report to HIV/AIDS 2016.*
4. *Baral S, Sifakis F, Cleghorn F, Beyrer C. Elevated Risk for HIV Infection among Men Who Have Sex with Men in Low- and Middle-Income Countries 2000–2006: A Systematic Review. PLoS Med 2007; 4(12).*
5. *UNAIDS. Prevention Gap Report. Geneva 2016.*
6. *Ministry H. National Drug Information System: National Anti-Drug Agency (AADK) Malaysia 2017.*
7. *Le TM, Lee PC, Stewart DE, Long TN, Quoc CN. What are the risk factors for HIV in men who have sex with men in Ho Chi Minh City, Vietnam?- A cross-sectional study. BMC Public Health 2016; 16: 406.*
8. *Barmania S. Malaysia makes progress against HIV, but challenges remain. The Lancet; 381(9883): 2070-2071.*
9. *AVERT. Men who have sex with men (MSM), HIV and AIDS. 2017 [Online] [Accessed 30 Oct 2017], Available from https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/men-sex-men.*
10. *Koh KC, Yong LS. HIV Risk Perception, Sexual Behavior, and HIV Prevalence among Men-Who-Have-Sex-with-Men at a Community-Based Voluntary Counseling and Testing Center in Kuala Lumpur, Malaysia. Interdisciplinary Perspectives on Infectious Diseases 2014; 2014: 6.*

E. Mental Health in Men

Mental illnesses post a significant health problem in the Malaysian population. In the recent National Health Morbidities Survey 2015, the prevalence of mental health problems, as measured by the Twelve-item General Health Questionnaire (GHQ-12), in both men and women were 27.6% and 30.8% respectively[1], which showed a marked increase since 2006 (10.4% and 12.1% respectively)2. In the same morbidity survey, those who suffer from mental health problems were noted to have 68% higher odds of being disabled compared to those without mental health problems[3]. Although the prevalence of mental health problems in men was slightly lower than women, they resulted in a higher mortality rate in men compared to women. Based on the Malaysian Burden of Disease and Injury study 2000, mental disorders accounted for 8% of the total Disability Adjusted Life Years (DALYs) in men and ranked 4th after cardiovascular disorders, accidents and infectious diseases[4].

In men, major depression is the most common cause of mental health problems, which accounted for 45% of the total burden of mental disorders. Alcohol and drug dependence, suicide, and violence occurred predominantly in men, whereas anxiety and depression were more common in women (Figure 1)[4]. Alcohol and drug dependence are risk factors to other morbidities such as liver disease, accident and HIV infection. Violence and suicide were the main causes of intentional injuries. Although intentional injuries accounted for only 1.7% of DALYs for the total population, up to 98% of DALYs from intentional injuries was attributed to the mortality caused by it. Thus, mental health problems are not only prevalent in men, they also carry higher risks of mortality compared to mental health problems in women. These patterns are not unique to Malaysia, similar patterns are seen globally.[5-7]

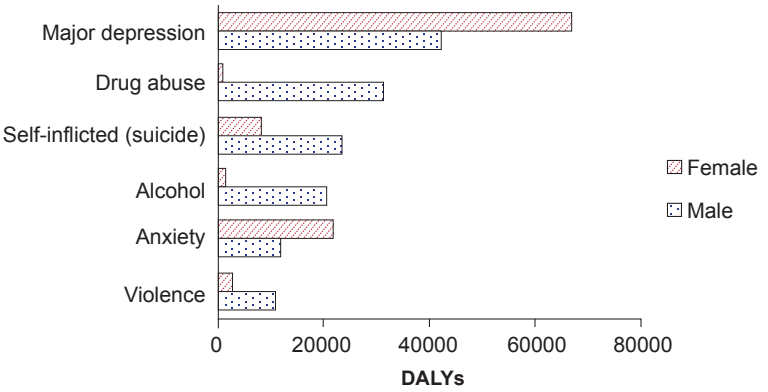

Figure 1: Disability Adjusted Life Years (DALYs) due to mental health problems in Malaysia for the year 2000[4]

Mental health problems for men are compounded not only by its high prevalence, but also by its different presentations and underdiagnosis[9]. Men present with more aggression and agitation compared to women when they have depression. Thus, their presentations may not fulfil the classic criteria for depression[10]. Men's distress may not fit a formal diagnosis of psychiatric illness and could be silent[9]. Furthermore, they are less likely to present to health care providers for their mental health problems because of their unique help-seeking behaviour. Men are raised to be mentally strong since young and thus being diagnosed with a mental illness challenges their masculine image[10,11]. Managing men with mental health problems requires a gender-sensitive approach and what constitutes men's mental health may need to be redefined9.

Health promotion for mental health has been implemented in Malaysia. However, the pre-existing approaches have not considered the concept of masculinity and men's help seeking behaviour. Governmental approaches such as Mental Health Innovation Network (MENTARI), and NGO movements such as those organised by the Malaysian Mental Health Association have been active in promoting mental health, but most of them lack consideration of men's unique needs. Men's mental health may require different approaches such as online self-help services and community programmes that promote mental well-being, rather than the conventional illness-response approaches. The latter often carry a stigma and may form a barrier for men who has always been socialised to portray a masculine image[9].

Mental health services are arguably accessible through conventional healthcare service provided by health clinics, private general practitioners, private psychiatrists and psychologists, NGOs and social support services. These approaches have responded to the needs highlighted by the National Health Morbidities Survey and Disease Burden Study illustrated above. However, gender-sensitive approach to men's mental health have not been taken into consideration. Issues of confidentiality, reluctance to ask for help, lack of male-friendly environment and inconvenience / time constraints are a few major factors that influence men's help seeking behaviour when they encounter an illness, particularly mental illness. Different models of healthcare addressing men's mental health needs are required, such as social support and work place support.

Specialisation in men's mental health services is yet to be developed. This is mainly because the recognition that men have different mental health needs is only recent. Furthermore, expertise needed to cater for general psychiatric services is also insufficient. Primary care offers another option for providing men's mental health services. However, specific training for primary health care providers in recognising and managing men's mental health is yet to be developed.

Besides, even though sex segregation of mental health data is available in the current health information system, analysis of the data to highlight mental health morbidities and mortality is not done regularly. Regular monitoring and trending is needed to keep an eye on any interventions for men's mental health.

The current body of literature on men's mental health is constituted largely of Western literature. Although the concept of masculinity is socially and culturally constructed, and the Malaysian culture is different from the West, this concept may not differ significantly between the West and Malaysia. What may actually post a great difference is Malaysian men's approach to help-seeking. As Malaysia is a collectivist society, family and peer influences may well be significant factors that have not been fully explored within the Western literature. However, other than the conventional measurements of men's mental health status, local information about men's help seeking behaviours in terms of mental health is relatively scarce. More research may be required to inform the provision of evidence-based interventions in men's mental health services.

The current approach to mental health based on the illness-response model does not resonate with men's mental health needs. A large portion of men's life revolves around work and family. Thus, addressing men's mental health necessitates cross disciplinary and professional collaborations between the Ministry of Human Resource, Ministry of Women and Family Development, and Ministry of Health. The aim is to create a culture of mental health awareness in the workplace and family.

References:

1. *Institute for Public Health (IPH) 2015. National Health and Morbidity Survey 2015 (NHMS 2015). Vol. II: Non-Communicable Diseases, Risk Factors & Other Health Problems.Kuala Lumpur: Ministry of Health Malaysia. 2015.*
2. *Institute for Public Health (IPH) 2006. The Third National Health and Morbidities Survey. Kuala Lumpur: Ministry of Health Malaysia; 2006.*
3. *Ahmad N, et al. Prevalence and determinants of disability among adults in Malaysia: Results from the National Health and Morbidity Survey (NHMS) 2015 BMC Public Health (2017) 17:756*
4. *Yussof AF, Mustafa AN, Kaur G, Omar MA, Vos T et al. Malaysian Burden of Disease and Injury Study. Kuala Lumpur: Institute of Public Health, Ministry of Health Malaysia, 2004.*
5. *Tong SF, Ho C, Tan HM. Managing the aging man in Asia: A review. Int J Urol. 2011;18:32-42.*
6. *White A, Holmes M. Patterns of mortality across 44 countries among men and women aged 15-44 years. Journal of Men's Health and Gender. 2006;3(2):139-51.*
7. *WHO. The global burden of disease: 2004 update. Switzerland: World Health Organisation Press; 2008 [cited 2009 11 Jul]. Available from: http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html.*
8. *Tong SF, Low WY, Ng CJ. Profile of men's health in Malaysia: problems and challenges. Asian J Androl. 2011;13(4):526-33.*
9. *Ridge D, Emslie C, White A. Understanding how men experience, express and cope with mental distress: where next? Sociol Health Illn. 2011;33(1):145–59.*
10. *Oliffe JL, Phillips MJ. Men, depression and masculinities: a review and recommendations. J Mens Health. 2008;5(3):194–202*
11. *Möller-Leimkühler AM. Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. J Affect Disord. 2002;71(1–3):1–9*

F. Health Screening in Men

The major causes of male disease burden and mortality in Malaysia are cardiovascular diseases, colorectal cancer and lung cancer[1,2,] all of which are amenable to early intervention. Cardiovascular diseases which top the ranks can be attributed to risk factors such as hypertension, diabetes and dyslipidaemia. Further upstream factors for all these diseases include unhealthy lifestyles and behaviours, such as poor healthcare utilization, smoking, excessive alcohol intake and physical inactivity. Targeting these risk factors through early identification, pharmacological interventions and lifestyle modifications may result in significant mortality benefit at a modest cost[3]. However, many of these risk factors and conditions are either ignored by men or undiagnosed, thus evading the opportunity for intervention. According to the National Health Morbidity Survey 2015, for every known case of hypertension, diabetes or dyslipidaemia, at least one other case remain undiagnosed1Although effective interventions are available for these conditions, the first hurdle is to identify them. Thus, health screening is arguably the most important first step. Cohort studies and epidemiological data have proven the mortality benefit of screening and effective risk factor management of cardiovascular diseases[4-9]. Colorectal mortality benefit is also proven with risk stratified screening strategies[10].

Besides the disease burden described above, many cases of male specific problems such as erectile dysfunction and premature ejaculation also go unnoticed and undertreated[11]. These conditions are also amenable to treatment. An enquiry about these conditions in an appropriate setting offers opportunity for treatment and preventive measures.

Despite mounting evidence regarding the benefits of specific health screening, the uptake of health screening among men is still low. Research has found that the utilization of health screening for cardiovascular risk factors ranged from 12.3% to about 40.4%[4,5,12]. In Malaysia, the uptake of health checks remains low. The Malaysian National Health Morbidity Survey 2011 reported that only 34.9% of men aged 18 and above underwent health checks in the past year[13]. This is significantly lower than the uptake for women, which was 40.7%. In addition, the Social Security Organisation (SOCSO) under the Malaysian Ministry of Human Resources provided a free one-time voucher for CVD risk assessment to all members aged 40 and above in 2013. Despite the incentives, the uptake of this programme was only 16.2%[14].

Factors influencing men's undertaking of health checks were reviewed. They include individual factors such as fear of contracting a disease and low risk perception, as well as external factors such as cumbersome screening procedures, complicated health care systems and inadequate health care professionals' effort in recommending health checks[15]. There also appeared to be general misunderstandings about men's health and a reluctance to offer men's health screening among primary care doctors [16-21].

Promotion of health checks in Malaysia has been carried out through various programmes in the community and primary health care facilities. The community screening programme which is under KOSPEN, a bigger community project, was initiated in 2013[22]. This, along with health screening at all health clinics in Malaysia, are among the initiatives of the Ministry of Health. However, these initiatives do not take into account factors contributing to the low rate of health checks among men and are not streamlined according to gender. Other countries such as the United Kingdom[23,24,] Ireland25, Australia[26-28] and the United States of America[29] have implemented community intervention programmes to raise health awareness among men and increase detection of male morbidities. Reports of positive response to such community programmes were numerous. The key factors of success include an outreach programme and a male friendly environment. Supporting policies that are specific to men's health is also

a key factor. Health policies must be supported by adequate funding, high levels of political commitment, cross sectoral activities and good governance[30].

At present, health care services for men are clustered within adult health services with minimal sensitivity to specific men's needs. However, help seeking behaviours of men are unique and can directly affect their responses towards health checks. Thus, incentives to stay healthy need to be relevant to men's lives, for example, through provision of appropriate time for health checks, and empowerment of men to make healthcare decisions for themselves. Also, increasing the contact points for health checks and not limiting them to health facilities only may yield better responses from men.

References:

1. *Institute for Public Health (IPH) 2015. National Health and Morbidity Survey 2015 (NHMS 2015). Vol. II: Non-Communicable Diseases, Risk Factors & Other Health Problems.Kuala Lumpur: Ministry of Health Malaysia. 2015.*
2. *Department of Statistics Malaysia. Statistics on Causes of Death, Malaysia, 2014*
3. *Lim SS, Gaziano TA, Gakidou E, Reddy KS, Farzadfar F, Lozano R, Rodgers A. Prevention of cardiovascular disease in high-risk individuals in low-income and middle-income countries: health effects and costs. The Lancet. 2007 Dec 15;370(9604):2054-62.*
4. *Lee H, Cho J, Shin DW, Lee SP, Hwang SS, Oh J, Yang HK, Hwang SH, Son KY, Chun SH, Cho B. Association of cardiovascular health screening with mortality, clinical outcomes, and health care cost: a nationwide cohort study. Preventive medicine. 2015 Jan 1;70:19-25.*
5. *Hozawa A, Kuriyama S, Watanabe I, Kakizaki M, Ohmori-Matsuda K, Sone T, Nagai M, Sugawara Y, Nitta A, Li Q, Ohkubo T. Participation in health check-ups and mortality using propensity score matched cohort analyses. Preventive medicine. 2010 Nov 1;51(5):397-402.*
6. *Björck L, Rosengren A, Bennett K, Lappas G, Capewell S. Modelling the decreasing coronary heart disease mortality in Sweden between 1986 and 2002. Eur Heart J. 2009; 30(9):1046–56.*
7. *Capewell S, Beaglehole R, Seddon M, McMurray J. Explanation for the decline in coronary heart disease mortality rates in Auckland, New Zealand, between 1982 and 1993. Circulation. 2000; 102 (13):1511–6.*
8. *Ford ES, Ajani UA, Croft JB, Critchley JA, Labarthe DR, Kottke TE, et al. Explaining the decrease in U.S. deaths from coronary disease, 1980–2000. N Engl J Med. 2007; 356(23):2388–98.*
9. *Vartiainen E, Laatikainen T, Peltonen M, Juolevi A, Männistö S, Sundvall J, et al. Thirty-five-year trends in cardiovascular risk factors in Finland. Int J Epidemiol. 2010; 39(2):504–518.*
10. *Sung JJ, Ng SC, Chan FK, Chiu HM, Kim HS, Matsuda T, Ng SS, Lau JY, Zheng S, Adler S, Reddy N. An updated Asia Pacific Consensus Recommendations on colorectal cancer screening. Gut. 2015; 64(1): 121-32.*
11. *Tong SF, Low WY, Ng CJ. Profile of men's health in Malaysia: problems and challenges. Asian journal of andrology. 2011; 13(4): 526*
12. *Robson J, Dostal I, Sheikh A, Eldridge S, Madurasinghe V, Griffiths C, Coupland C, Hippisley-Cox J. The NHS Health Check in England: an evaluation of the first 4 years. BMJ open. 2016 Jan 1;6(1):e008840.*
13. *Institute for Public Health (IPH) 2015. National Health and Morbidity Survey 2015 (NHMS 2015). Vol. III: Non-Communicable Diseases, Risk Factors & Other Health Problems.Kuala Lumpur: Ministry of Health Malaysia. 2015.*
14. *The Star online. Half found with health risks. Available: http://www.thestar.com.my/News/Nation/2015/02/27/Half-found-with-health-risks-Socso-screening-reveals-worrying-trend-among-employees/.Accessed 13 July 2015.*
15. *Teo CH, Ng CJ, Booth A, White A. Barriers and facilitators to health screening in men: A systematic review. Social Science & Medicine. 2016 Sep 1;165:168-76.*
16. *Tong SF, Low WY, Ismail SB, Trevena L, Willcock S. Physician's intention to initiate health check-up discussions with men: a qualitative study. Family practice. 2010 Nov 29;28(3):307-16.*
17. *Tong SF, Low WY, Ismail SB, Trevena L, Willcock S. Malaysian primary care doctors' views on men's health: an unresolved jigsaw puzzle. BMC family practice. 2011 Dec;12(1):29.*
18. *Hale S, Grogan S, Willott S. Male GPs' views on men seeking medical help: a qualitative study. Br J Health*
19. *Psychol2010 Nov;15(Pt 4):697-713.*
    Tudiver F, Talbot Y. Why don't men seek help? Family physicians' perspectives on help-seeking behavior in men. J Fam Pract. [Article]. 1999 Jan;48(1):47-52.
20. *Seymour-Smith S, Wetherell M, Phoenix A. 'My wife ordered me to come!': A discursive analysis of doctors' and nurses' accounts of men's use of general practitioners. Journal of Health Psychology2002;7(3):253-67.*
21. *McKinlay E, Kljakovic M, McBain L. New Zealand men's health care: are we meeting the needs of men in general practice? Journal of Primary Health Care. 2009; 1(4):302-10.*

References:

22. *Ministry of Health, Health information. Available: http://www.infosihat.gov.my/index.php/projek-khas/kospen Access 18 April 2018*
23. *Conrad D, White A. Men's health - how to do it. Abingdon: Radcliffe; 2007.*
24. *Linnell S, James S, Linnell S, James S. Involving men in targeted primary health care: men's health MOTs. Community Practitioner May;83(5):31-4.*
25. *Richardson N, Carroll P. Men's Health in Ireland. In: Wilkins D, Savoye E, editors. Men's Health Around The World: A review of policy and progress across 11 countries. Brussels: European Men's Health Forum; 2009. p. 33-8*
26. *Bentley M. A primary health care approach to men's health in community health settings: It's just better practice. Australian Journal of Primary Health2006;12(1):21-6.*
27. *Russell N, Harding C, Chamberlain C, Johnston L, Russell N, Harding C, et al. Implementing a 'Men's Health Pitstop' in the Riverina, South-west New South Wales. Aust J Rural Health2006 Jun;14(3):129-31.*
28. *Milligan C, Neary D, Payne S, Hanratty B, Irwin P, Dowrick C. Older men and social activity: a scoping review of Men's Sheds and other gendered interventions. Ageing & Society 2016; 36(5):895-923.*
29. *Whitley EM, Jarrett NC, Young AMW, Adeyemi SA, Perez LM. Building effective programs to improve men's health. American Journal of Mens Health 2007;1(4):294-306.*
30. *Baker PE. Review of the National Men's Health policy and Action Plan 2008-2013.*

G. Men and Cancer

In the Malaysian Burden of Disease and Injuries Study 2000, cancer was responsible for 6% of the total DALYs in men[1]. Neoplasm is among the biggest causes of death in both private and MOH's hospitals in 2016[2]. According to the Malaysia National Cancer Registry Report 2007-2011, the age-standardized male cancer incidence was 86.9 per 100,000 males and 99.3 per 100,000 for females. The annual cancer incidence in Malaysia varied over the 5 years (2007-2011) from 80.9 to 90.2 per 100,000 in males, and 93.8 to 102.6 per 100,000 in females. Apart from that, the incidence in males rises more than females from the age of 30, eventually exceeding the incidence rate in females by the age of 60[3].

The Malaysia National Cancer Registry Report 2007-2011 also reported that colorectal cancer (16.4%) was the most common cancer in men, followed by lung (15.8%) and prostate cancer. However, there were ethnicity variations between the different types of cancers among male. The commonest cancers in Malay males were lung cancer, colorectal cancer and lymphoma. In Chinese males, colorectal cancer was the first followed by lung and nasopharyngeal carcinoma. In Indian males, rates of colorectal, lung and prostate cancer were among the highest. As for staging, most of the cancers were diagnosed at a later stage. Only 17.1% were reported at stage 1[3]. This was very much related to the lack of awareness about screening and early detection of symptoms. Moreover, lifestyle, diet, tobacco, alcohol, obesity, radiation, environmental pollution and occupational carcinogens have all been identified as risk factors of cancer[4].

Between 30-50% of all cancer cases are preventable. Prevention constitutes the most cost-effective long-term strategy for the control of cancer. National policies and programmes should be implemented to raise awareness, reduce exposure to cancer risk factors and to ensure that people are provided with the information and support they need to adopt healthy lifestyles[4].

References:

1. *Yussof AF, Mustafa AN, Kaur G, Omar MA, Vos T, et al. Malaysian Burden of Disease and Injury Study. Kuala Lumpur; Institute of Public Health, Ministry of Health Malaysia; 2004.*
2. *Malaysian Health Facts 2017.*
3. *National Cancer Registry Report (2007-2011).*
4. *WHO-cancer prevention (http://www.who.int/cancer/prevention/en/)*

PLAN OF ACTION FOR MEN'S HEALTH IN MALAYSIA

The plan of action is divided into seven domains, which are:

1 Health promotion
2 Accessible and appropriate health care services
3 Human Resource Development
4 Health Information System
5 Inter-sectoral Collaboration
6 Research and Development
7 Legislation

Each of these domains is made up of several strategies. Each strategy contains several activities with the monitoring indicators and agencies involved. Some of the strategies are supported with evidence, examples or useful references, which may be used to guide the operationalisation of the activities. All of the indicators are to be reported yearly.

1. HEALTH PROMOTION

Strategy 1.1: To develop or strengthen men's health agenda through health promotion strategies across different agencies and settings

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Conduct of men's health campaign**	No. of campaigns conducted No. of male participants in each campaign	MOH (Lead) MOE NGO
B	**Implementation of health promotional programmes targeting men**	No. of health promotional programmes implemented No. of participants in each programme Improvement of health outcomes	MOH (Lead) MOE NGO
C	**Development, production and dissemination of men's health related, evidence-based, educational materials**	No. of health education materials produced No. of health materials disseminated No. of online posts and hits	MOH (Lead) MOE PIBG Universities NSM MASO MDA MOWFCD MOHR SOCSO MIROS

Case Studies:

A. Men's Health Campaigns

International Men's Health Week is held in June every year in conjunction with Father's Day. Many countries organise this including the United Kingdom, Ireland, Australia, Canada and the United States. Different themes are set and various activities are conducted each year.[1-4]

The November campaign is held in November to promote men's health awareness. Men are encouraged to keep their moustaches to invite/initiate conversations about men's health. The Movember campaign has successfully raised funds for men's health services and research. It has achieved 1.1 million registered supporters up to 2012.[5]

The International Men's Day falls on 19 November. It is also celebrated in many countries.[6]

A 3-day university-wide health promotion programme was organised in a South Korean university in 2013. Its objectives were to heighten health awareness; promote healthy behaviours, especially active lifestyle and healthy diet; disseminate health knowledge and skills; and provide access to health resources to young people. The programme was comprised of 14 health lectures, 12 events, and 25 booths. The programme evaluation showed that it effectively provided opportunities for students to access health information, knowledge, skills, services and other resources. Participants' feedback on the programme was largely positive (83% rated the overall programme as "excellent" or "good"; 86% showed intention to participate again; 80% reported increased awareness of health; and 87% reported the need for a university health promotion programme).[7]

The Moustache for Men (M4M) men's health campaign has been organised in the University of Malaya since 2015. In M4M2017, a series of activities were conducted including health screening for men, "learn how to exercise", "learn your calorie", planking competition, Instagram photo competition and a poster exhibition. A total of 212 men (students and staff) attended the health screening. Diseases ranging from mild to severe were picked up in many participants and they were sent for detailed follow up or admission. Feedback obtained from the participants showed that 96.7% of them were satisfied or very satisfied with the campaign. Open text feedback from participants suggested that they want the campaign to be organised again.[8]

B. Health Programmes

Robertson et al has published a systematic review to evaluate the effectiveness of interventions aimed at improving men's health in 2008. The health topics covered are smoking cessation, diet and physical activity, cardiovascular disease, prostate cancer, testicular cancer, preventive health screening, skin cancer and alcohol.[9]

Cook et al. conducted a workplace intervention consisting of a monthly health promotion workshop for 6 months. There were significant self-reported changes in the intervention group in terms of vegetable intake, physical activity and dietary knowledge compared to a control site.[10]

Holland et al used an intervention that promotes health screening through men's partners. The study showed that communication with a man's loved one, combined with a reminder system for providers, may increase the uptake of preventive healthcare screenings.[11]

The Football Fans in Training (FFIT) programme in Scotland showed that professional sport can be an effective medium for engaging men in lifestyle improvement programmes. The FFIT consisted of a total of 12 weekly sessions delivered in clubs' stadia. It combined effective behaviour change techniques with dietary information and physical activity sessions. Participation in FFIT led to significant reductions in weight at 12 months, with 4.94 kg mean difference as compared to the control group. [12]

C. Educational Materials

Hammer and Vogel used a male-sensitive brochure to improve attitudes about seeking counselling and to reduce self-stigma in seeking counselling among 1397 depressed men. They found that the male-sensitive brochure, which incorporated information about the psychology of men, masculinity and mental health marking, improved participants' attitudes and reduced their self-stigma towards counselling.[13]

Taylor et al used a booklet and video to improve knowledge and decision-making in prostate cancer screening. The booklet and video resulted in a significant improvement in knowledge and a reduction of decisional conflicts about prostate cancer screening relative to the control group.[14]

Hanrahan et al sent two educational brochures about melanoma to men in an industrial complex. The brochures significantly increased the participants' knowledge on melanoma as compared to the control group who didn't receive any educational materials.[15]

References:

1. *Men's Health Network. International Men's Health Week 2018 is June 11-17. Available from: http://www.menshealthmonth.org/imhw/imhw.html. Accessed: (19 Apr 2018).*
2. *Men's Health Forum. Men's Health Week 2018. Available from: https://www.menshealthforum.org.uk/mhw. Accessed: (19 Apr 2018).*
3. *Western Sydney University. Men's Health Week. Men And Families: Making Healthy Connections – 2018 Available from: http://www.menshealthweek.org.au/En/Pages/1611cf/2017-Theme-Healthy-Body-Healthy-Mind-Keeping-The-Balance.aspx. Accessed: (19 Apr 2018).*
4. *Men's Health Forum in Ireland. International Men's Health Week. Available from: http://www.mhfi.org/mhw/about-mhw.html. Accessed: (19 Apr 2018).*
5. *Jeffcott M, Cagiannos I, Zorn KC. Movember update: the Canadian perspective. Canadian Urological Association Journal. 2012 Jun;6(3):E111.*
6. *International Men's Day. Available from: http://www.internationalmensday.com/international.html. Accessed: (19 Apr 2018).*
7. *Joh H-K, Kim H-J, Kim Y-O, et al. Health promotion in young adults at a university in Korea: A cross-sectional study of 625 participants in a university. Leischik. R, ed. Medicine. 2017;96(7):e6157. doi:10.1097/MD.0000000000006157.*
8. *Ng CJ et al. Moustache for Men 2017: Post-event Report. Department of Primary Care Medicine, University of Malaya; Kuala Lumpur.*
9. *Robertson LM, Douglas F, Ludbrook A, Reid G, van Teijlingen E. What works with men? A systematic review of health promoting interventions targeting men. BMC Health Services Research. 2008;8:141. doi:10.1186/1472-6963-8-141.*
10. *Cook C, Simmons G, Swinburn B, Stewart J: Changing risk behaviours for non-communicable disease in New Zealand working men–is workplace intervention effective? N Z Med J 2001, 114(1130):175-178.*
11. *Holland DJ: Sending men the message about preventive care: an evaluation of communication strategies. International Journal of Men's Health 2005, 4(2):97-114.*
12. *Wyke S, Hunt K, Gray CM, et al. Football Fans in Training (FFIT): a randomised controlled trial of a gender-sensitised weight loss and healthy living programme for men – end of study report. Southampton (UK): NIHR Journals Library; 2015 Jan. (Public Health Research, No. 3.2.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK273998/ doi: 10.3310/phr03020*
13. *Hammer JH, Vogel DL. Men's help seeking for depression: The efficacy of a male-sensitive brochure about counseling. The Counseling Psychologist. 2010 Feb;38(2):296-313.*
14. *Taylor KL, Davis JL, Turner RO, Johnson L, Schwartz MD, Kerner JF, Leak C. Educating African American men about the prostate cancer screening dilemma: a randomized intervention. Cancer Epidemiology and Prevention Biomarkers. 2006 Nov 1;15(11):2179-88.*
15. *Hanrahan PF, Hersey P, Watson AB, Callaghan TM. The effect of an educational brochure on knowledge and early detection of melanoma. Australian and New Zealand Journal of Public Health. 1995 Jun 1;19(3):270-4.*

Strategy 1.2: To improve the wellbeing of men by emphasising the roles of being a father and spouse

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Conduct of health promotional programmes which focus on the father's role**	No. of programmes conducted No. of male participants involved in the programmes	MOH (Lead) MOE NGO
B	**Involvement of male spouse in prenatal, antenatal and postnatal care**	No. of programmes conducted No. of male participants involved in the programmes	MOWFCD LPPKN MOH JAKIM NGO Religious bodies MINDEF – RSAT

Case Studies:

A. Heath promotional programmes which focus on the father's role

Stanton et al employed a national footballer to introduce a video that targeted fathers-to-be, focussing on the health risks of passive smoking to the newborn. The intervention group showed higher smoking cessation rates at the end of their partner's pregnancy (intervention 16.5% vs control 9.3%).[1]

Evidence showed that promoting positive models of manhood (such as caring and involved fatherhood) while concurrently addressing structural barriers can improve men's help and health–seeking behaviours.[2]

Many studies found increased depressive symptoms in men during early parenthood. Habib proposed several models of intervention to tackle paternal perinatal depression (PPND) including web-based parenting information; education and support seminar; as well as group or individual treatment for PPND positive men. A clinical management decision tree to manage PPND positive patients was also proposed.[3-5]

B. Involvement of male spouse in prenatal, antenatal and postnatal care

Mohlala et al. used an intervention that involved pregnant women inviting their male sexual partners to attend a voluntary counselling for couples and testing for HIV. A significantly higher number of men (32%) in the intervention group underwent HIV testing as compared to the control group (11%).[6]

A study by Byamugisha et. al. evaluated the effect of a written invitation letter to the spouses of new antenatal clinic attendees on attendance by couples and on male partner acceptance of HIV testing at subsequent antenatal clinic visits. The letter described the women's upcoming appointment date. It also mentioned that: (i) the antenatal and prevention of mother-to-child transmission (PMTCT) services are free (no user charges); (ii) these services are beneficial to the couple and their unborn baby; (iii) their utilization by men is low; (iv) the man is cordially invited to accompany the woman at her next scheduled antenatal visit to discuss important issues concerning her antenatal care; and (v) the time spent in hospital would be minimal. 15.5% of men in the intervention group underwent HIV testing while 12.8% who received leaflets (control group) underwent HIV testing.[7]

References:

1. *Stanton WR, Lowe JB, Moffatt J, Del Mar CB: Randomised control trial of a smoking cessation intervention directed at men whose partners are pregnant. Prev Med 2004, 38(1):6-9.*
2. *Levtov R, van der Gaag N, Greene M, Kaufman M, Barker G. State of the World's Fathers: A MenCare Advocacy Publication. Washington, DC: Promundo, Rutgers, Save the Children, Sonke Gender Justice, and the MenEngage Alliance; 2015.*
3. *Giallo R, D'Esposito F, Christensen D, Mensah F, Cooklin A, Wade C, Lucas N, Canterford L, Nicholson JM. Father mental health during the early parenting period: results of an Australian population based longitudinal study. Social psychiatry and psychiatric epidemiology. 2012 Dec 1;47(12):1907-16.*
4. *Da Costa D, Zelkowitz P, Dasgupta K, Sewitch M, Lowensteyn I, Cruz R, Hennegan K, Khalifé S. Dads get sad too: Depressive symptoms and associated factors in expectant first-time fathers. American journal of men's health. 2017 Sep;11(5):1376-84.*
5. *Habib C. Paternal perinatal depression: An overview and suggestions towards an intervention model. Journal of Family Studies. 2012 Jun 1;18(1):4-16.*
6. *Mohlala BK, Boily MC, Gregson S. The forgotten half of the equation: randomized controlled trial of a male invitation to attend couple voluntary counselling and testing. Aids 2011;25(12):1535-41. Pmc3514892.*
7. *Byamugisha R, Astrom AN, Ndeezi G, Karamagi CA, Tylleskar T, Tumwine JK. Male partner antenatal attendance and HIV testing in eastern Uganda: a randomized facility-based intervention trial. J Int AIDS Soc 2011;14:43. Pmc319269.*

Strategy 1.3: To integrate men's health agenda into the activities and strategies of MOH and other ministries

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Identification of existing programmes and responsible agencies that integrate men's health promotion into ministerial strategic plans/ plans of action/ ministerial blue prints, etc.**	No. of national documents, strategic plans, blue prints and programmes that address and analyse outcomes using sex disaggregated data	MOH MOWFCD LPPKN PDRM JPJ MIROS MOHR JAKIM NGO's Religious bodies MYS
B	**Incorporation of men's health agenda into ministerial strategic plans, plans of action and ministerial blue prints**	No. of programmes/ activities addressing men's issue (health, economic, education, etc)	MOH MOWFCD LPPKN PDRM JPJ MIROS MOHR JAKIM NGO's Religious bodies MYS

Case Studies:

Incorporation of men's health agenda into ministerial strategic plans, plans of action and ministerial blue prints

The first theme of the Ireland Men's Health Policy 2017-2021 includes 'Appoint a men's health representative on all priority programme committees in the Health Service Executive to ensure the integration of men's health policy on these programmes'. This served the same purpose for this strategy 1.3.[1]

References:

1. *Health Service Executive. National Men's Health Action Plan. Healthy Ireland – Men 2017-2021. 2016. Dublin: The Stationery Office Dublin; 2008.*

2. ACCESSIBLE AND APPROPRIATE HEALTHCARE SERVICES

Strategy 2.1: To improve availability and accessibility of health services to men

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Increase number of clinics with extended opening hours**	No. of male clinic attendance Male-to-female ratio in clinic attendance	MOH MOE MINDEF
B	**Increase availability of treatments and services for male-specific conditions including ED and BPH at primary care level**	No. of new services available to men No. of male patients receiving treatments for male-specific conditions	MOH MOE MINDEF
C	**Increase accessibility of health screening at the workplace**	No. and percentage of males screened in KOSPENPlus programmes No. and percentage of males screened in SOCSO Health Screening Programmes No. and percentage of males detected having health risk factors: DM, HPT, Hyperchol., Obesity and Smoking	MOH MOE MINDEF SOCSO Other Ministries Private Companies
D	**Increase accessibility of health screening in the community**	No. and percentage of males screened in KOSPEN programmes No. and percentage of males detected having health risk factors: DM, HPT, Hyperchol., Obesity and Smoking	MOH

Case Studies:

A. Increase number of clinics with extended opening hours

Extended consultation hours are often needed to assess men's health needs comprehensively.[1]

Out-of-hours services in primary care are still widely practised and needed in many countries.[2]

B. Increase availability of treatments and services for male-specific conditions

Wider use of sexual health nurses within general practices could result in substantial improvements in HIV and STI screening uptake by MSM in the community.[3]

There is good evidence that men will use targeted primary care services but there remains a need for more research into men's use of primary care services and how it can be improved.[4]

References:

1. *Strange P, Tenni M. Bendigo CHS Men's Health Clinic Improving access to primary care. Australian Family Physician. 2012;41:731-3.*
2. *Huber CA, Rosemann T, Zoller M, Eichler K, Senn o. Out-of-hours demand in primary care: frequency, mode of contact and reasons for encounter in Switzerland. Journal of evaluation in clinical practice. 2011;17(1):174-9.*
3. *Snow AF, Vodstrcil LA, Fairley CK, El-Hayek C, Cummings R, Owen L, et al. Introduction of a sexual health practice nurse is associated with increased STI testing of men who have sex with men in primary care. BMC Infectious Diseases. 2013;13(1):298.*
4. *Banks I, Baker P. Men and primary care: improving access and outcomes. Trends in Urology & Men's Health. 2013;4(5):39-41.*

Strategy 2.2: To provide male-friendly services in healthcare settings

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Availability of services that engage male-centric approaches**	No. of services that use male-centric approaches e.g. ED Clinic, LUTS Clinic No. of men screened for male-related health problems e.g. ED, LUTS	MOH MOE MINDEF
B	**Development of screening tools for SRH in men**	No. of screening tools developed	MOH MOE

Case Studies:

A. Services that engage male-centric approaches

Services could become more 'male-friendly' by having men's magazines in waiting rooms and displaying health information (posters, leaflets, etc.) aimed at men. NHS Health Checks can provide a useful engagement tool: there is good evidence that men will use them, including men from the most-at-risk groups, if the marketing is male-targeted. Taking services such as health checks or talks on specific health issues to 'where men are' has been shown to be an effective strategy. The workplace, faith and leisure venues (such as clubs, pubs and sports stadia) are all settings where men can be engaged.[1]

A systematic review showed that health systems and healthcare professionals are among the important factors that influence health screening uptake in men. Male-unfriendly healthcare settings have been shown as a barrier for men attending screening. One other factor that facilitates men's screening uptake is physicians' recommendation.[2]

A study showed that it is important for men to feel comfortable in the clinic where they seek health services. Many clinics are more female-centric than male-centric. Provision of more male medical staff and medical staff who are more male-sensitive are facilitators to men seeking health services in clinics.[3]

References:

1. *Baker P. Men's health: an overlooked inequality. British Journal of Nursing. 2016;25(19):1054-7.*
2. *Teo CH, Ng CJ, Booth A, White A. Barriers and facilitators to health screening in men: A systematic review. Social Science & Medicine. 2016;165:168-76.*
3. *Leichliter JS, Paz-Bailey G, Friedman AL, Habel MA, Vezi A, Sello M, et al. 'Clinics aren't meant for men': sexual health care access and seeking behaviours among men in Gauteng province, South Africa. SAHARA J: Journal of Social Aspects of HIV/AIDS Research Alliance. 2011;8(2):82-8.*

Strategy 2.3: To develop and strengthen services that are related to reduction of high-risk behaviours in men

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Availability of services which promote reduction of high-risk behaviours in males**	Retention rates for methadone replacement therapy Uptake of needle and syringe exchange Incidence of HIV in men Smoking cessation rates	MOH MOE AADK

Case Studies:

A. Services which promote reduction of high-risk behaviours in males

"This study showed that men were not better than women in quitting smoking."[1]

"After ten years of development of the needle exchange programme, there was a significant decrease in the prevalence of HIV and HCV in the prison population at the centre, and the programme is accepted as beneficial by most of the inmates and staff participating in the survey."[2]

"In males, significant predictors of more than1-year retention of opioid abstinence were urine samples negative for opioids and cannabinoids during the first month, and not cocaine dependent. Significant predictors of higher long-term opioid abstinence were first-month urine samples negative for opioids and cocaine metabolites."[3]

References:

1. *Jarvis MJ, Cohen JE, Delnevo CD, Giovino GA. Dispelling myths about gender differences in smoking cessation: population data from the USA, Canada and Britain. Tobacco Control. 2012.*
2. *Ferrer-Castro V, Crespo-Leiro MR, Garcia-Marcos LS, Perez-Rivas M, Alonso-Conde A, Garcia-Fernandez I, et al. [Evaluation of needle exchange program at Pereiro de Aguiar prison (Ourense, Spain): ten years of experience]. Revista espanola de sanidad penitenciaria. 2012;14(1):3-11*
3. *Levine AR, Lundahl LH, Ledgerwood DM, Lisieski M, Rhodes GL, Greenwald MK. Gender-Specific Predictors of Retention and Opioid Abstinence During Methadone Maintenance Treatment. Journal of Substance Abuse Treatment. 2015;54:37-43.*

3. HUMAN RESOURCE DEVELOPMENT

Strategy 3.1: To build capacity in providing men's health services

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Development and conduct of training modules on men's health**	No. of training modules developed on men's health No. of basic and post-basic training programmes that incorporate men's health in the curriculum No. of training sessions/ workshops conducted	MOH MOE MINDEF NGO-MSASAM Allied Health Colleges
B	**Training of healthcare professionals in the management of men's health issues at both basic and post-basic levels**	No. of healthcare professionals trained in men's health	MOH MOE MINDEF NGO-MSASAM Allied Health Colleges LPPKN
C	**Training of healthcare professionals in the management of men's health issues at both basic and post-basic levels**	No. of healthcare professionals trained in men's health	MOH MOE MINDEF NGO-MSASAM Allied Health Colleges LPPKN

Case Studies:

Existing training programmes on men's health globally

The Irish government has developed the ENGAGE (National Men's Health Training) programme and delivered it to a range of health professionals (GPs, nurses, community workers, etc.) in the previous cycle of their National Men's Health Policy. ENGAGE aimed to increase gender competency among those working with men and boys across a variety of sectors. It consists of six Units that are delivered in two distinct one-day training programmes [Units 1-5; Unit 6 - Connecting with Young Men].[1]

Andrology Australia provides evidence-based information, training programmes and other resources about reproductive health disorders and associated conditions for health professionals providing care to males. The accredited training aims to provide knowledge and core skills in the detection and management of a range of common male reproductive health disorders and associated conditions to all interested health professionals, including those in training for general practice. It also provides health professionals with special interests in men's reproductive health with advanced level knowledge and skills.[2&3]

The Men's Health Forum UK conducts a one-day training course on how to engage men and how to keep them engaged. The training also provides the latest insights and information around the issues affecting men's health and wellbeing; and issues pertaining to working with men and boys.[4]

References:

1. *Health Service Executive. National Men's Health Action Plan. Healthy Ireland – Men 2017-2021. Dublin: The Stationery Office Dublin; 2016.*
2. *Andrology Australia. Education and training for health professionals. Available from: https://andrologyaustralia.org/health-professionals/ (Accessed 20 Apr 2018)*
3. *Andrology Australia. Education for primary health care nurses. 2018. Available from: https://andrologyaustralia.org/health-professionals/practice-nurses/ (Accessed 20 Apr 2018)*
4. *Men's Health Forum. 'How to…' – The Workshop. Available from: https://www.menshealthforum.org.uk/how-workshop. Accessed 20 Apr 2018*

4. MEN'S HEALTH INFORMATION SYSTEM

Strategy 4.1: To establish a system to monitor men's health status

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Regular analysis, reporting and dissemination of men's health statistics**	Documentation of data on: • Injuries • Mental health • CVD risk factors • Prostate cancer • LUTS • ED • Screening (BSSK)	MOH (Lead) MOE SOCSO DOSH MSASAM MOT JKM PDRM
B	**Improvement in the quality and documentation of data on men's health**	No. of clinics with complete data and documentation on ED and BPH	MOH MOE MINDEF

Case Studies:

The monitored men's health indicators in Ireland

The evaluation of Ireland National Men's Health Policy looked at the life gap between male and female in terms of life expectancy, mortality by cause of death and lifestyle risk factors.[1]

A composite indicator to monitor men's health

A research project which aims to construct a composite indicator that measures men's health status at a national level is currently being conducted. The composite indicator can serve as a guide for policy makers to identify gaps in men's health and help them to prioritise health policies for men in their country. It will also allow countries to share experiences and effective strategies with one another, and to monitor the progress of men's health initiatives.[2&3]

References:

1. *Health Service Executive. National Men's Health Action Plan. Healthy Ireland – Men 2017-2021. Dublin: The Stationery Office Dublin; 2016.*
2. *Ng CJ et al. Developing and Evaluating the Global Men's Health Index to Inform Policy Decision Making in Men's Health. Available from: https://menshealth.um.edu.my/mhi (Accessed 20 Apr 2018).*
3. *Teo CH, Ng CJ. Development and pilot testing of a National Men's Health Index. BMC health services research. 2014 Jul 1;14(S2):P126.*

Strategy 4.2: To establish a one-stop centre that collates all information regarding men's health in Malaysia

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Establishment of a clearinghouse on men's health at the national level**	Establishment of the Malaysian Clearinghouse for Men's Health (MCMH) No. of reports produced	MOH MOE MINDEF

Case Studies:

A. Establishment of a clearinghouse on men's health at the national level

The Malaysian Clearinghouse for Men's Health (MCMH) was established in 2017. It archives all research, education, clinical services and public activities that are related to men's health in Malaysia. The committee of MCMH consisted of experts from various institutions including the Ministry of Health, local public and private universities, international universities and non-governmental organisations. The MCMH was funded by the MOH and is currently hosted by the University of Malaya.[1]

References:

1. *Malaysian Clearinghouse for Men's Health. Available from: http://menshealthmalaysia.org. (Accessed 19 Apr 2018).*

5. MEN'S HEALTH INFORMATION SYSTEM

Strategy 5.1: To expand the capacity and output of men's health research in Malaysia

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Conduct of men's health research in Malaysia**	No. of research projects on men's health (On-going and completed)	MOHE MOH NGO MESTECC
B	**Expansion of number of researchers in men's health**	No. of researchers in area of men's health	MOHE MOH NGO MESTECC
C	**Establishment of men's health research collaboration with international institutions**	No. of international research collaborations	MOHE MOH NGO MESTECC
D	**Publication of men's health research**	No. of publications on men's health	MOHE MOH NGO MESTECC
E	**Presentation of men's health research**	No. of presentations on men's health research	MOHE MOH NGO MESTECC

Case Studies:

The contents of the Malaysian Clearinghouse for Men's Health

The Malaysian Clearinghouse for Men's Health archives all research that are related to men's health in Malaysia. The information available include: research projects, researchers, collaborations and publications. The statistics for these can be found on the website.[1]

References:

1. *Malaysian Clearinghouse for Men's Health. Available from: http://menshealthmalaysia.org. (Accessed 19 Apr 2018).*

6. INTERSECTORAL COLLABORATION

Strategy 6.1: To strengthen intersectoral collaboration with stakeholders through networking and smart partnership

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Advocate the utilization of new and existing partnerships to address men's health issues at national, state and district levels**	No. of intersectoral collaborations on men's health activities/ programmes/ research No. of activities/ programmes/ research conducted via intersectoral collaboration	MOH MOWFCD MOE MYS MIA JAKIM NGOs MMA FFPAM PS The Children WCC Uniform Bodies (PBSM, Scouts, Cadets, etc) PIBG

Case Studies:

A. Advocating intersectoral collaboration

The World Health Organization recommends intersectoral collaboration as it has been demonstrated to be effective in addressing service integration problems, duplications, gaps and inconsistencies in service provision. It also promotes efficient use of limited resources and pooling of skills and resources to address health on a broad level. Through ISC, it is possible to work across structural levels, attract a diversity of participants and decision makers, address a variety of health factors, and mobilize social capital to address health equity issues.[1&2]

References:

1. *Alberta Health Services. Social environments and health: Healthy Public Policy concept paper [Internet]. Edmonton, AB: Healthy Public Policy, Health Promotion, Disease and Injury Prevention, Alberta Health Services; 2011 March. [cited 2014 Oct 16]. Available from: http://www.albertahealthservices.ca/poph/hi-poph-hpp-healthy-public-policy-concept-paper.pdf*
2. *Axelsson R, Axelsson SB. Integration and collaboration in public health – a conceptual framework. Int J Health Plan M [Internet]. 2006 [cited 2014 Oct 16];21:75-88:[about 14pp]. Available from: https://www.k4health.org/sites/default/files/axelsson_bihari_axelsson_2006.pdf*

7. LEGISLATION

Strategy 7.1: To identify the legislations and policies related to men's health

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Identification of legislations and policies related to men's health**	No. of legislations and policies related to men's health in Malaysia	MOH AG's Chamber MOE MOWFCD MOHR Ministry of Local Housing MOTAC MOI JPM JAKIM NGOs, eg: FOMCA

Case Studies:

A. Existing legislations and policies related to men's health

To date, only Ireland, Australia, Brazil and Iran have established national policies for men's health. Having policies that target males are important in order to improve men's health. The Irish government has renewed their national men's health policy in view of the improvement in men's health status, as indicated in its evaluation report.[1-6]

The United States approved the Men's Health Act of 2002 which established the Office of Men's Health within the Department of Health and Human Services. This office coordinates and promotes the status of men's health in the United States.[7]

References:

1. *Baker P, Shand T. Men's health: time for a new approach to policy and practice?. Journal of global health. 2017 Jun;7(1).*
2. *Peter B. Worth the paper they're written on? The potential role of national men's health policies. Eurohealth. 2015;21:27-9.*
3. *Australia Department of Health and Ageing. National Male Health Policy. Barton: Commonwealth of Australia; 2010.*
4. *Esmailzade H, Mafimoradi S, MIRBAHAEDDIN SE, Rostamigooran N, Farshadfar F. Devising a National Men's Health Policy Document: The Current Challenges to Men's Health in Iran. International Journal of Men's Health. 2016;15(2).*
5. *Department of Health and Children. National Men's Health Policy 2008-2013 (Ireland). Dublin: The Stationery Office Dublin; 2008.*
6. *Ministry of Health. National Policy of Integral Attention to Men's Health (PNAISH). Brasilia: Ministry of Health; 2009.*
7. *GovTrack. S. 2616 (107th): Men's Health Act of 2002. Available from: https://www.govtrack.us/congress/bills/107/s2616/textt (Accessed 19 Apr 2018).*

Strategy 7.2: To support the development, revision and enforcement of legislations and policies related to men's health

Timeline: 2019-2030

	ACTIVITIES	INDICATORS	AGENCIES
A	**Participation in activities around legislations and policies related to men's health**	No. of meetings on legislations and policies related to men's health No. of new legislations and policies developed in relation to men's health	MOH AG's Chamber MOE MOWFCD MOHR Ministry of Local Housing MOTAC MOI JPM JAKIM NGOs, eg: FOMCA
B	**Strengthening of the enforcement of legislations and policies**	No. of public areas that are smoke-free No. of road speeding summons issued No. of drunk driving captured No. of new legislations and policies implemented in relation to men's health	MOH SOCSO DOSH PDRM JPJ

Case Studies:

Recommendation to introduce men's health policy in all relevant areas

As part of a comprehensive approach to gender and health, experts recommend that global health organisations and national governments address the health and well–being needs of men and boys in all relevant policies (e.g. on obesity, cardiovascular disease and cancer) alongside introduction of specific men's health policies. In order to implement men's health initiatives successfully, there must be a commensurate policy and programming response.[1]

References:

1. *Baker P, Shand T. Men's health: time for a new approach to policy and practice?. Journal of Global Health. 2017 Jun;7(1).*

WAY FORWARD

For many years, inequities in women's health have been acknowledged by policy makers and health service planners. However, it is only recently that inequalities in health outcomes for men receive more attention. This lead to further assessments into men's health issues for potential solution.

The way forward in Men's Health has been paved according to the following objectives:

1) To affirm men's health as an issue that require commitment for improvement, with particular focus on the target population of men within the community.
2) To identify and promote ways in which health agencies and other agencies can develop partnerships to improve the health of men.
3) To provide direction and support for further research into why men and women differ in their health outcomes.
4) To look into interventions that may be required to prevent disease and injury and promote good health in men.
5) To provide improved service delivery that is more structured and coordinated to meet the needs of different groups of men.

Moving forward in Men's Health requires strategies that are mainly aimed at promoting and protecting men's health. These are grouped into the following key focus areas:

a) Making health services more accessible and appropriate for men through the empowerment of community men's health screening programmes such as KOSPEN. This should be followed by a referral system that gives priority based on their health issues.
b) Developing supportive and conducive working environments in which men's health issues can be raised either by occupational health services or by men themselves. A supportive environment also establishes stronger social support networks for men and better pathways for seeking help.
c) Improving coordination and collaboration of services by working together and looking outside the health system, forming partnerships involving both governmental and non-governmental agencies. Examples of potential collaborative partnerships are: workplace safety programmes, driver and road safety campaigns, innovative approaches to sporting and recreational activities to reduce injuries, alternative and complementary medicine services, partnerships with the media to raise awareness on specific issues for men, etc.
d) Conducting research and accumulating information to evaluate the effectiveness of all interventions targeting men's morbidity and mortality causes. Such causes may include risk-taking behaviours, smoking, sedentary lifestyle and mental illness.
e) Building capacity by conducting structured training to all healthcare professionals, including clinicians, health promotion workers and primary healthcare workers so that they are fully competent in engaging men's health needs. Patient-centred team based approaches can also be implemented through the management of health services.

In summary, the way forward in Men's Health requires multiple agencies and the community working together in partnership. For these partnerships to be successful, men must be involved as end users throughout the entire process of developing and delivering men's health services.

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