Birmingham City Council

Birmingham Men's Health Needs

Report with Recommendations

Public Health Division
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ACKNOWLEDGMENTS

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FOREWORD

As a city, Birmingham is proud of its diversity, resilience, and commitment to improving the lives of all its residents. Yet, when it comes to men's health, we are faced with stark and sobering realities that demand urgent attention.

This report shines a light on the deep-rooted inequalities affecting men across Birmingham — inequalities that are shaped not only by biology but by the social and economic conditions in which our residents live in. From lower life expectancy in our most deprived wards to the disproportionate impact of COVID-19 on men from Black and Asian communities, the evidence is clear: gender and place matter profoundly when it comes to health outcomes.

Men's mental health, substance misuse, and suicide rates are of particular concern. Harmful gender norms such as the pressure to remain stoic, avoid seeking help, and suppress emotion continue to take a devastating toll. These cultural expectations, combined with socioeconomic disadvantage, contribute to higher rates of preventable illness, addiction, and premature death.

We must do better. Healthy ageing should be a right, not a privilege. That means investing in prevention, tackling stigma, and ensuring that services
are accessible, inclusive, and responsive to the needs of men in every part of our city.

This report is not just a call to action—it is a roadmap for change. I commend the Public Health team for their dedication to highlighting these issues and for working tirelessly to build a fairer, healthier Birmingham for all.

Let us move forward together, with compassion, courage, and a shared commitment to equity.

1. INTRODUCTION

Gender is recognised as one of the most relevant determinants of health inequalities. A report on health equity in England found that improvements in life expectancy have stalled for over a decade for both men and women.[1] ONS data highlighted that between 2021-2023, the average life expectancy for males was 79.0 years compared to 83.0 years for women.[2] For men in Birmingham, average life expectancy between 2021-2023 was 77.1 years.[3] As of 2022, the male mortality rate for COVID-19 was 50% higher than females, and specific ethnic groups were disproportionately impacted such as Black/ Black British and Asian/Asian British people.[4] Whilst sex affects the health of an individual through anatomy, i.e., prostate cancer is exclusive for males and cervical cancer is exclusive for females, gender affects health at a social level through differences in roles, responsibilities and through the social determinants of health such as lower income, poorer working conditions and employment, and housing. Men in Birmingham's more deprived areas have significantly lower life expectancies than those in more affluent areas. For example, men in Balsall Heath West have a life expectancy of just 12.9 years from age 65, compared to 22.7 years for men in Sutton Four Oaks.[5] This stark difference of nearly 10 years highlights the deep-rooted health inequalities across the city, driven by factors such as socioeconomic status, access to healthcare, and living conditions. Gender inequality negatively impacts men's health by reinforcing harmful masculinity norms such as stoicism and emotional suppression, discouraging help-seeking, and promoting risk-taking behaviours such as alcohol and substance misuse. These factors contribute to higher rates of mental health issues, preventable diseases, workplace injuries, and suicide among men, highlighting the need for prevention and targeted intervention for cis-gendered men and men with intersectional identities.

1.1 BIRMINGHAM GENDER HEALTH INEQUALITIES PROJECT

In 2022, the Inclusion Health Team (Public Health, Birmingham City Council) developed a gender-related health inequalities project, which aims to influence and support the delivery of local action to reduce those inequalities in Birmingham, recognising inequalities exist for women, men, trans and non-binary communities, and these are often larger where there is intersectionality between identities and experiences.

The development of the project coincided with the publication of the Women's Health Strategy for England (2022) [6] which shaped Phase 1 on Women's Health, and 'The Case for a Men's Health Strategy' [7] All-Parliamentary Party Group (2022) report which has helped to frame Phase 2 of the local gender health inequalities project focussing on men's health.

The content of this report is a product of the second phase of the gender health inequalities project, which started to be developed in September 2023 and focused on men's health inequalities in Birmingham. It has been compiled through a consolidation of published data and local evidence, including various stakeholders' insight.

The report aims to highlight challenges for men's health in Birmingham, with a focus on inclusive, intersectional aspects of key male populations in the city with an inclusion health lens.

The recommendations identify local opportunities for action against the national priorities highlighted in the Men's Health Strategy and focus on the following public health outcomes and inequalities:

- Under 75 Premature Mortality
- Cancer and Cardiovascular Disease
- Diabetes and Obesity
- Mental Health and Suicide
- Alcohol and Substance Misuse
- Male Risk Behaviours and Health Literacy

The report also highlights 'what works' to address many of those inequalities.

The overarching aim of this project and the report is to influence change in the local health and wellbeing system through focused work streams and strengthen existing work and community assets to reduce health inequalities for men in Birmingham.

This work is overseen by a multi-agency men's health advisory group, the terms of reference for which can be found in Appendix 1. The advisory group comprising of the local NHS services, Birmingham & Solihull ICB, cancer-based charities, local GPs, community organisations, and health and well-being practitioners aims to influence and drive change in the broader health and care system to improve men's health and outcomes and reduce health inequalities. The group also aims to identify and develop initiatives and research where there are gaps and ensure men's voices feed into the work and longer term - into the health and care system.

1.2 NATIONAL PRIORITIES FOR MEN'S HEALTH

The APPG (2022) Report on a Men's Health Strategy for England is a call to action to address gender-specific health inequalities through transformational system change. The strategy is based on ten core principles:

1. Focusing on a positive 'what works' model
2. A health-based system that understands how men and boys want to access help
3. A health system that is responsive to the needs of men and boys
4. Quality and accessibility of information and education
5. Investment in research, evidence and data on men's health
6. An understanding of how COVID-19 has impacted men
7. Accountability and goal-orientated improvement
8. Preventative approach to health promotion and awareness
9. Effective governance and implementation
10. A broad coalition of health professionals and organisations from the third section

The following 7 key priority areas are identified in the strategy, taking a life course approach:

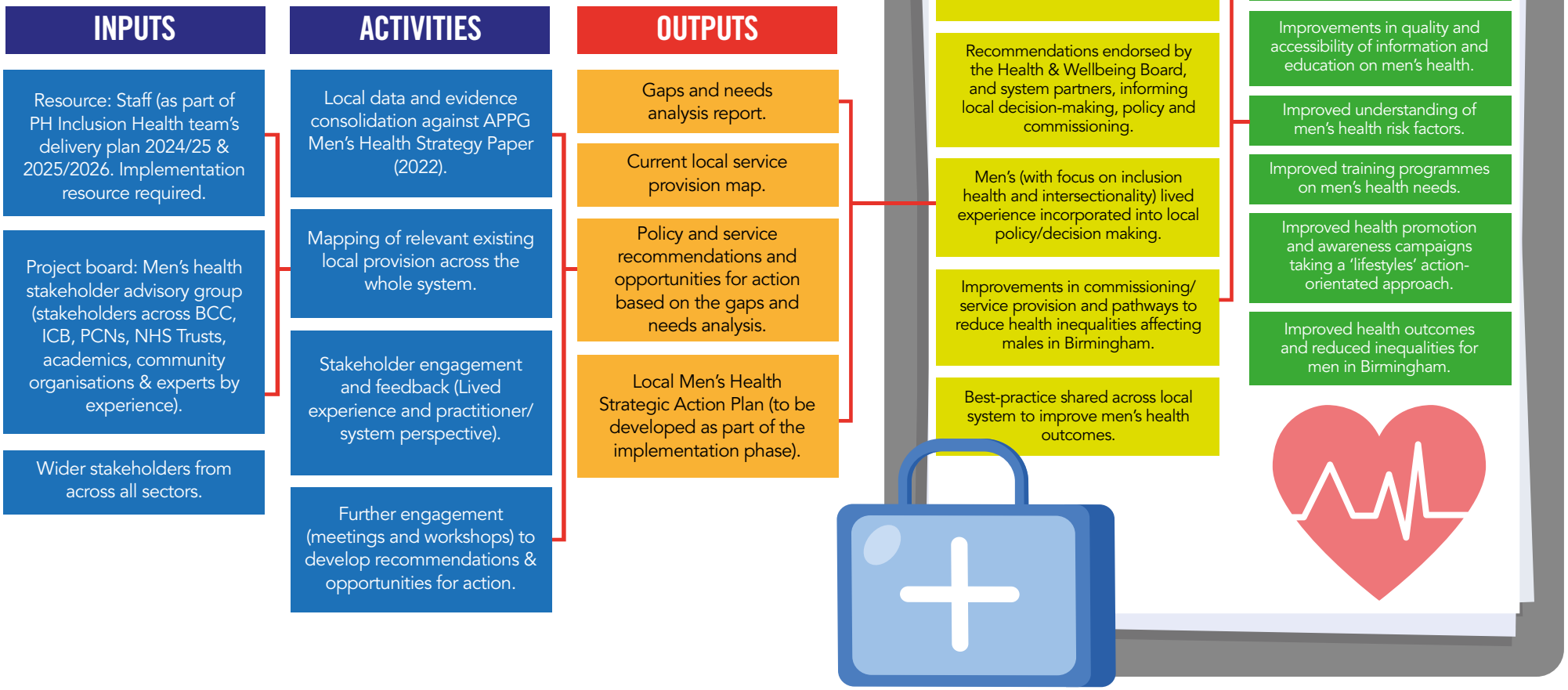
- Premature Mortality
- Cardiovascular Disease
- Cancer
- Diabetes and Obesity
- Mental Health and Suicide
- Substance Misuse
- Health Literacy

The Gender Health Inequalities Project led by Birmingham Public Health has used the APPG (2022) priorities as a framework for identifying and addressing inequalities in men's health locally and exploring opportunities for action based on local best-practice.

2. OUR APPROACH TO DEVELOPING ACTION TO IMPROVE MEN'S HEALTH IN BIRMINGHAM

2.1 THE LOGIC MODEL

Based on the APPG framework and ambitions, the following diagram presents the logic model that has been used to deliver Phase 2 of the Gender Health Inequalities project, starting from local evidence reviews, gaps and needs analysis, and identifying priority areas for action through the recommendations within this report. The project activities involved collaboration with stakeholders, including local men experiencing health inequalities.

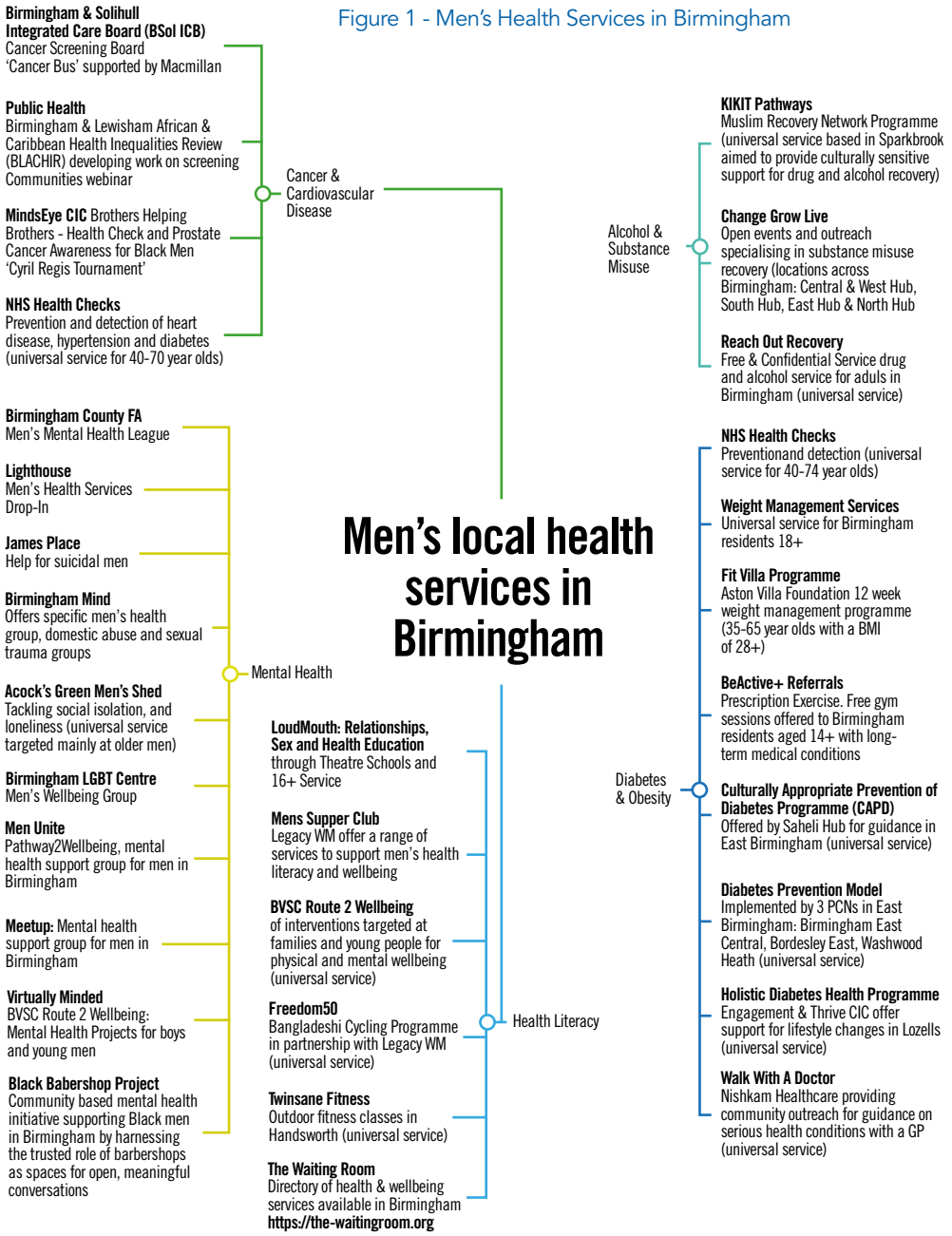


2.2 MAPPING OF LOCAL PROVISION AGAINST NATIONAL PRIORITIES

To identify gaps in local policy and service provision, the Inclusion Health Team conducted a mapping exercise to establish existing and planned service provision and projects against the national ambitions and priorities (Figure 1).

Below is a summary map of existing local services and initiatives that focus specifically on improving men's health and wellbeing and addressing health inequalities affecting men in Birmingham. These have been highlighted by the stakeholder advisory group, the map indicates services that are specifically targeted at men and services that are universal but support men's health needs.

Figure 1 - Men's Health Services in Birmingham



2.3 METHODOLOGY

The following approach was used to collate and review available evidence and data on men's health and disparities in Birmingham, using the 10-core principles and ambitions within the APPG Proposed Men's Health Strategy for England as a framework.

To narrow the focus of the evidence, search and review, the following categories were identified for gathering issues and ideas in the initial stages of the evidence review.

Table 1. Men's health issue categories, Birmingham Public Health, 2023 projects against the national ambitions and priorities (Figure 1).

CATEGORY	EXAMPLES OF WHAT WAS INCLUDED:
Wider determinants	Housing, income, poverty, education, gender norms and attitudes, homeless populations
Inequalities related to Ethnicity	Higher rates of obesity amongst Black/British men, higher rates of alcohol and substance misuse amongst White men and homeless populations
System changes	Data, research, training for healthcare professionals, co-production, mechanisms to bring men's voices into health system e.g. local men's health forums and third sector partners
Prevention of morbidity and mortality	Avoidable deaths, disabling illnesses, and look at drivers of poor outcomes to ascertain intervention needed. Including general (e.g., CVD, diabetes) and men's specific illnesses (e.g. prostate cancer)
Men's specific health needs	Increasing awareness, reducing stigma around mental health and substance misuse – addressing inequalities in access to healthcare. Ensure including issues from across the life course.

This review comprised of five main components:

1. systematic review of evidence on gender related health inequalities (delivered through a commissioned external provider)
2. supplementary rapid desktop review of relevant published research and literature
3. review and assessment of routinely collected local health data
4. consolidation of qualitative local evidence obtained through stakeholder engagement
5. gaps and needs analysis.

2.3.1 REVIEW OF PUBLISHED EVIDENCE

At the initiation stage of the overall gender health inequalities project, a separate systematic review of evidence was commissioned to explore gender-specific health inequalities experienced by the male, female and non-binary populations in Birmingham, UK. A systematic search of Medline, Embase, Science Direct, Web of Science, Cochrane Library, Google Scholar, and other relevant grey literature was conducted to find and retrieve relevant studies.

Since the commissioned review of evidence did not provide sufficiently conclusive outcomes specifically in the Birmingham context, a supplementary desktop review of local and national public health publications was conducted. This included research papers, needs analyses, best-practice, local service data including health checks diabetes services, GP data, substance misuse service data, policies and other grey literature was also conducted by the project lead. This was synthesised with qualitative evidence from front-line practitioners, which has been included in this report.

2.3.2 LOCAL DATA REVIEW

Data sources accessed for the review included:

- Birmingham Joint Strategic Needs Assessment – Local Area Health Profiles
- End of Life in Birmingham JSNA Deep Dive, 2021 - 2022
- Director of Public Health Annual Report 2019 to 2020 – Complex Lives, Fulfilling Futures
- Director of Public Health Annual Report 2021 – COVID-2019: 'The Year I Stopped Dancing'
- Birmingham Community Health Profiles
- Office for Health Improvement and Disparities (OHID)
- Fingertips/ Public Health Outcomes Framework
- Birmingham City Observatory/ Census 2021 data
- National Drug Treatment Monitoring System
- Substance Misuse Service Data
- Local GP and health service data

2.3.3 QUALITATIVE EVIDENCE REVIEW

The project has also collated qualitative evidence and intelligence from across the wider stakeholder group and local publications, which included commissioners and providers of relevant public health and health services (listed on stakeholders' group). Their views and experiences within the local healthcare system were factored in to extract key issues of concern where there are clear gaps in the data.

2.4 STAKEHOLDER ENGAGEMENT

The evidence gathered during the rapid evidence assessment was consolidated into a briefing report to summarise priority areas to address men's health inequalities in Birmingham through evidence and co-producing recommendations for action.

Following on from the stakeholder mapping and engagement as part of the evidence collation and analysis, an advisory group was established. The purpose of this exercise was to review and consolidate the findings from the data and evidence review with stakeholder and service user feedback to ensure the lived experience was reflected in findings. This helped to identify opportunities for action to address the key issues and gaps for men's health in Birmingham.

The group invited stakeholders with a special interest in men's health and health inequalities from the following organisations:

- Birmingham Public Health Adult Services (incl. Addictions, Mental Health & Wellbeing)
- Third sector partners delivering men's health and wellbeing interventions, including MindsEye Development, Cruse Bereavement
- National Charities promoting men's health including Prostate Cancer UK and Birmingham Mind
- Office for Health Improvement & Disparities (OHID)
- Primary Care including General Practitioners
- Commissioned services for drug and alcohol treatment (Change Grow Live)
- Birmingham and Solihull Integrated Care Board
- University Hospital Birmingham NHS Trust.

3. OVERVIEW OF BIRMINGHAM'S MALE POPULATION

Birmingham has an estimated population of 1.145 million people, of these 51.05% are female and 48.95% are male.[8] ONS data shows that gender distribution between males and females is relatively equal city-wide and at the ward level. As demonstrated in Table 2, the city's gender distribution remains relatively the same at the constituency level.

Table 2. Birmingham gender distribution by constituency, ONS data, Census 2021[9]

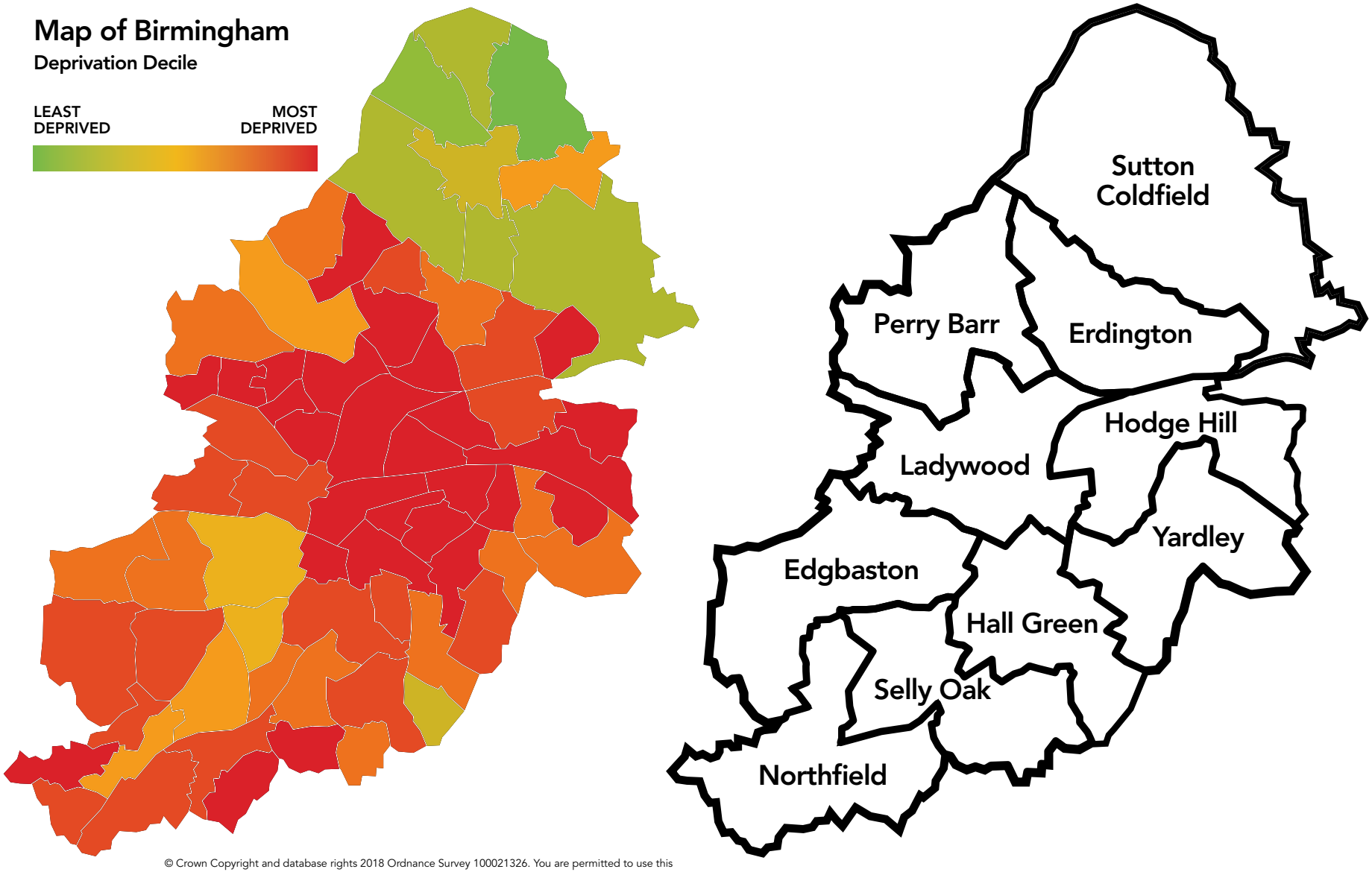
CONSTITUENCY	FEMALE (%)	MALE (%)
Birmingham Edgbaston	51.2	48.8
Birmingham Erdington	51.4	48.6
Birmingham Hall Green & Moseley	50.3	49.7
Birmingham Hodge Hill & Solihull North	51.6	48.4
Birmingham Ladywood	50.0	50.0
Birmingham Northfield	52.3	47.7
Birmingham Perry Barr	50.2	49.8
Birmingham Selly Oak	52.0	48.0
Birmingham Yardley	50.8	49.2
Sutton Coldfield	51.5	48.5

Census 2021 data estimates that there are approximately 28,804 residents in the city who identify as lesbian, gay, bisexual, queer and all other (non-heterosexual) sexual orientations.[10] As the 2021 Census did not include a specific category for gay men to self-identify, there is no official data on this population. However, based on population estimates, approximately 0.9% of Birmingham's male population—around 7,711 individuals—can be estimated to identify as gay or lesbian[11]. Approximately 7,826 residents in the city identify as gender different than that assigned at birth, 1,327 identifying as trans women.[12] However, there is very limited national, regional, or local quantitative data on the population of trans/non-binary groups, so it is believed these numbers may be underestimated.

The Census 2021 data also shows that ethnic communities make up 51.4% of the city's population. Of the 11 core cities in the UK, Birmingham has the highest percentage of residents from ethnic communities outside of London.[13]

Poor health disproportionately affects those experiencing poverty and social exclusion. Forty three percent of the population living in LSOAS1 in Birmingham are in the ten percent most deprived areas in England. Birmingham is the 7th most deprived local authority in England and the 3rd most deprived English Core City. Deprivation is most heavily clustered around the city centre as illustrated in Figure 2.

Figure 2: Map of Birmingham, Deprivation Decile. Source: Birmingham City Observatory, 2021



4. BIRMINGHAM MEN'S HEALTH NEEDS

HEADLINE STATISTICS

- Birmingham men are almost a third more likely (30%) to die prematurely than men across England
- Men living in the most deprived neighbourhoods in Birmingham, Ladywood are, on average, more than 3.5 times as likely to die prematurely than men living in Beckenham.
- Male baby born in Birmingham today can expect to live on average 4.6 fewer years than a female baby born
- men in Birmingham being 44% more likely to be smokers than women
- In Birmingham, for every 10 women that die prematurely from cardiovascular disease, a total of 23 men will die
- A Birmingham man is, on average, 46% more likely to have high blood pressure contribute to their death than a woman in Birmingham, and 37% more likely than an average man in England.
- Birmingham men 12% more likely than women to be diagnosed with diabetes across the city[14]
- Between 2019 to 2022, the male suicide rate (MSR) both nationally and locally have been steadily increasing at a similar rate.
- The emergency hospital admissions for intentional self-harm for males in Birmingham is higher than the England rate at 130.7 per 100,000
- The prevalence of alcohol dependency for males in Birmingham was 3.76 times higher than females in Birmingham between 2019-20
- The prevalence rate for illicit Opiate and/or Crack Cocaine Use (OCU) was 3.65 times higher for males in Birmingham compared to females, and substantially higher than the England rate

The following sub-sections explore key differences in health outcomes impacting life expectancy and quality of life for Birmingham's male population based on findings from the data and evidence reviews carried out as part of this project. As this phase of the project is underpinned by the objectives and ambitions of the APPG Proposed Men's Health Strategy, the data narrowly focuses on health outcomes for men in Birmingham and benchmarks them against the local female population or national average for men in England to understand where there is a need for greater intervention.

4.1 LIFE EXPECTANCY AND MORTALITY

KEY FINDINGS

Premature mortality refers to death before the 'average' life expectancy, which the Office for National Statistics deems to be 75 for England.

The premature mortality rate is the under-75 mortality rate from all causes. It is a good high-level indicator of the overall health of a population, being correlated with many other measures of population health. In other words, inequalities in many other important health parameters (e.g. cardiovascular mortality, cancer survival, suicide rates) all contribute to the premature mortality 'headline'.

Many of the causes of premature mortality are preventable, and significant differences in rates between different areas or between different groups can therefore be very instructive and help to target public health action.

Table 3

PREMATURE (UNDER 75) MORTALITY RATE, PER 100,000[15]	
England, males	420
England, females	267
Birmingham, males	553
Birmingham, females	328

As Table 3 (above) shows, males are significantly more likely than females to die prematurely, both nationally and locally – but this difference is noticeably greater at a local level (males 69% more likely to die prematurely) than at a national level (57% more likely).

Furthermore, the data shows that Birmingham men are almost a third more likely (30%) to die prematurely than men across England.

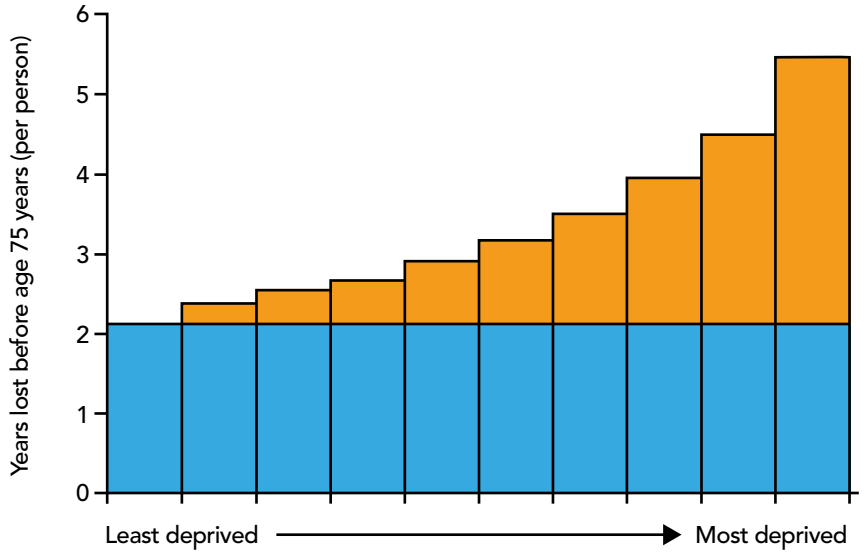
Of note, Birmingham has the 2nd highest rate of male premature mortality across the West Midlands (the highest rate is in Sandwell, marginally exceeding Birmingham at 564 per 100,000. The lowest rate across the region is in Lichfield, whose rate of 309 per 100,000 is almost half that of Birmingham (56%)).

Such large discrepancies in premature mortality rates clearly require explanation, and several important factors will become evident in the discussion of the six other areas of health need that follow this section.

It is likely that further variation in premature mortality rates might be found between smaller geographies across the city, but this data is unfortunately not available.

However, national data shows that premature mortality (for both genders) is strongly associated with deprivation, as illustrated in Figure 3.

Figure 3 - Premature mortality and deprivation in England [16]



Another key mortality indicator is life expectancy (which encompasses data from deaths at any age). As shown below in Table 4, the latest data confirms the pattern seen for premature mortality.

Table 4

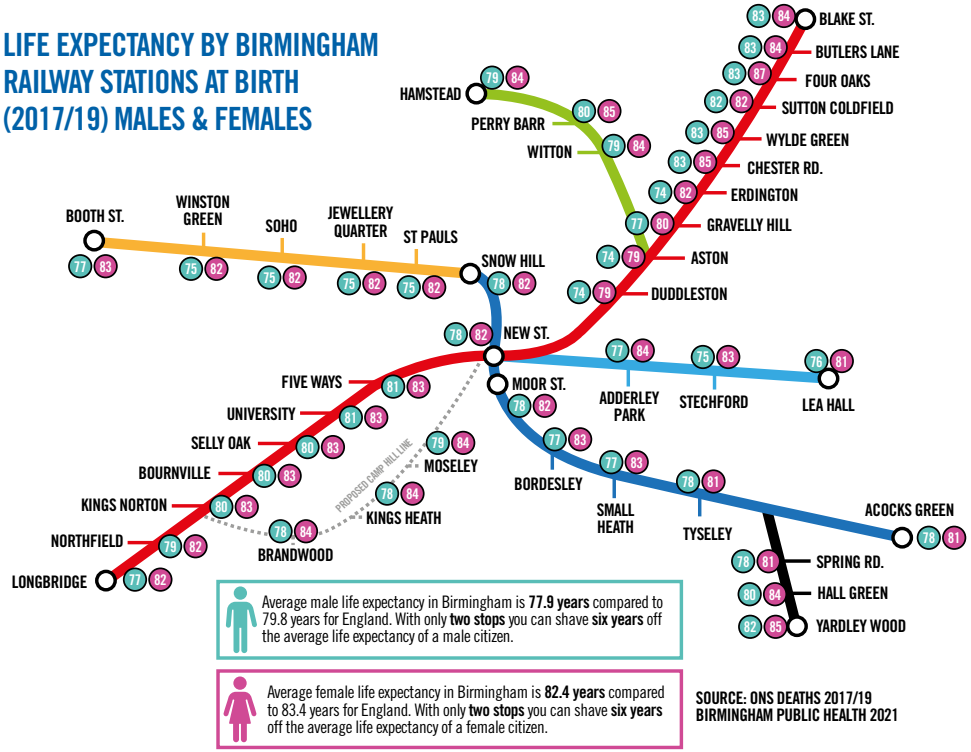
LIFE EXPECTANCY AT BIRTH (YEARS)[17]			
	Male	Female	Gap
England	79.3	83.2	3.9
West Midlands	78.7	82.6	3.9
Birmingham	77.2	81.8	4.6

This data shows that the life expectancy gap between males and females is nearly a fifth (18%) higher in Birmingham than at either regional or national level.

A male baby born in Birmingham today can thus expect to live on average 4.6 fewer years than a female baby born in the same city, and 2.1 fewer years than an average English male baby.

For life expectancy, we also have data to demonstrate further wide variation within Birmingham itself, and this is powerfully illustrated in the infographic developed by the Public Health Knowledge and Evidence team below. Using railway stations in Birmingham as a proxy for place, the map highlights the differences in health outcomes for men in Birmingham. Across nearly all stations, male life expectancy is lower than female, reinforcing the need for male-focused health interventions. Moreover, a male in Witton has an average life expectancy of 79, whilst a male in Sutton Coldfield has an average life expectancy of 82.

Figure 4 - Life expectancy by Birmingham railway stations at birth, 2017-2019 [18]



A final metric worth considering here is healthy life expectancy – since our aim should not only be to extend life, but also to increase its proportion lived in good health. Healthy life expectancy is the average number of years a new-born baby could expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

Table 5 shows the disparities between average healthy life expectancy for men across England and in Birmingham.

Table 5

LIFE EXPECTANCY AND HEALTH LIFE EXPECTANCY, MALES, 2018-2020[19,20]			
Area	Healthy life expectancy	Overall life expectancy	Proportion of life lived in poor health
England	63.1	79.0	20%
Birmingham	59.2	77.1	23%

LIFE EXPECTANCY AND HEALTH LIFE EXPECTANCY, FEMALES, 2018-2020[21,22]			
Area	Healthy life expectancy	Overall life expectancy	Proportion of life lived in poor health
England	63.9	83.1	23%
Birmingham	57.2	82.1	30%

This data shows that not only do Birmingham men have comparatively shorter lives than the national average, but they also encounter ill health at a younger age, and a greater proportion of their overall lifespan is spent in poor health. Compared to women in Birmingham, men have a lower overall life expectancy by 5 years.

Of particular note, the average male in Birmingham can expect to endure (self-reported) poor health almost 7 years before state pension age (currently at 66, but due to rise to 67 by March 2028).

CONCLUSIONS

Both locally and nationally, male life expectancy is shorter than female, and men are significantly more likely to die prematurely. Compared to the national male average, men in Birmingham have shorter lives, become unwell at a younger age, and spend a greater proportion of their lifespan in poor health. These findings reinforce the urgency of targeted, male-focused public health interventions and support the strategic commitments made by Birmingham City Council and the local Integrated Care Board. Achieving the ambition to halve the gap in healthy life expectancy by 2030 will require sustained, place-based action that addresses the wider determinants of health and prioritises the most affected communities.

The report's recommendations that follow aim to expand upon current system priorities.

4.2 CARDIOVASCULAR DISEASE

KEY FINDINGS

Figure 5 shows the five leading causes of death in males in England (2018 data). Despite declining since the mid-1960s, ischaemic heart disease (also known as 'coronary artery disease') remains the single most common cause of death for men nationally. Although there is no universally agreed definition of cardiovascular disease, it is usually taken to include stroke also – which is the fourth most common cause of male mortality.

Figure 5 – The 5 leading causes of death for males in England, 2018 [7]

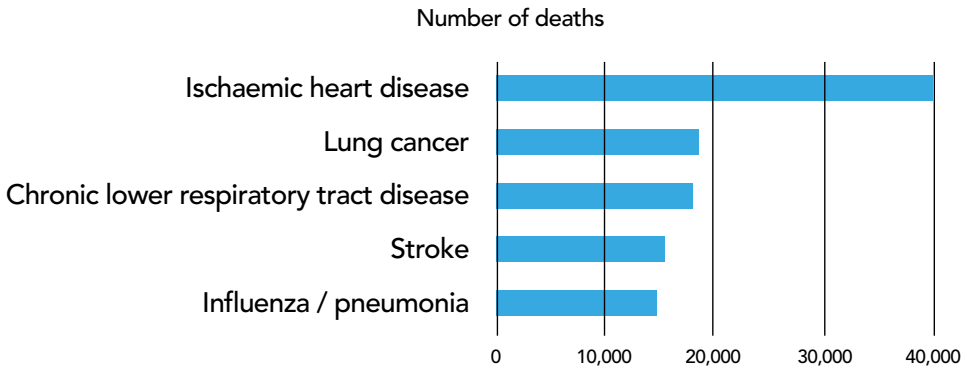


Table 6 compares premature mortality from cardiovascular disease across the genders and between England, the West Midlands and Birmingham.

Table 6

PREMATURE MORTALITY FROM CARDIOVASCULAR DISEASE / 100,000 (2023 DATA)[23]		
	Male	Female
England	109.4	47.3
West Midlands	120.4	55.2
Birmingham	146.1	62.5

At local, regional and national levels, men are clearly far more likely to die prematurely from cardiovascular disease than women. In Birmingham, for every 10 women that die prematurely from this cause, a total of 23 men will die. Furthermore, men in Birmingham are around 1/3 more likely to die prematurely than the average man in England from cardiovascular disease.

To understand this discrepancy, the risk factors for cardiovascular disease and their relationship with gender must be examined. Up to 80% of cardiovascular disease is estimated to be potentially preventable[24], with just nine modifiable risk factors accounting for 90% of cases of coronary artery disease[25].

These are as follows: hypertension, smoking, diabetes, poor diet, lack of exercise, psychosocial stress, high cholesterol, excess weight/obesity, and excess alcohol consumption.

Of these risk factors, the two most important are hypertension and smoking.

HYPERTENSION

High blood pressure (BP) is responsible for more than half of all heart attacks and strokes nationally (as well as being a risk factor for heart failure, kidney disease and vascular dementia).

In England, 31% of men and 26% of women have high BP.[26] It is estimated that over half of all people with high BP are not diagnosed and, of those that are aware of their condition, less than half have their blood pressure adequately controlled.[27] Table 7 shows mortality rates for deaths involving hypertensive disease.

Table 7

MORTALITY RATES FOR DEATHS INVOLVING HYPERTENSIVE DISEASE, 2020-2022, PER 100,000[28]

	Male	Female
England	166.5	118.5
Birmingham	228.5	156.8

A Birmingham man is, on average, 46% more likely to have high blood pressure contribute to their death than a woman in Birmingham, and 37% more likely than an average man in England.

SMOKING

Smoking is the most important cause of preventable ill health and premature mortality in the UK, causing 1/4 of cancer deaths, for example. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Smoking rates continue to fall locally and nationally, but recent data from the GP Patient Survey suggests that the overall prevalence of smoking amongst adults across Birmingham is higher than the national average (15.2% versus 13.5%).[29]

Within the UK population, men are nearly a third more likely to smoke than women (15.1% prevalence versus 11.5%).[30] Data from 2019 [31] for Birmingham showed a considerably wider gap locally (19.2% prevalence amongst men versus 13.3% amongst women – i.e. men being 44% more likely to be smokers than women).

We do not have a more recent gender breakdown for Birmingham, but NHS Health Check data provides supportive evidence of significantly higher rates amongst males, as shown in figure 6 (which also stratifies the data by ethnicity) and Figure 7 (which stratifies by deprivation). Figure 6 consistently shows higher smoking prevalence amongst men than women across all ethnic groups. Among men, White men have the highest smoking rates. Black and Asian men show lower smoking prevalence, though still higher than their female counterparts. This suggest that ethnicity intersects with gender in determining smoking behaviours. Those may also be influenced by cultural factors, more information can be found in the Birmingham Community Health Profiles.

Figure 6 – smoking prevalence amongst Birmingham and Solihull NHS Health Check attendees by gender and ethnicity, 2018-2023

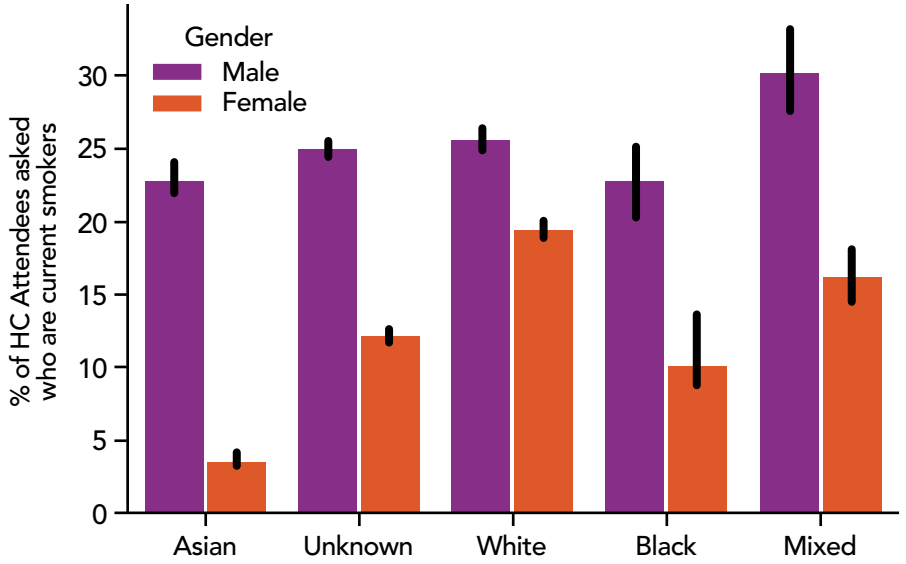
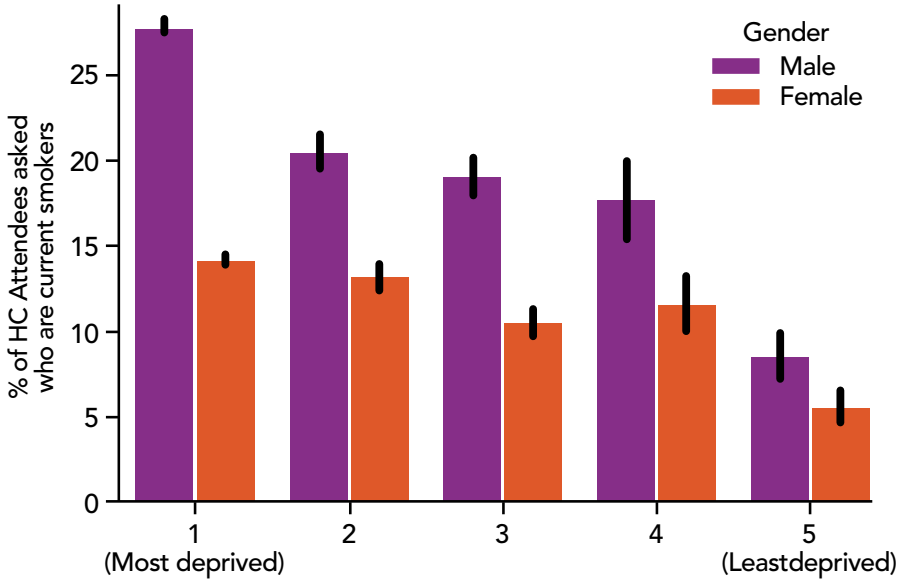


Figure 7 shows that men in more deprived areas have significantly higher smoking rates than those in less deprived areas. The gradient demonstrates clearly that as deprivation increases, so does smoking prevalence among men.

This highlights a strong link between socioeconomic status and smoking in men.

Figure 7 - smoking prevalence amongst Birmingham and Solihull NHS Health Check attendees by gender and deprivation, 2018-2023



Two key groups with particularly high rates of smoking are those with routine/manual occupations, and those with long-term mental health conditions. Table 8 shows how Birmingham compares poorly to the national average for both these groups.

Table 8

POPULATION GROUP	ENGLAND SMOKING PREVALENCE %[10]	BIRMINGHAM SMOKING PREVALENCE %[10]
Routine/manual occupation (18-64 yrs)	19.5	25.5
Long-term mental health condition (18+ yrs)	25.1	28.2

Smoking rates in Birmingham are notably higher than the national average among key vulnerable groups. 25.5% of adults in routine/manual jobs and 28.2% of those with long-term mental health conditions smoke, compared to 19.5% and 25.1% nationally. People in routine or manual jobs, as well as those living with long-term mental health conditions, are more likely to experience social and economic disadvantage, which contributes to higher smoking prevalence. Factors such as stress, limited access to support services, and targeted tobacco marketing make these groups particularly vulnerable, reinforcing existing health inequalities. This highlights a need for targeted smoking cessation efforts in the city.

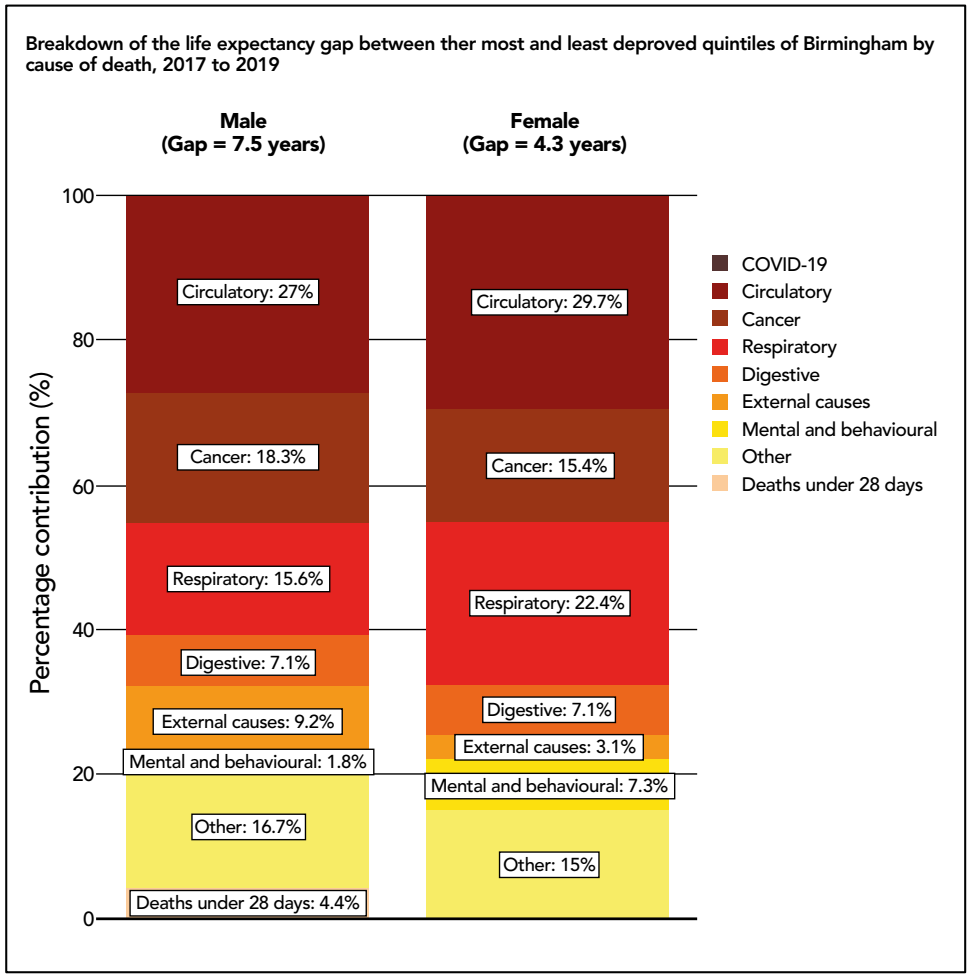
Data from Birmingham's 'Stop Smoking Service' for the last 2 financial quarters of 2024-25[32] show 764 males successfully quitting compared to 709 females. This is a limited data set but the difference between the genders (8%) is smaller than we might expect, given the likely differences in smoking prevalence – suggesting men may be under-represented. This therefore requires further analysis.

Based on the latest NHS Digital report for April 2024 to March 2025, Birmingham's self-reported quit success rate for those setting a quit date was approximately 28%, aligning with the national average for similar urban areas. However, the West Midlands region, which includes Birmingham, had one of the lowest regional quit rates at 42.3%[33], suggesting that local engagement and follow-through may be weaker compared to other regions. The report highlights that while smoking cessation services are effective, engaging smokers — especially during transitions like hospital discharge or in vulnerable groups—remains a challenge. Improving referral pathways and outreach could significantly enhance service uptake and quit success.

CARDIOVASCULAR DISEASE AND DEPRIVATION

Cardiovascular disease is the single largest cause of the inequality in life expectancy between the most and least deprived quintiles of the Birmingham population, as illustrated in figure 8, where circulatory illness account for 27% (over a quarter of the cause of death for men between 2017-19.

Figure 8



CARDIOVASCULAR DISEASE AND ETHNICITY

Figure 9 demonstrates that ischaemic heart disease is the leading cause of death for males (in England and Wales) of all ethnicities except Black Caribbean (where dementia accounts for a slightly higher level of mortality). Of note, this data shows that South Asian ethnicities (Bangladeshi, Indian and Pakistani) have higher heart disease mortalities than the White population (with Bangladeshi men having a 39% higher mortality rate than White men). Mortality from stroke (cerebrovascular disease) is also approaching double the rate amongst Bangladeshi males compared to White males.

Figure 9

Deaths registered in England and Wales, 2017-19, age standardised mortality rates per 100,000 for the most common leading causes of death for each ethnic group, males aged 10 years and above

	Heart diseases	Dementia	Respiratory diseases	Lung cancer	Influenza & pneumonia	Cerebrovascular diseases	Prostate cancer
White	157.9	121.6	73.8	70.9	64.7	62.3	52.4
Bangladeshi	219.1	97.6	76.3	80.6	42.7	112.6	
Indian	190.9	76.9	35.2	29.1	62.4	69.7	22.6
Pakistani	206.7	66.4	41.7	44.9	54.1	70.4	19.7
Asian Other	138.6	80.7	36.7	30.1	47.6	57.4	19.2
Black African	103.2	72	17.1	28.2	31.1	58.7	60.6
Black Carribean	116.2	122.2	36	58	41.8	66.8	88.2
Black Other	138.9	95	36.5	49.7	44.3	54.2	71.5
Mixed	188.4	111.1	72.8	80.6	51.4	71.8	50.3
Other	103.4	67.8	36.6	45.6	46.6	57.5	25.2

Source: Office for National Statistics - Mortality from leading causes of death by ethnic group

There is a lack of data available to determine whether Birmingham's relatively larger populations of global majority ethnic communities contribute to increased male mortality from cardiovascular disease.

CONCLUSION

Cardiovascular disease remains the leading cause of premature death among men in Birmingham, with local male mortality rates significantly exceeding both regional and national averages. Men in Birmingham are 33% more likely to die prematurely from CVD than the average English male, and for every 10 women who die prematurely from CVD, 23 men will. These disparities are driven by modifiable risk factors—particularly hypertension and smoking—which are more prevalent among men, especially those in deprived areas and vulnerable groups such as those with manual occupations or long-term mental health conditions.

Ethnic inequalities also compound the issue, with South Asian and Black men experiencing disproportionately high rates of heart disease and stroke. Despite the availability of services such as NHS Health Checks, smoking cessation programmes, and community-based initiatives like Million Hearts, male engagement remains low, highlighting the need for more targeted and culturally appropriate outreach.

Strategic priorities outlined in the Birmingham Health and Wellbeing Strategy and the Integrated Care System (ICS) Strategy provide a clear framework for action. These include reducing physical inactivity and smoking rates, improving uptake of preventative services, and addressing inequalities in CVD outcomes across ethnic and socioeconomic groups.

To meet these ambitions, Birmingham must prioritise: (1) enhanced case finding for hypertension and smoking; (2) equitable access to CVD checks in deprived areas; (3) culturally tailored interventions for high-risk ethnic groups and (4) robust evaluation of workplace and community-based programmes to engage harder-to-reach male populations.

These actions are essential to reduce the burden of cardiovascular disease and close the health gap for men in Birmingham.

RECOMMENDATIONS

THEME 1: CARDIOVASCULAR DISEASE		
Ref #	Recommendation	Lead Organisation(s)
1	Prioritise Action on Modifiable Risk Factors: Develop targeted interventions for preventing and reducing cardiovascular disease in men that should prioritise modifiable risk factors, particularly hypertension and smoking.	Birmingham & Solihull ICB
2	Improve Local Data Availability: Address critical gaps in local data, especially smoking prevalence by gender across Birmingham's localities.	Birmingham & Solihull ICB
3	Enhance Hypertension Case Finding: Evaluate existing programmes such as Million Hearts and NHS Health Checks to identify inequalities in access and uptake among sub-groups of men.	Birmingham & Solihull ICB supported by Public Health
4	Evaluate Workplace CVD Check Pilots: Explore the effectiveness of workplace-based CVD checks, with a focus on reaching under-served male populations, particularly those who do not typically attend NHS Health Checks.	Birmingham Public Health
5	Assess Smoking Cessation Services for Equity: Review current smoking cessation offers to determine their effectiveness in engaging men—especially those who are at a higher risk.	Birmingham Public Health
6	Ensure Cultural Appropriateness of Interventions Recognise and address the disproportionate impact of CVD on Black and South Asian men by ensuring all interventions are culturally appropriate. This includes exploring community-based initiatives, such as delivering health checks in mosques or through initiatives like the Black barber shop programme.	Birmingham Public Health

4.3 CANCER SCREENING AND SURVIVAL

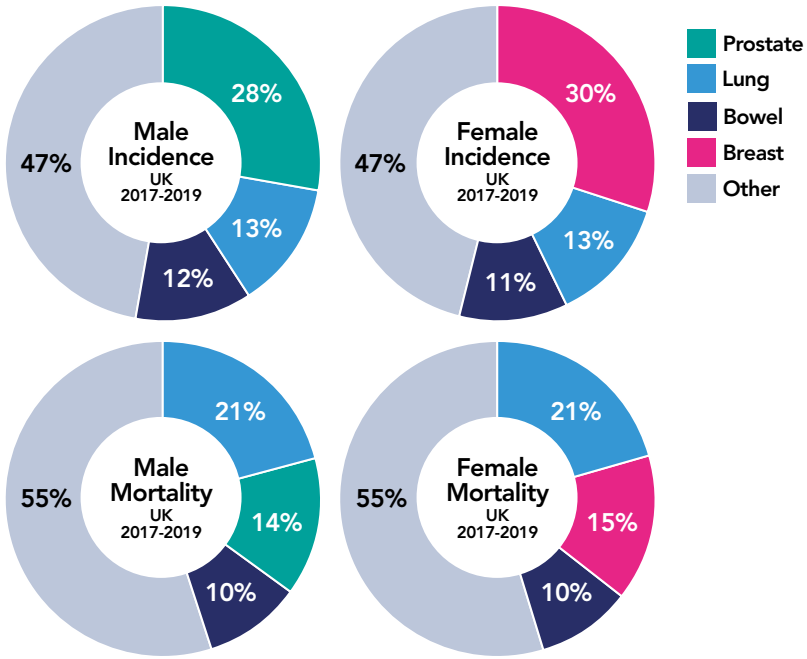
KEY FINDINGS

Cancer causes around one in four deaths in the UK [34], with more than half (54%) of all cancer deaths in the UK in people aged 75 years and over. Around half of people with cancer survive for at least 10 years. In both the UK and Birmingham, men are around 42% more likely to die from cancer than women [35] i.e. for every 10 women who die of cancer in a year, we can expect around 14 men to die.

In 2023, the average Birmingham man was nearly 9% more likely to die from cancer than the English average. From a public health perspective, around 38% of cancer is thought to be potentially preventable.

Figure 10 shows the most prevalent cancers for men and women in the UK in terms of incidence and mortality.

Figure 10 – UK cancer incidence and cancer mortality, by gender, 2017-2019[25]



As figure 10 shows, both bowel and lung cancers have similar incidence and similar mortality rates for both men and women. The major gender difference is that the 2nd most significant cause of cancer mortality for both sexes is gender specific – prostate cancer for men and breast cancer for women.

Encouragingly, cancer mortality is projected to decline for both men and women over the next 15 years[25], including decreases in mortality from all the major cancer types listed above. Only three cancer types are projected to show increases in mortality, of which by far the most important is liver cancer. Liver cancer mortality has increased 43.5% over the past decade.[36]

LIVER CANCER

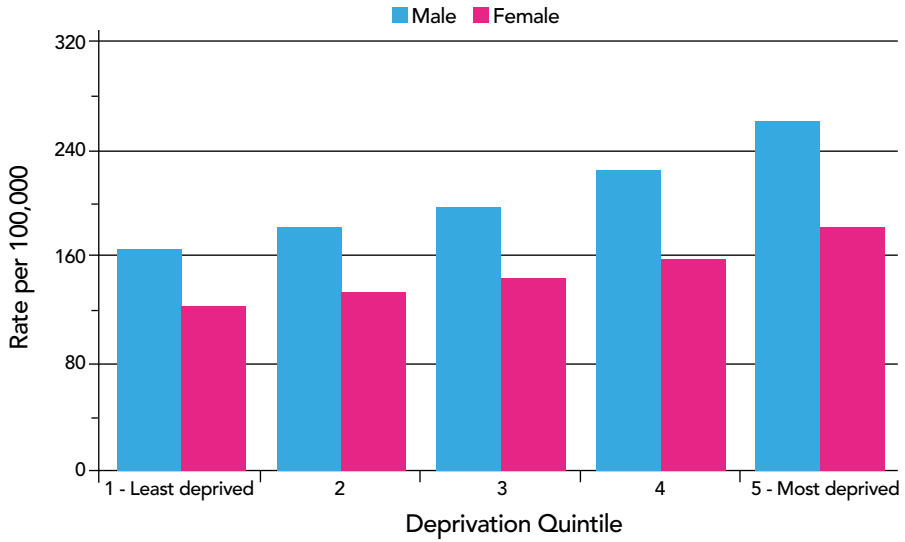
Liver cancer has shown the fastest increase in mortality (within the top 20 of cancer types) over the past decade in the UK – for both females and males (increased by 45% for females and 42% in males). It is currently in 8th position for men. Liver cancer incidence rates are 89% higher in males in the most deprived quintile than in the least.

Liver cancer usually develops in people with existing liver damage (cirrhosis), and the major causes of this damage are infections (10%), smoking (20%), alcohol (7%), and overweight and obesity (23%). It is noteworthy that three times more people will develop liver cancer due to being overweight than due to excess alcohol.

CANCER MORTALITY AND DEPRIVATION

Overall, cancer mortality is strongly correlated with deprivation for both sexes, as illustrated in figure 11. It is estimated that there are 19,000 extra deaths from cancer, per year, in England because of socio-economic variation.

Figure 11 – cancer mortality for England, 2007-2011, by deprivation quintile[25]



CANCER AND ETHNICITY

For all cancers combined, age-standardised rates in non-White minority ethnic groups are actually significantly lower than in the White population – with the exception of Black males where cancer incidence nationally is 14% higher than in White males.[25] This difference is driven by prostate cancer, the rate of which is roughly double in Black males compared to White males (Black men in the UK have a 1 in 4 lifetime risk of developing prostate cancer whilst White men in the UK have a 1 in 8 lifetime risk).[37]

Black men also develop prostate cancer at a younger age on average, are more likely to have advanced cancer (stage 3 or 4) at diagnosis and are more likely to die from it. Data from the National Prostate Cancer Audit from January 2019 – December 2023 shows that Black men aged 50 and over had more new prostate cancer diagnoses relative to population size than White and Asian populations in England. This was highest among Black men aged 70 to 74, with 17 new diagnoses per 1000 men.[38]

SCREENING PROGRAMMES FOR MEN

There are currently four screening programmes for which men may be eligible and these are outlined in table 9. Two programmes are concerned with cancers (bowel and lung).

Table 9 – National screening programmes for men in the UK

SCREENING PROGRAMME	DETAILS INCLUDING ELIGIBILITY
Abdominal aortic aneurysm (AAA)	Men only, one-off screening for all men over the age of 64. Involves ultrasound scan of abdomen
Bowel cancer	Both sexes, aged 50-74, every 2 years. Requires submission of stool sample – kits sent through post
Diabetic eye screening	Both sexes, from aged 12, everyone with diabetes invited for retinal scan every 1-2 years
Targeted Lung Health Checks	Both sexes, aged 55-74 who have ever smoked, initial risk assessment and then if required low-dose CT scan. The ICB and Targeted Lung Cancer Screening has also developed a homelessness pathway with a drop-in screening service to provide vulnerable populations access to this service.

We know that cancer screening uptake in Birmingham is among the country's lowest. For example, bowel cancer screening uptake (both genders) averages 72% of the eligible population across England, but the rate in Birmingham and Solihull ICS is just 64.8%[27] (the worst performing area in Birmingham (Nechells, Saltley and Alum Rock PCN) has an uptake of just 43.3%).

LUNG CANCER

The Targeted Lung Health Checks (TLHC) have only recently completed their pilot phase, and it is planned for them to be rolled out across the entirety of the UK by 2029. Individuals are invited to attend via a letter or phone call from their GP or other local NHS service.

Lung cancer causes more deaths than any other cancer in the UK, and long-term survival remains substantially low with an average 10-year survival of just 5% (compared to an average 10-year survival for all cancers combined of 50%). A major reason for this is that late diagnosis is unfortunately the norm for lung cancer – two thirds of cases are diagnosed at a late stage, when curative treatment is no longer possible.

2 years of (yet to be published) data from TLHCs in Birmingham have been shared by the ICB. As of January 2025, this data shows that almost 51,000 people have been screened thus far [39], with almost equal numbers of men and women (a ratio of 1.06:1) which is similar to the gender ratio for lung cancer incidence in the UK (1.05 :1).[40]

Most encouragingly, data shows that the majority of lung cancers detected were earlier stage cancers (stages 1 and 2), which are more amenable to curative treatment (74% were stage 1 or 2 in men, and 83% in women).

Alongside the 82 lung cancers detected thus far, the low dose CT scans have also detected other pathologies including seven other non-lung cancers (e.g. breast) and aortic aneurysms.

PROSTATE CANCER

The remaining major cancer for which there is not a national screening programme is prostate cancer – the 2nd most common cause of male cancer mortality. Large trials to date have failed to demonstrate a consistent mortality benefit from screening, and the UK National Screening Committee (UKNSC) continues to advise that the risks of screening outweigh any potential benefits. These risks include relatively high rates of false positives from PSA testing, complications from biopsy, potential overdiagnosis, uncertainty around best treatments and complications of treatments.

However, in recent years, there have been important advances in the field with the introduction of improved and safer diagnostic procedures (multi-parametric MRI and transperineal biopsy), and 'active surveillance' (rather than immediate aggressive treatment) of selected low-grade cancers. It is unclear at present whether these will alter the balance of risks and benefits sufficiently for UKNSC to recommend a national screening programme.

2025 will see the launch of the TRANSFORM trial, a £42 million trial comparing different tests for prostate cancer and their impact on cancer mortality. The trial has committed to ensuring that at least 1 in 10 of the men who are invited to participate are Black men. However, it will be several years before the results of this trial are known.

In the meantime, the UK operates an 'informed choice' approach, with NICE guidelines[41] stipulating that men over 50 can be screened with a PSA test - provided they request this from their GP and are given appropriate advice regarding the potential risks and benefits of testing. This tends to benefit men who know about the PSA blood test and know how to request one from their GP (frequently the more health literate and affluent).

NICE advises GPs not to proactively raise the issue of testing with asymptomatic men. However, there is a growing clinical consensus that men in higher-than-average risk groups (e.g. Black ethnicity or family history of prostate cancer) should be made aware of their risk and proactively offered testing[42]. A simple and rapid online risk checker has been developed by Prostate Cancer UK[43] and many organisations currently signpost men to this.

In the last few years, many local GP practices have undertaken prostate cancer case finding under the 'Early Cancer Diagnosis' Directed Enhanced Service (DES). Men at higher risk of prostate cancer were identified according to risk factors coded in their medical records, and they were then contacted and offered appropriate counselling and the opportunity for a PSA test. Unfortunately, this was removed from the DES in the last year, but there was a consensus opinion at the Advisory Group meetings that this had been a very promising approach.

Case study – Prostate cancer 'case finding' in General Practice
The Midlands Medical Partnership experience
With thanks to Dr Liz Gonalez and Dr Kay Crossman

The Midlands Medical Partnership is a General Practice 'super-partnership' formed in 2009 and caring for 72,000 Birmingham patients across 11 sites.

As part of the 'Early Cancer Diagnosis' Directed Enhanced Service, the practice decided to take steps to increase the uptake of PSA testing amongst Black men on their register.

Using medical records, they identified all Black men aged 45 or over, who had not previously had PSA testing. These men were then sent information, including a link to the PCUK risk checker[26], and invited to book an appointment.

At these appointments they were then counselled about PSA testing and offered the opportunity to have the test. Initially these risk conversations were undertaken by doctors, but latterly nurses and health care assistants (HCAs) were also trained up to be involved.

Prior to this initiative, annual PSA testing uptake amongst Black Caribbean men registered with the practice was 16% (2021/2022). 2 years later – with the introduction of the proactive case-finding, uptake had risen to 39%.

Case study – Using a walking football tournament to improving health screening amongst Black men in Birmingham "Brothers Helping Brothers 2024" With thanks to Michael Brown, Director, Mindseye Development CIC

This walking football tournament – branded as the 'Cyrille Regis Tournament' (in honour of the famous footballer - a well-known and much-loved Black man from the local community) – was aimed at Black men aged over 40 in Birmingham and took place at Aston Villa Academy on 3rd February 2024.

The intention was to use football as the 'hook' to attract men to attend, and then to offer them on-site counselling for prostate cancer screening. In addition, a number of other stands were set up to offer a more comprehensive 'health MOT' – including blood pressure checks, BMI checks, tests for diabetes, smoking cessation advice and vaccinations.

This was the first year of running the event, and it is hoped to scale up the offer this coming year with the aim of reaching even greater numbers of local Black men.

Case study – 'Meeting men where they are' with cancer screening NHS Birmingham and Solihull ICB – 'Cancer Bus Tour' 2nd – 6th September 2024

A 6-day outreach campaign was conducted using a red double-decker bus, which travelled through economically disadvantaged areas of Birmingham and Solihull raising awareness of cancer screening and early diagnosis. It was originally planned to be a 5-day tour, but an additional date was added at the Birmingham Open Markets aiming to showcase this exciting initiative to the Secretary of State and the Chief Executive Officer of NHS England.

The locations were carefully selected based on Birmingham Community Health Profiles data, aiming to engage with communities most impacted by health inequalities.

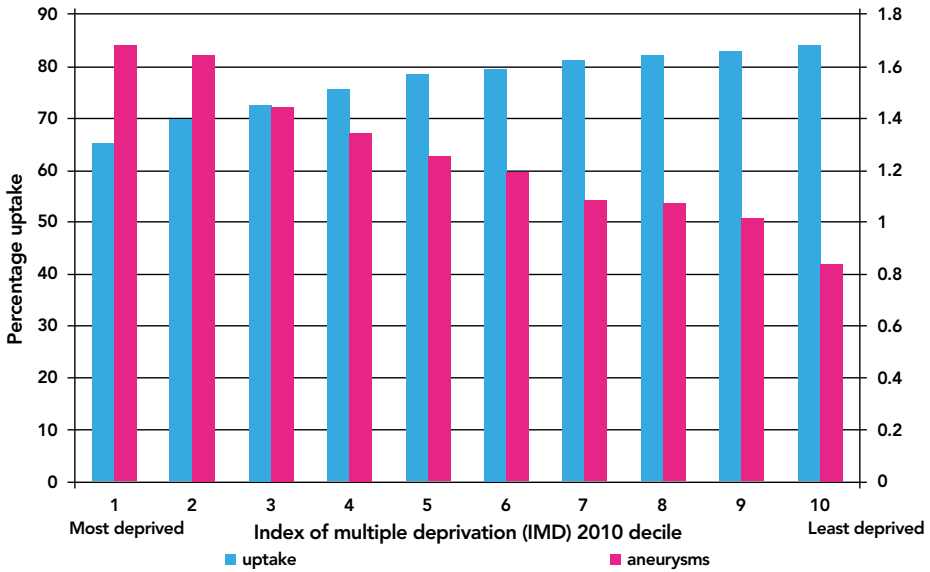
Around 1/3 of attendees over the 6 dates were male[44].

Around 1 in 5 attendees disclosed that they did not attend routine screening appointments, citing reasons such as fear and stigma.

INEQUALITIES IN SCREENING

Screening inequalities can manifest themselves at any point along the screening pathway – from cohort identification (invitation) through to access to screening, and onwards to referral and eventual outcomes. Figure 12 shows inequalities in uptake of AAA (Abdominal Aortic Aneurysm) screening in England by deprivation, with a clear social gradient.

Figure 12 – uptake of AAA screening with prevalence of AAA by deprivation index (IMD 2010 decile), 2013-2015[45]



Any intervention to improve screening uptake for men in Birmingham must also tackle existing inequalities due to deprivation and ethnicity, for example.

CONCLUSIONS

Men in Birmingham experience significantly worse cancer outcomes than women and men nationally, with higher mortality rates and lower screening uptake. These disparities are particularly pronounced among Black men, who face elevated risks for prostate cancer, and in deprived communities where late-stage diagnosis is more common. While local outreach initiatives have shown promise, systemic barriers such as stigma, low health literacy and unequal access persist.

The Birmingham Health and Wellbeing Strategy and ICS Strategy both commit to improving early diagnosis, increasing screening uptake, and reducing inequalities by 2030. Achieving these goals will require targeted action to improve data insight; expand culturally tailored outreach; and strengthen primary care engagement to ensure equitable access to cancer prevention and early detection services for all men in the city.

RECOMMENDATIONS

THEME 2: CANCER		
Ref #	Recommendation	Lead Organisation(s)
7	Improve data collection and insight for male screening programmes • Commission detailed analysis of uptake for the four male screening programmes (AAA, bowel, lung, and prostate-related case finding). • Disaggregate data by gender, ethnicity, deprivation, and smaller geographies. • Use findings to identify gaps and inform targeted interventions. • Follow up with qualitative research to explore reasons for disparities in uptake.	Birmingham & Solihull ICB & Birmingham Public Health
8	Expand Prostate Cancer Awareness and Case Finding • Recognise the absence of a national screening programme and prioritise local action. • Scale up successful local interventions targeting high-risk men (e.g. Black men, those with a family history). • Use community-based approaches such as trained ambassadors, culturally tailored messaging, and trusted venues (e.g. churches, barbershops).	Birmingham & Solihull ICB, WM Cancer Alliance

THEME 2: CANCER		
Ref #	Recommendation	Lead Organisation(s)
9	Extend Mobile Outreach Models • Build on the success of the ICB Cancer Bus and Targeted Lung Health Checks. • Explore other services that could benefit from mobile delivery (e.g. prostate awareness, AAA promotion). • Ensure strategic location selection, focusing on areas of low uptake and high deprivation. • Incorporate innovative venues such as mosques, sports clubs, and community centres to reach traditionally underserved groups.	Birmingham & Solihull ICB, Community Organisations
10	Tackle Stigma and Build Trust • Develop targeted communication campaigns that address stigma, myths and mistrust. • Involve community voices and lived experience to make messaging authentic and impactful.	Birmingham Public Health, Community Leaders
11	Mobilise Primary Care Networks • Engage the six Cancer Clinical Lead GPs in Birmingham in all relevant initiatives. • Activate Cancer Champions within GP practices to support outreach and reduce barriers. • Address perceived access issues, such as difficulty booking appointments, through staff training and patient navigation support.	GP Practices, PCNs, Birmingham & Solihull ICB

4.4 DIABETES & OBESITY

KEY FINDINGS

DIABETES

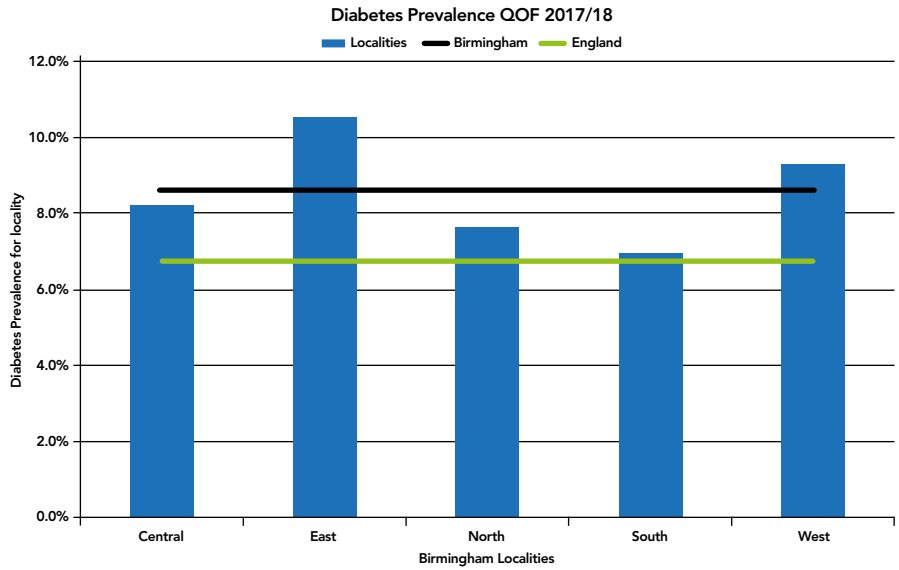
More than 5.6 million people are living with diabetes in the UK (4.4 million diagnosed and an estimated additional 1.2 million people yet to be diagnosed)[46].

Quality and Outcomes Framework (QOF) data from General Practice shows that Birmingham has a nearly 1/5 higher adult prevalence of diabetes than England overall [47]– (9.2% versus 7.7%).

Figure 13 shows that this higher prevalence applies to all areas of Birmingham, with East Birmingham having the highest rate (10.25%).

Nationally, men are 25% more likely to be diagnosed with type 2 diabetes than women. However,, interestingly, in Birmingham the gender discrepancy is less marked, with men only 12% more likely than women to be diagnosed across the city[14].

Figure 13 – Diabetes QOF prevalence for Birmingham localities 2017/2018[48]

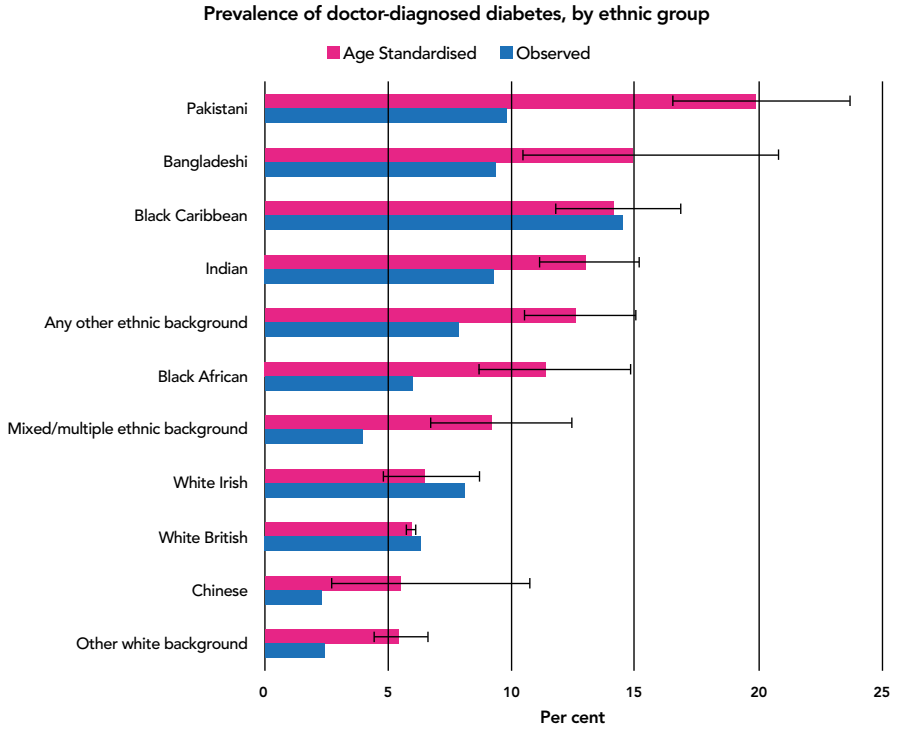


There is a key relationship between the burden of diabetes and ethnicity. People of Black and South Asian ethnicity are more likely to be diagnosed with diabetes as shown in Figure 14. Compared to the White population they are also:

- At risk of developing diabetes at a younger age (with risk thought to increase significantly from age 25, rather than above the age of 40 as in White populations)
- More than twice as likely to be diagnosed with pre-diabetes[49]
- More than twice as likely to have as yet undiagnosed diabetes[15]

South Asian communities have also been shown to have the highest rates of diabetic retinopathy – a complication of diabetes.[50]

Figure 14 – Prevalence of doctor-diagnosed diabetes by ethnic group[15]



Nationally, 24% of people with diabetes are recorded as being of minority ethnic origin, but this figure is more than double in Birmingham – 52.4%[14]. This clearly reflects the city's ethnically diverse population. What is less clear from the data is the extent to which this demography explains the overall higher rates of diabetes in Birmingham compared to England, or whether other factors are at play.

OBESITY

Obesity is a global and complex public health concern. It is associated with reduced life expectancy and is a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, at least 12 kinds of cancer, liver, and respiratory disease, and can also impact on mental health. The risk and severity of these diseases increases with a higher body mass index (BMI).

Between 2022-23, 39.2% of Birmingham residents are overweight (BMI 25-<30) (compared to 37.8% in England), and 25.9% are obese (BMI 30+) (compared to 26.2% in England)[51]

There is a clear relationship between obesity and deprivation, as illustrated in figure 15. People in the most deprived areas are 64% more likely to be obese than those in the least deprived.[52]

Figure 15 – Overweight and Obesity Among Adults in England, Health Survey for England[53]

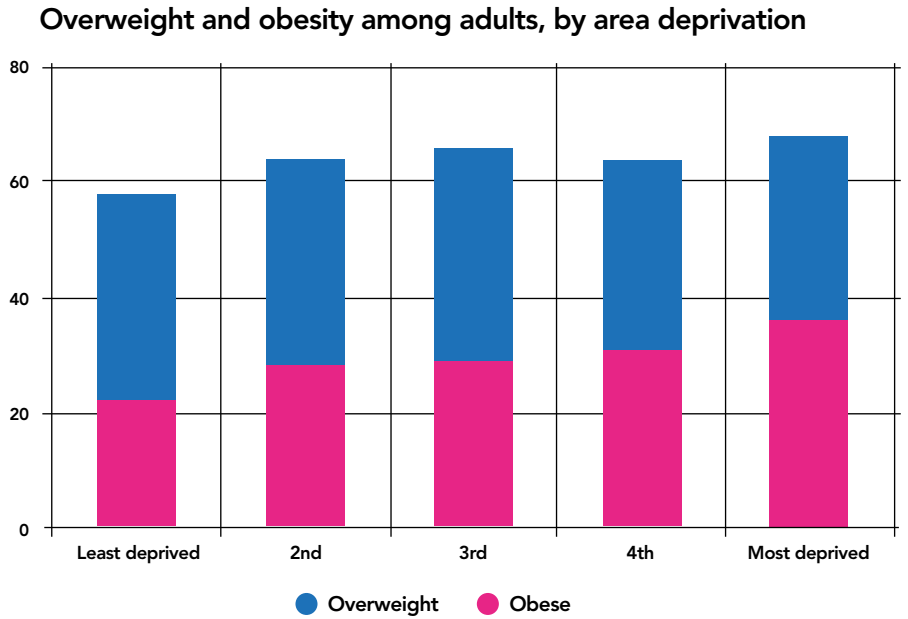


Table 10 shows how overweight/obesity affects men and women across England – unfortunately data is not available by gender for Birmingham. Men are about 10% more likely to exceed a healthy BMI than women, with this being driven by greater numbers in the 'overweight' category.

Table 10 – prevalence of overweight/obesity in England by gender, 2022[18]

CATEGORY	MALES PREVALENCE (%)	FEMALES PREVALENCE (%)
Overweight	39	31
Obese	28	30
Combined	67	61

CURRENT SERVICES IN BIRMINGHAM

NHS Health Checks do more than just screen for diabetes and measure BMI. They are a comprehensive cardiovascular risk assessment offered to adults aged 40 to 74 who are not already diagnosed with certain pre-existing conditions (such as heart disease, stroke, diabetes, or kidney disease). The aim is to identify early signs of these conditions and support individuals to reduce their risk through lifestyle changes or medical intervention.

National Diabetes Prevention Programme – can be referred by GP or self-refer via website if they have been diagnosed with prediabetes (HbA1c 42-48). A free, peer-support programme to help individuals make sustainable, healthy lifestyle changes.

NHS Type 2 diabetes 'Path to Remission' programme – joint initiative between NHS and Diabetes UK – provides a 12-week programme of low calorie, total diet replacement treatment and support for people who are living with type 2 diabetes and obesity or overweight. Can be referred by GP or secondary care.

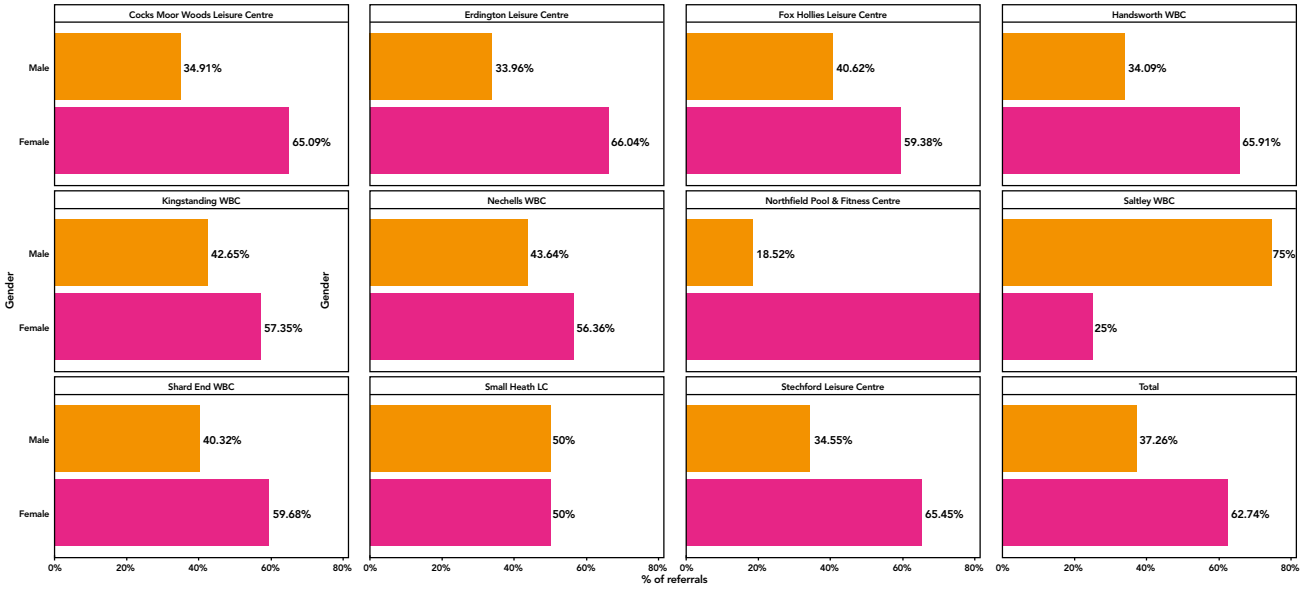
Weight loss services are ordered into 4 tiers –

- Tier 1: universal interventions – focusing on prevention and reinforcement of healthy eating and physical activity messages
- Tier 2: lifestyle weight management services – delivered by local community weight management services, that provide community-based diet, nutrition, lifestyle and behaviour change advice. Commissioned by Birmingham City Council
- Tier 3: psychology led specialist weight management services – clinics to support non-surgical intensive medical management with a multi-disciplinary team approach
- Tier 4: consultant led bariatric surgery

Adult weight management app (Healum) – (this is Birmingham's Tier 2 weight management service) - a comprehensive 12-week adult weight management programme delivered via a mobile app (a self-referral service available to anyone age 16 and above with a BMI over 25). Delivery via an app may potentially remove some of the traditional barriers to access, although only for those who are digitally literate.

Be Active+ Exercise Referral Scheme (requires GP referral) – available to sedentary or inactive individuals aged 14 and over, registered with a Birmingham GP, and have an existing health condition or other risk factors for disease. The programme is 12 weeks long and offered at a number of leisure facilities across the city (provides access to free swimming, gym-based exercise and fitness classes). Figure 16 shows that in 10 out of the 12 Birmingham areas where the scheme has been operating female referrals have outnumbered male referrals over the last 5 years. It may be informative to investigate why higher male referrals have been achieved in the key outliers – Saltley Wellbeing Centre.

Figure 16 – BeActive+ referrals by area of Birmingham and by gender (2018-2023)[54]



NHS Digital Weight Management Service (requires GP or pharmacist referral) – supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both. It is a 12 week online behavioural and lifestyle programme that people can access via smartphone or computer.

MAN v FAT – founded in 2014 by a writer, Andrew Shanahan, in Solihull who was struggling with his weight but was frustrated at how local slimming clubs were aimed at women. Now over 150 MAN v FAT football clubs with weekly sessions across the UK. Launch of MAN v FAT rugby in 2024 also.

Case study – increasing physical activity among men
The Aston Villa Foundation and 'FitVilla'
With thanks to Aimee Jefferson and Neil de Costa

The Fit Villa programme was a lifestyle behaviour change programme for overweight and obese football supporters aged 35-65, run by the Aston Villa Foundation, to help fans improve their fitness, health, and overall lifestyle.

It provided men with a space where they could share experiences and support each other in a group setting with individuals that had similar interests. The programme leveraged Aston Villa Football Club's branding to appeal to fans and the broader community. It was delivered at Villa Park for 12-weeks and combined physical fitness sessions with educational workshops.

"It's been fantastic, I've lost nearly two-stone during the programme"

"I met some good guys who all wanted to do the same thing"

"It's a lifestyle change, not just losing weight in the short-term"

"I've managed to drop 22lb in the first 6 weeks of the course with another 6 weeks to go."

The success of the programme demonstrated how sports clubs can play an active role in improving community health and wellbeing.

CONCLUSIONS

Men in Birmingham face a higher burden of diabetes and obesity compared to national averages, with prevalence particularly elevated among ethnic minority groups and those living in deprived areas. While services such as NHS Health Checks, weight management programmes, and physical activity schemes are available, male engagement remains lower than expected, especially in community and referral-based interventions.

The Birmingham Health and Wellbeing Strategy and ICS Strategy both prioritise reducing obesity, increasing physical activity, and improving diabetes outcomes by 2030. To meet these ambitions, Birmingham must strengthen data collection, improve service accessibility, and tailor interventions to better engage men—particularly those from high-risk groups and underserved communities.

RECOMMENDATIONS

THEME 3: DIABETES & OBESITY		
Ref #	Recommendation	Lead Organisation(s)
12	Develop and Maintain a Directory of Services • Create an up-to-date, accessible directory of diabetes and weight management services across Birmingham. • Include details on target audiences, referral pathways, eligibility criteria, and contact information. • Promote the directory to GPs and other professionals to support social prescribing and improve service navigation.	Birmingham & Solihull ICB & Birmingham Public Health
13	Improve Data Collection and Monitoring • Strengthen data collection on service uptake, including NHS Health Checks and digital tools like the Healum app. • Ensure data is disaggregated by gender, ethnicity, and language spoken. • Use insights to identify gaps in access and inform targeted outreach strategies.	Birmingham Public Health and NHS Health Checks Providers
14	Adopt a Nuanced Approach to Obesity Terminology and Intervention • Reflect emerging evidence by distinguishing between preclinical obesity (risk factor) and clinical obesity (chronic disease). • Tailor public health and NHS interventions, accordingly, recognising the different needs and risks of each group. • Avoid stigmatising language and promote inclusive, evidence-based messaging.	Birmingham Public Health
15	Ensure Equity in Referral Criteria and Clinical Practice • Promote awareness among clinicians of NICE guidance on adjusted BMI thresholds for ethnic minority groups (e.g. 27.5 for Black, Asian and minority ethnic populations). • Monitor referral patterns to assess whether these adjustments are being applied in practice. • Provide training and resources to support equitable decision-making	GP Practices, PCNs, BSol ICB
16	Assess the Impact of GLP-1 Agonist Drugs on Health Inequalities • Monitor uptake and outcomes of new weight loss medications (e.g. semaglutide, tirzepatide) across different population groups. • Evaluate gender differences and potential disparities in access, adherence, and effectiveness. • Use findings to inform equitable rollout and support strategies.	Office for Health Improvement & Disparities
17	Increase Male Engagement in Physical Activity Programmes • Investigate low male referral rates to BeActive+ across Birmingham. • Conduct qualitative research to understand barriers and preferences. • Re-shape programme design and promotion to better appeal to men, including through male-focused messaging and community partnerships.	Birmingham Public Health, Physical Activity

Ref #	Recommendation	Lead Organisation(s)
18	Address Structural Drivers of Obesity • Ensure obesity strategies go beyond individual behaviour change to address systemic factors. • Advocate for policies that regulate unhealthy food environments and tackle commercial determinants of health. • Collaborate across sectors to create healthier environments and reduce the impact of the obesogenic landscape.	Birmingham Public Health, Birmingham & Solihull ICB

4.5 MENTAL HEALTH

KEY FINDINGS

Men's mental health remains a critical public health concern, with evidence from the All-Party Parliamentary Group (APPG)[55] on Men's Health highlighting persistent disparities in mental health outcomes, help-seeking behaviours, and suicide rates. The report emphasises that men are less likely to seek professional support, more likely to engage in high-risk coping mechanisms such as substance use and continue to face barriers in accessing appropriate mental health services.

Generally, Birmingham has a significantly higher estimated prevalence of common mental health disorders, depression and anxiety prevalence and claimants for mental and behavioural disorders are higher than the national average.[56] 1 in 4 adults in Birmingham experience a mental health illness.[57]

DIFFERENCES IN MENTAL HEALTH OUTCOMES BETWEEN MEN AND WOMEN

Between 2015 and 2017, whilst the suicide rate in Birmingham was the lowest among the core cities, the male rate is similar to the England average.[58] Between 2019 to 2022, the male suicide rate (MSR) both nationally and locally have been steadily increasing at a similar rate. MSR in Birmingham was 14.1 per 100,000 between 2019-2021 and MSR nationally was 15.9 per 100,000, significantly higher than the national female suicide rate of 5.2 per 100,000.[59]

In Birmingham and Solihull, an audited sample of suicides between 2016-21 found that 79.1% of suicides were amongst men (53 of 67).[60] Males continued to account for around three-quarters of suicide deaths registered in 2023 in England and Wales (4,506 male deaths; 1,563 female deaths).[61] The age-specific suicide rate nationally was highest for males aged 45 to 49 years (25.5 deaths per 100,000), compared to the general population average of 11.4 deaths per 100,000 people.[62]

Additionally, the emergency hospital admissions for intentional self-harm for males in Birmingham is higher than the England rate at 130.7 per 100,000 and 109.2 per 100,000 respectively.[63] This is a clear indication that targeted intervention for mental health support and suicide prevention for men is needed within the city.

Birmingham City Council's Mental Health team published a citizen survey on Mental Health in 2024 using WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale) questions. Out of 307 respondents, only 76 identified as male. Whilst only 25% of men responded to the survey, 82% of male respondents said that affordable, healthy housing was important for mental health, 50% also replied it was important for employers to create healthy workplaces and 25% responded the need for debt management support. A higher proportion of men than women, 58% and 50% respectively, said that intergenerational cafes were needed to address loneliness in old age. Over 50% of male and female respondents felt that investment in mental health training was needed.

BARRIERS TO MENTAL HEALTH CARE FOR MEN

Depression in men is often underdiagnosed due to differences in how symptoms manifest compared to traditional diagnostic criteria. Many men do not exhibit classic signs such as persistent low mood or withdrawal but instead experience atypical symptoms [64] , which can lead to misdiagnosis or missed opportunities for early intervention. The British Journal of Guidance and Counselling (2019) published report in recognising these variations to detect and improve mental health outcomes amongst men.

These include:

- Behavioural and Emotional Manifestations: Irritability and Anger - Rather than appearing sad, many men express distress through sarcasm, frustration, or outbursts of anger. These behaviours may be mistaken for personality traits rather than signs of underlying depression.
- Physical Symptoms and Misdiagnosis: Unexplained Aches and Pains - Depression in men is often linked to a heightened experience of physical discomfort without a clear medical cause.
- Continued Productivity: Unlike the stereotype of withdrawal and inactivity, some men with depression remain highly active in their work or fitness routines, making their struggles less visible. Overworking, excessive exercise, or engaging in high-risk activities can serve as coping mechanisms, preventing recognition of mental distress.
- Health system challenges: Lack of male-focused mental health services
- Healthcare Bias: Mental health professionals may overlook depression in men who do not fit conventional diagnostic models, particularly if they appear functional in daily life.

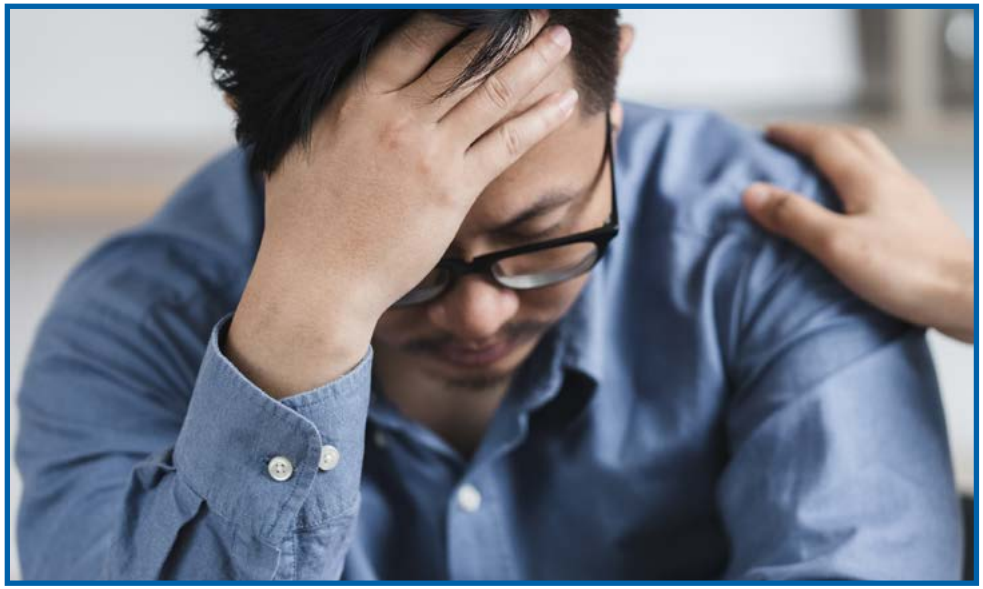
RISK FACTORS: AGE AND ETHNICITY

Ethnicity: Black Caribbean and Black African individuals face a higher risk of being treated for severe mental illnesses, including schizophrenia and mania. Data from the ONS on age-standardised suicide rates (ASMR) per 100,000 by ethnic group highlights concerning disparities. Suicide rates were the third highest among Black Caribbean males (ASMR 10.0, 7.7-12.7), following White and Mixed/Multiple ethnic groups, as well as the Black Other category. Among Black Caribbean females, the ASMR stood at 3.3 (2.2-4.7), within a broader range of 7.1 (Mixed) to 1.3 (Pakistani), compared to an overall ASMR of 4.7 for all females.[65]

In 2019, Chinese men had the lowest scores on the Warwick-Edinburgh Mental Wellbeing Scale (50.8) across all ethnic groups in England, scoring significantly lower than Chinese women (52.3).[66,67]

Sexual Orientation: In a 2016 study, 21% of gay men and MSM (men who have sex with men) reported being depressed, 17% were anxious, 7% had self-harmed and 3% had attempted suicide within the last 12 months.[68]

These disparities underscore the need for culturally responsive mental health support tailored to the specific challenges faced by different ethnic groups and sexual orientations.



UNEMPLOYMENT, JOB INSTABILITY, FINANCIAL STRESS

As of January 2025, Birmingham has the highest claimant unemployment rate (14.5%) amongst the core cities, well above the UK average (5.1%).[69] Unemployment poses significant health risks beyond financial hardship, with strong evidence linking it to poorer mental and physical health outcomes. Unemployed individuals face higher mortality rates and increased prevalence of mental health disorders.[70] These negative health effects persist even after adjusting for factors such as social class, poverty, age and pre-existing health conditions.

Suicide has complex causes, but Samaritans research highlights strong links between deprivation, financial insecurity and unmanageable debt, and an increased risk of suicide in men. Studies also show that 66.1% of adults aged 16 to 64 receiving Employment and Support Allowance (ESA) have a common mental health condition, and nearly half of ESA claimants have attempted suicide at some point.[71] A health audit of over 2,500 homeless people in England in 2014 found much higher prevalence of mental health issues. In 2019, 88.3% of total deaths amongst the homeless and rough sleeping population nationally were male.[72]

SOCIAL ISOLATION AND LONELINESS: IMPACT ON EMOTIONAL WELL-BEING

Loneliness is now understood to be a social determinant of health and a public health priority.[73] Older men in the UK face distinct challenges in coping with loneliness, often shaped by masculinity norms and key life transitions such as retirement, widowhood and separation.[74] Older adults represent the largest group of one-person households in the UK [75], with living alone recognised as a risk factor for loneliness, though not always synonymous with social isolation.[76] Many older men struggle to seek help due to traditional expectations of self-reliance and stoicism, often delaying support until reaching a crisis point.[77]

Group-based interventions, such as Acock's Green Men's Sheds (detailed in chapter 5), have shown potential in reducing loneliness. Addressing loneliness in older men requires tailored public health strategies that challenge restrictive masculinity norms, promote accessible social support, and recognise the varied ways men experience and manage loneliness.[78]

MASCULINITY AND MENTAL HEALTH: THE INFLUENCE OF GENDER NORMS ON HELP-SEEKING BEHAVIOURS

The rise of Andrew Tate as a role model for many boys and men highlights not only the persistence of toxic masculinity but also its growing appeal among the younger generation in the UK—a concern explicitly noted in a report by the British Medical Association.[79] Masculinity norms that define socially accepted ways of "being a man" emphasise control, stoicism, emotional restraint, risk-taking, hypersexuality, and aggression. Research shows that these norms are widespread and have harmful effects on men's health and well-being. Masculinity-related behaviours — including poor diet, tobacco and alcohol use, occupational risks, unsafe sex, drug use and reluctance to seek help - contribute to over half of all premature male deaths and 70% of men's illnesses. Young men and boys are especially vulnerable, displaying distinct health risks and lower engagement with health services compared to adult men and young women.[80]

The research highlights that toxic masculinity traits are linked to clear negative effects, including mental health issues. Across the life-course, these can contribute to school difficulties, legal troubles, substance abuse, tobacco use, violence, and sexual aggression.[81] The impact on veterans and men with disabilities have been explored in the 2021 Health Wellbeing of Veterans Deep Dive [82] and the 2024 Learning Disabilities Deep Dive [83].The relationship between men's mental health and substance abuse is explored in the following chapter.

Case Study: Birmingham County FA Mental Health League

The newly set up league includes a variety of teams from the Midlands area, ranging from Aston Villa to Alvechurch and West Brom to Walsall. There are now 12 different teams that play in a monthly league. Various partners have participated in providing health advice / screening alongside the matches – including discussions around cancer, blood pressure and substance misuse. Team Talk consists of regular 5-a-side football tournaments alongside informal workshops and activities that share information on supporting mental health issues. The programme is completely free of charge for all participants and aims to improve the health and wellbeing of men living in the Sandwell Borough.

"A lot of people keep things bottled up, but social events like Team Talk mean you've always got someone you can talk to, which a lot of men don't do enough," said Jordan, a regular Team Talk participant.

"I would recommend it to anyone if they are struggling. Just reach out, there is always someone there who can help you."

CONCLUSIONS

Successful mental health interventions for men require accessible, culturally relevant, and engaging approaches that account for gender-specific barriers to help-seeking. Schools serve as key intervention spaces, where group-based programmes incorporating interactive methods, media, and sports can foster healthy gender norms and social connections. Training school staff in gender awareness further enhances the sustainability of these efforts.

Additionally, creating safe, male-friendly spaces is crucial, as it allows for peer-support to be fostered. It also helps to counter barriers in traditional mental health services which are perceived by men to be unwelcoming or feminised. Delivering interventions in culturally familiar settings or physical activity, such as barbershops and community hubs, ensures greater comfort, trust, and engagement. By embedding mental health support within spaces that align with men's lived experiences, interventions can overcome stigma, improve engagement and promote long-term mental well-being.[84]

RECOMMENDATIONS

THEME 4: MENTAL HEALTH		
Ref #	Recommendation	Lead Organisation(s)
19	Develop Peer Support Networks in Community Settings • Use activities men already engage in — such as sports clubs, gyms, creative arts, or local community hubs — as vehicles for mental health engagement. • Facilitate peer support networks that encourage open conversations, reduce isolation, and provide mutual encouragement. Partner with grassroots organisations to deliver programmes in trusted, non-clinical spaces.	VCSE organisations supported by BCC Public Health and the Bsol Mental Health Collaborative
20	Strengthen Training and Education for Mental Health Professionals • Strengthening understanding of mental health professionals in specifically men's mental health. • Develop mandatory cultural competency training for mental health staff to address the specific needs of Black, South Asian, and other ethnic minority groups, co-designed by these groups.	Birmingham & Solihull Mental Health NHS Foundation Trust supported by Public Health and community partners
21	Improve Outreach to Ethnic Communities • Identify barriers such as language, stigma, lack of awareness, and mistrust that prevent individuals from seeking support. • Introduce flexible service options (e.g. extended hours, community-based provision e.g. black barbershop programme, multilingual staff) to improve accessibility.	Birmingham Public Health
22	Enhance Community Engagement and Co-Design of Campaigns and Services • Partner with community leaders, faith groups, and grassroots organisations to co-design culturally sensitive mental health campaigns. • Use trusted channels (e.g. community radio, local influencers, places of worship) to share messages that normalise seeking support and highlight diverse role models to reduce stigma.	Birmingham Public Health
23	• Monitor outcomes and embed accountability to reduce disparities in treatment experience and outcomes	Bsol Mental Health Collaborative

4.6 ALCOHOL & SUBSTANCE MISUSE

KEY FINDINGS: OVERVIEW OF ALCOHOL & SUBSTANCE MISUSE IN MEN

The APPG report for a men's health strategy highlighted increased alcohol and substance misuse as a key public health issue impacting negatively on men, their families and wider society.[85] In England and Wales, excessive alcohol consumption is a leading cause of avoidable premature death, contributing to 1.4% of all registered deaths in England and Wales in 2012.

In the UK, men are more likely than women to drink alcohol at all ages and are at a higher risk of developing dependency issues, which are more common in men (6%) than in women (2%).[86, 87] This is a specific gendered risk-behaviour to health which is a pattern found common globally. Alcohol also plays a greater role in male-perpetrated violence compared to female-perpetrated violence, as demonstrated in the 2012/13 and 2013/14 Crime Survey for England and Wales (CSEW), where 80% of alcohol-related violent incident involved male offenders.[88]

A1. PREVALENCE OF DRUG AND ALCOHOL USE IN MEN VS. WOMEN IN BIRMINGHAM ALCOHOL

In England, alcohol is the leading risk factor for ill health, early mortality, and disability among individuals aged 15 to 49, and the fifth leading risk factor across all age groups.[89] Birmingham's alcohol-specific mortality rate remains consistently and significantly higher than the England rate. In 2023, the rate was 21.4 per 100,000 and 15.0 per 100,000 respectively, and the Birmingham rate is increasing.[90] While alcohol-related health issues such as cardiovascular disease, dementia, cancer, liver disease and mental health disorders affect both men and women, men experience a higher burden of alcohol-related morbidity and mortality. In 2023, the potential years of life lost (PYLL) due to alcohol-related conditions for men in England was 1,246 per 100,000 - more than double the rate for women (533 per 100,00).[91]

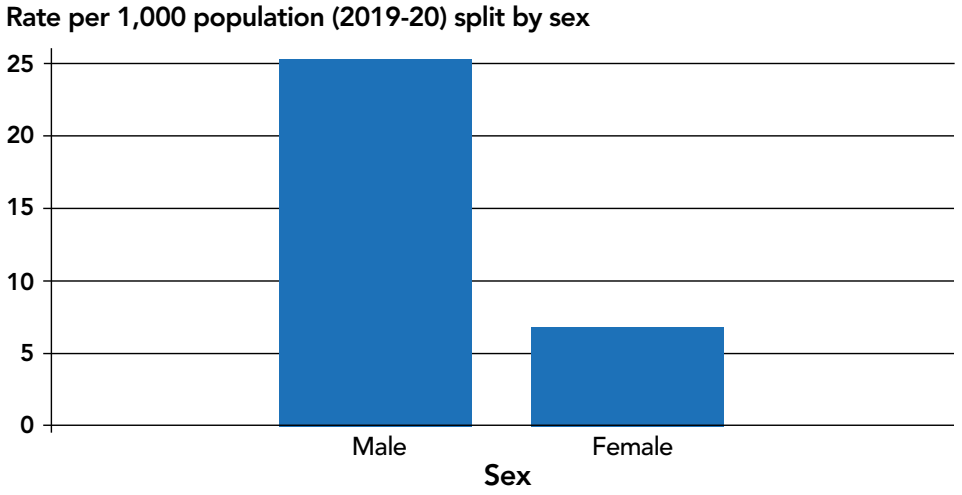
Alcohol also significantly impacts male mental health and contributes to 'externalising' problems such as substance abuse.

As highlighted in the tables and charts below (Table 11, Figure 17), the prevalence of alcohol dependency for males in Birmingham was 3.76 times higher than females in Birmingham between 2019-20, and higher than the England rate for males.

Table 11. Estimates of Alcohol Dependency Prevalence in Birmingham compared to England (2019-20) by Sex, NDTMS (2025)

Sex	Prevalence estimate (Alcohol) (Birmingham)	Rate per 1,000 population (Birmingham)	Population estimates (Birmingham)	Rate per 1,000 population (England)	Population estimates (England)
Male	10,514	25.20	417,174	21.54	21,661,879
Female	2,942	6.73	437,249	6.27	22,601,514

Figure 17-Alcohol Dependency Prevalence Chart in Birmingham (2019-20) by Sex, NDTMS (2025)



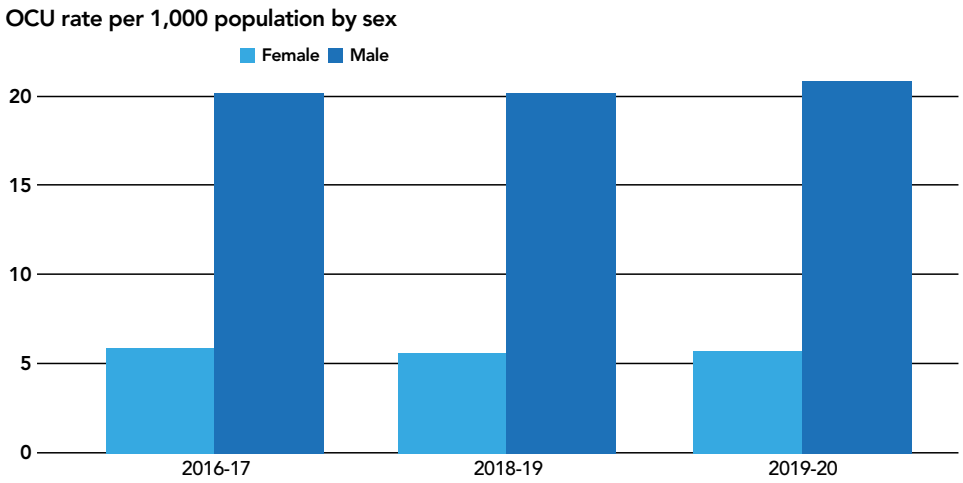
SUBSTANCE MISUSE

In Birmingham, the mortality rate from drug misuse rate has been steadily increasing, from 6.1 per 100,000 (2016-18) to 7.8 per 100,000 (2020-22), higher than the England rate of 5.2 per 100,000 (2020-22).[92] In 2019-20, the prevalence rate for illicit Opiate and/or Crack Cocaine Use (OCU) was 3.65 times higher for males in Birmingham compared to females, and substantially higher than the England rate.

Table 12. Prevalence estimates of illicit opiate and/or crack cocaine us (OCU) Birmingham (2019-20) by sex, NDTMS (2025)

Sex	Prevalence estimate (OCU) Rate per 1,000 population (Birmingham)	Population estimates (Birmingham)	Prevalence estimate (OCU) Rate per 1,000 population (England)	Population estimates (England)
Male	20.8	372,349	15.1	17,866,491
Female	5.7	376,199	4.0	17,874,665

Figure 18. OCU Prevalence Chart in Birmingham (2019-20) by Sex, NDTMS (2025)



A2. HOSPITAL ADMISSIONS

Between 2016/17 – 2022/23, in Birmingham and Solihull, admissions to hospital where the primary or any of the secondary diagnoses are for alcohol-specific (wholly attributable) conditions for men have remained relatively static. As demonstrated in Figure 19, in 2022/23, the rate was 5,994 per 100,000, which is similar to the 2016/17 rate of 5,055 per 100,000.[93] For females, the rate was 1,066 per 100,000 in the same period.

For men in Birmingham, data highlights a concerning upward trend in alcohol-specific hospital admissions, as shown in Figure 20. The rate per 100,000 populations has consistently exceeded the national average for England across all years observed. In 2023/23, the rate was 1,190 per 100,000 for men in Birmingham, compared to the national England rate for men at 868 per 100,000.[94]

Figure 19: Admission episodes for alcohol-specific conditions (Male) Birmingham & Solihull Integrated Care Board (2016/17 – 2023/24)

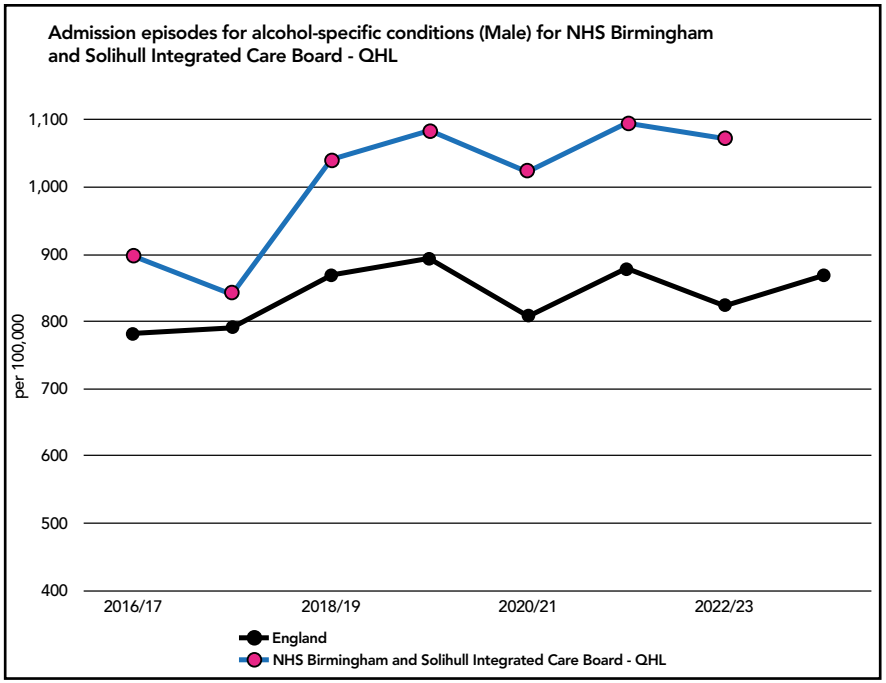
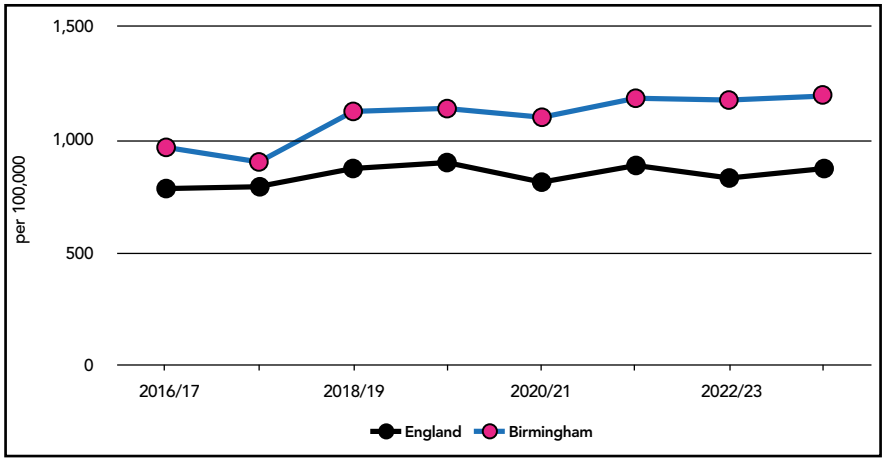


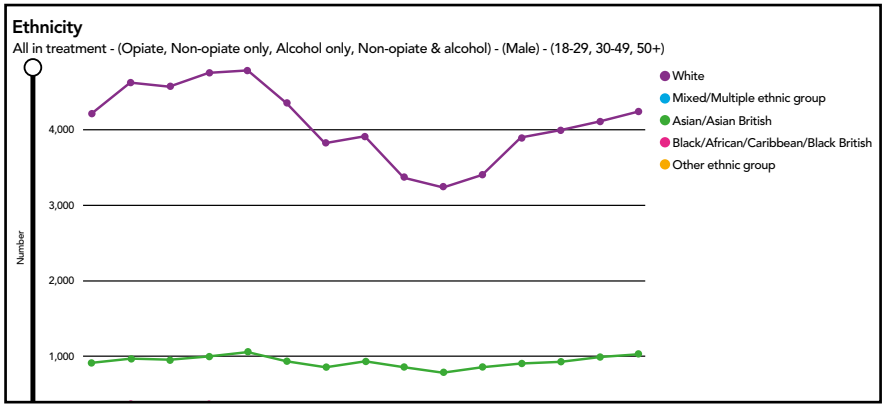
Figure 20: Admission episodes for alcohol-specific conditions (Male) Birmingham (2016/17 – 2023/24)



CO-OCCURRING MENTAL HEALTH ISSUES

Rates of hospital admissions for mental and behavioural disorders due to use of alcohol for males has also remained relatively stable over the last 6 years. In Birmingham, the rate was 739 per 100,000 in 2023/24, higher than the England rate of 575 per 100,000. For females in Birmingham, the rate was 227 per 100,000 in 2023/24.[95]

Figure 21. Admissions for mental and behavioural disorders due to use of alcohol (broad) (male) for Birmingham and England.



B. LOCAL DATA: PATTERNS AND TRENDS IN SUBSTANCE MISUSE AMONG MEN

B.1 TYPES OF SUBSTANCES COMMONLY USED BY MEN

The types of substances commonly used by men are listed below against the NDTSM database (updated for 2023/24). The most commonly used are opiates, alcohol, crack cocaine, cannabis and cocaine. An extended list for those in treatment has been provided in the table 13 below.

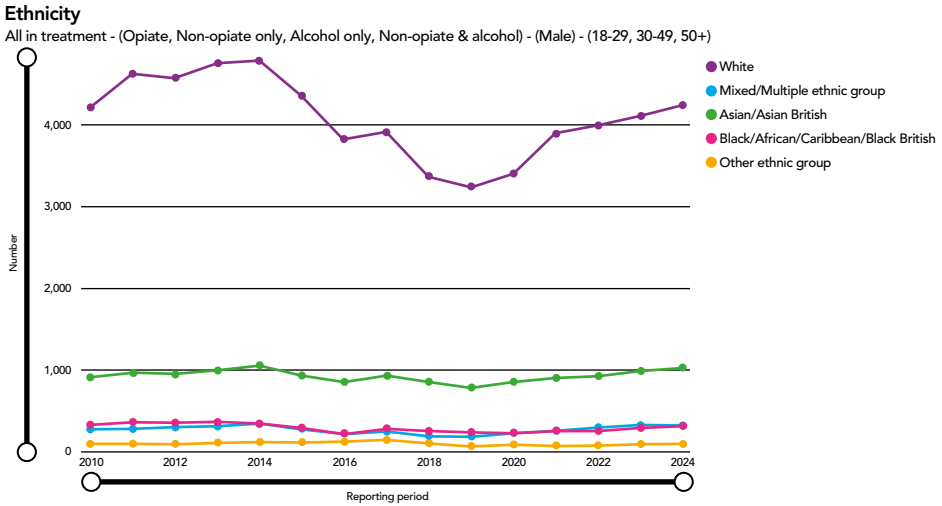
Table 13. Substance use – all in treatment – males, Birmingham 18-50+, NDTSM (2025)

SUNSTANCE USE - 2023/24		
	NUMBER	PROPORTION
Opiate & crack cocaine	2,895	47%
Opiate (not crack cocaine)	1,360	22%
Crack cocaine (not opiate)	130	2%
Cannabis	1,415	23%
Cocaine	615	10%
Benzodiazepine	155	3%
Amphetamine (not ecstasy)	55	1%
Hallucinogen	20	0%
Alcohol	2,205	36%
Other drug	85	1%
Total	**8,935**	**144%**

Opiates: Male opiate use in Birmingham is significantly higher than the national average of 11.18 per 1000. For women, rates in Birmingham are higher than the national average, but not significantly so.[96]

According to OHID 2022–2023 data, White British males account for 71% of males in treatment for drug and alcohol services in Birmingham. As this figure exceeds their proportion in the general male population, it suggests potential disproportionate representation. Further research is needed to understand the underlying causes and to inform targeted interventions for this cohort.

Figure 22 - Chart of Birmingham Data, Ethnicity and Male, All in Treatment, NDTSM (2024)



C. RISK FACTORS FOR SUBSTANCE MISUSE IN MEN

KEY SOCIAL DETERMINANTS INFLUENCING MEN'S ALCOHOL AND SUBSTANCE USE

It is important to note that, similar to alcohol use, there is a strong link between poverty and deprivation and the harms associated with illicit drug use, particularly opiates and crack cocaine.[97] Substance-related harm from alcohol and drugs is strongly linked to socioeconomic status and social exclusion in the general population.[98]

People in England's most deprived areas are twice as likely to die from alcohol-related illnesses, such as alcoholic liver disease, compared to those in the least deprived areas. They are also nearly twice as likely to die from alcohol-related conditions like chronic kidney disease and certain cancers.

This is known as the "alcohol harm paradox," where lower-income individuals tend to drink less on average than those with higher incomes but face greater alcohol-related harm and mortality.

People with learning disabilities are at higher risk of substance misuse, particularly those with borderline or mild disabilities, young men and individuals with mental health conditions.[99]

Other risk factors for substance misuse include:

- living independently
- Boredom/lack of meaningful occupation
- Loneliness / Social isolation
- Low self-esteem
- Lack of family contact
- Negative life events (for example, neglect, abuse, bereavement), unemployment, and poverty.

PSYCHOSOCIAL FACTORS: TRAUMA, ADVERSE CHILDHOOD EXPERIENCES (ACES), PTSD

A (2009) study highlights different trauma-related risk factors for substance abuse in men. For young men, physical abuse and post-traumatic stress disorder (PTSD) were common predictors of alcohol and drug abuse.[100] Notably, even in the absence of PTSD, exposure to physical abuse and violence increased the risk of substance abuse for young men. The findings suggest that sexual assault has a different impact on men and women, with young women being at greater risk for alcohol abuse following sexual assault. This reflects gender differences in trauma, vulnerability and substance use patterns. The clinical implications are that treatment, and targeted interventions should recognise specific trauma-related risk factors which differ between vulnerable males and vulnerable females. Men are more likely to use substances as a coping or adaptive mechanism to adverse life events and insecure environments[101].

ECONOMIC & SOCIAL DETERMINANTS: HOMELESSNESS, UNEMPLOYMENT, POVERTY

A 2010 study conducted on behalf of the Department of Work and Pensions highlighted the diverse needs and circumstances of people with alcohol and substance misuse issues, who are generally a marginalised group. Many, though not all, have faced early-life disadvantages. Research from the UK and Europe indicates that this marginalised group are predominantly male, with the highest prevalence among individuals in their 20s and 30s.[102] The same study found that housing instability and homelessness are recurring issues among drug-using populations, alongside low educational attainment.

Homelessness has major public health impacts, worsening substance abuse, health issues, HIV risk, and mental health symptoms through interconnected factors.[103] Research has consistently shown that a significant proportion of individuals who are homeless experience alcohol and drug problems[104] and have a lifetime history of an alcohol or drug disorder.[105]

In 2001, Crisis, a UK-based homeless charity, conducted one of the largest surveys on homelessness and drug use, surveying 389 homelessness people in London. Within this sample, 81% were male, 73% under the age of 35 and 83% identified as 'White'. The 2001 survey findings supported the literature that drug use is often considered a key pathway into homelessness. Before becoming homeless, 83% had used cannabis, nearly half had used heroin, over 40% had tried cocaine, ecstasy, or amphetamines and about a quarter had used crack. More significantly, 80% reported trying at least one new drug after becoming homeless. While drug use can be a factor leading to homelessness, homelessness itself appears to be a stronger driver of drug use.[106] Mental health problems, leaving care or leaving prison were each cited by one in five as a factor, while just over two in five (43 per cent) said that money problems played a role in becoming homeless.

MASCULINITY AND STIGMA: CULTURAL NORMS WHICH LEAD TO ADDICTION

Mind – A UK based mental health charity - published a report in December 2020 highlighted men's increased risk of using alcohol, smoking and drugs as a coping mechanism for poor mood and anxiety.[107] Gender-studies on masculinity and its role in addiction highlight men who strongly adhere to traditional masculine roles may experience masculine gender-role stress when they encounter situations that challenge their sense of masculinity.[108] Those with high levels of stress use substances as a coping mechanism to manage insecurities about meeting male role expectations. This, in turn, can heighten the risk of verbal and physical aggression.

THE IMPACT OF SUBSTANCE MISUSE ON MEN'S HEALTH

IMPLICATIONS ON MEN'S HEALTH

Some effects of alcohol are specific to men, including sexual dysfunction such as impotence and premature ejaculation. Research also suggests that alcohol consumption may reduce male fertility. A Danish study found that regularly drinking five or more units (~7.5 UK units) per week was linked to lower semen quality, with greater impacts at higher levels of consumption. Additionally, mental and physical health problems are common, particularly among long-term drug users, who experience higher rates of hepatitis C, HIV/AIDS and physical impairments that can limit daily functioning and employment opportunities. The high prevalence of mental health disorders among those with substance misuse problems is also well-documented.[109]

INCREASED SUICIDE RISK

Extensive research on the link between substance abuse and mental health indicates that individuals struggling with excessive drug or alcohol use are at a higher risk of experiencing suicidal thoughts and attempting suicide. This risk is even greater for those with co-occurring mental health disorders, where substance addiction or behavioural addiction exists alongside a mental health condition. Additionally, substance misuse can contribute to impulsive and reckless behaviours, increasing the likelihood of engaging in risky actions, which further elevates the risk of suicide.[110] This is explored further in the 2025 Birmingham Deep Dive Report – Co-occurring Mental Health Problems and Substance Misuse[111].

CRIMINAL JUSTICE INVOLVEMENT

While the relationship between drug use and crime is complex and influenced by multiple factors, research consistently shows that individuals dependent on illicit substances are disproportionately involved in crime, particularly acquisitive crimes committed for financial gain. In 2022, around half of homicides nationally are flagged as drug related.[112] Association is particularly strong among individual's dependent on opiates and crack cocaine, with the highest correlation found in those using both.[113]

Case Study: Reach Out Recovery, Change Grow Live - Birmingham [114]

Change Grow Live

Drug and Alcohol Service

Birmingham

Birmingham City Council has successfully restructured its substance misuse services, creating Europe's largest integrated support system, reaching nearly 7,000 people. The holistic, recovery-focused model replaced a previously fragmented system of 27 contracts across 19 providers and has led to significant improvements in substance abuse recovery, employment, and social reintegration.

Birmingham's integrated substance misuse service demonstrates the effectiveness of holistic, culturally sensitive, and community-driven approaches in reducing substance abuse among men.

By combining clinical treatment, employment support, housing assistance, and peer mentoring, the programme significantly improves recovery rates, enhances long-term social reintegration, and serves as a model for other regions aiming to tackle substance abuse in a sustainable, person-centred way.

Key Outcomes and Impact

- Over 3,000 individuals have successfully completed treatment, beating dependence on drugs or alcohol.
- The service ranks in the top quartile of national performance for three out of four key measures.
- Employment Success: One in three individuals leaving the programme have completed at least 10 days of work.
- Family Involvement: Over 50% of clients engage their families in their recovery journey.
- Court Treatment Compliance: Over 80% of individuals complete their mandated treatment orders (lasting 3, 6, or 12 months).

CONCLUSION

Men in Birmingham experience significantly higher rates of alcohol dependency, drug misuse, and related hospital admissions compared to women and national averages. These issues are closely linked to deprivation, homelessness, mental health conditions and harmful masculinity norms, which contribute to increased risk and reduced access to support. While integrated services such as Change Grow Live and community-based outreach have improved recovery outcomes, gaps remain in engagement, especially among marginalised male populations.

Birmingham's Inclusion Health team alongside Adults & Social Care are in the delivery stages of the Integrated Support for the Extremely Excluded (ISEE) Project. This project aims to develop a sustainable and scalable model for engaging and supporting extremely vulnerable individuals who are excluded from mainstream services. It will focus on assertive outreach that is psychologically and trauma-informed, stigma-free and relational in nature. The outreach will include advocacy, navigation and tailored support to build trust and address basic health and wellbeing needs. The goal is to establish safety and readiness for further engagement with services, including onsite support.

Alongside outreach, the project will identify or develop a multi-agency integrated care model for off-street or onsite support. This model will help individuals secure appropriate accommodation, address substance misuse and mental health needs, connect with primary care and meet basic healthcare and welfare needs. It will make use of existing resources and services, which may be adapted or co-located to ensure coordinated care that extends beyond crisis intervention.

The Birmingham Triple Zero Strategy and ICS Inequalities Strategy set clear ambitions to reduce substance-related harm, deaths and unmet need. Achieving these goals will require sustained investment in culturally tailored interventions, peer and family support and decentralised service delivery that meets men where they are—particularly those facing social exclusion and complex needs.

RECOMMENDATIONS

THEME 5: ALCOHOL & SUBSTANCE MISUSE		
Ref #	Recommendation	Lead Organisation(s)
24	Expand Integrated Community-Based Support • Deploy recovery coordinators to provide personalised case management, linking individuals with employment, housing, debt advice, and training opportunities. • Deliver services in accessible community venues such as libraries, fire stations, and local hubs to reduce stigma and barriers to engagement. • Strengthen pathways between recovery services and mainstream public services to ensure joined-up, holistic support.	Birmingham Drug & Alcohol Partnership (BDAP) & Public Health
25	Develop Culturally Tailored Interventions • Commission providers with expertise in supporting ethnic communities to deliver multilingual, culturally sensitive programmes. • Focus delivery in high-prevalence, high-BAME areas to address disproportionate impacts of addiction and substance misuse. • Engage faith leaders and community influencers to support outreach, challenge stigma, and improve trust in services.	Public Health & Providers

Ref #	Recommendation	Lead Organisation(s)
26	Enhance Peer and Family Support • Recruit and train former service users as peer mentors to provide lived-experience guidance and role-modelling for current clients. • Create structured opportunities for family involvement in recovery planning to rebuild relationships and strengthen long-term resilience. • Provide family-focused interventions that address intergenerational cycles of substance misuse.	Providers supported by Public Health and community partners
27	Expand Outreach to Homeless Populations • Delivering enhanced support through the Integrated Support for Extremely Excluded (ISEE) Project to deliver rapid, coordinated responses to vulnerable males experiencing substance misuse and homelessness. • Integrate health, housing, and substance misuse support into outreach to tackle immediate risks alongside longer-term needs. • Develop clear referral routes between homelessness services and recovery programmes to prevent revolving-door patterns of crisis intervention.	Public Health & Providers
28	Develop a Stigma and Shame Competency Framework for Inclusion Health Groups • Design and implement a stigma- and shame-competency framework to guide frontline staff, ensuring services are trauma-informed, compassionate, and non-judgemental. • Provide targeted training for staff working with extremely excluded and socially isolated groups (e.g. rough sleepers, sex workers, people leaving prison, and those with complex trauma histories). • Embed the framework into commissioning standards and service evaluation to improve engagement, trust, and recovery outcomes.	Birmingham Public Health

4.7 HEALTH LITERACY

Health literacy—the ability to access, understand and use health information—is crucial for making informed health decisions. In Birmingham, men face significant health challenges, with disparities in health literacy contributing to poorer outcomes. The challenges to men's health and men's health literacy rates are complex and multi-faceted, stemming from a range of issues, including socioeconomic barriers; cultural and gender norms, which differ between communities of identity and experience; and digital exclusion.

As highlighted at the beginning of this report, men in Birmingham have a life expectancy that is lower than the England average. Birmingham is one of the 20% most deprived districts/unitary authorities in England, with about 27% (67,500) of children living in low-income families. Life expectancy is 8.9 years lower for men in the most deprived areas of Birmingham compared to the least deprived areas. Men living in the most deprived neighbourhoods in Birmingham, Ladywood, are, on average, more than 3.5 times as likely to die prematurely than men living in Beckenham.[115]

Traditional masculinity norms discourage many men from seeking medical advice or discussing health concerns. This is particularly significant among certain ethnic communities where stigma around mental health and chronic illnesses prevails.

Case Study: Legacy WM – Men's Health Intervention

As reported in the Legacy WM (West Midlands) Annual Report for 2022-2023 [116], men have traditionally been considered a hard-to-reach group in healthcare engagement. This prompted a renewed focus on men's health through the recruitment of a Men's Health and Youth Worker, funded by Active Communities. This initiative aimed to address inactivity and improve health literacy by fostering a community-driven system that encourages collaboration and the development of innovative, engaging interventions.

As part of this approach, a local asset-based map has been created to outline men's healthcare services, screenings, and resources, ensuring greater accessibility and awareness of available support. In recognition of the role that social engagement plays in sustaining healthy behaviours, local men have been trained as ride leaders, equipping them to lead cycling excursions and a men's club designed to promote both physical activity and peer-led support.

The initiative has also introduced a Men's Supper Club, offering culturally tailored nutrition education and practical home-cooking sessions to encourage healthier eating habits.

This has proven to be a successful model, with Community Champion, Aliur, being recognised as a finalist in a men's chef competition. Additionally, men are being signposted to workshops, seminars, and digital resources to ensure that health engagement remains convenient and accessible, particularly for those balancing professional and personal commitments. By integrating physical, social, and nutritional health interventions, this approach seeks to create a sustainable and inclusive framework that empowers men to take an active role in managing their health.

CONCLUSION

Enhancing men's health literacy in Birmingham requires targeted, culturally sensitive and community-driven approaches. By addressing socio-economic disparities, challenging harmful gender norms and improving access to clear health information, public health initiatives can empower men to take proactive steps toward better health outcomes. Collaboration between healthcare providers, local authorities and grassroots organisations is essential to bridge the health literacy gap and reduce health inequalities in the city.

RECOMMENDATIONS

THEME 6: HEALTH LITERACY		
Ref #	Recommendation	Lead Organisation(s)
29	Expand Community-Based Outreach for Men's Health • Deliver culturally tailored health education initiatives through trusted spaces such as mosques, community centres, sports clubs and workplaces. • Use male community leaders and role models to promote health literacy and encourage engagement. • Focus outreach on conditions with high male inequalities (e.g. cardiovascular disease, diabetes, mental health).	Birmingham Public Health
30	Strengthen Workplace Health Interventions • Develop workplace wellness programmes that promote men's health awareness, preventive checks and mental wellbeing. • Partner with large employers and trade unions to embed occupational health initiatives. • Provide tailored resources for industries with high male workforces (e.g. construction, manufacturing, transport).	Bsol ICB and local employers supported by Public Health
31	Localise and Diversify Male-Focused Health Campaigns • Expand awareness initiatives such as Movember by embedding them within Birmingham's diverse communities. • Feature local male voices, including those from Black, Asian, and diverse ethnic backgrounds, to ensure cultural relevance. • Address topics beyond cancer - including mental health, suicide prevention and healthy lifestyles- to broaden impact.	Birmingham Public Health
32	Improve Digital and Visual Health Communication • Produce health resources in multilingual, visually accessible formats such as infographics and short videos. • Prioritise digital communication strategies that reach men with lower literacy levels or limited healthcare engagement. • Disseminate resources through community-based digital platforms and social media trusted by local men.	Birmingham & Solihull ICB supported by Public Health

5. WHAT WORKS? EXAMPLES OF EFFECTIVE INTERVENTIONS FOR MEN'S HEALTH

Best-practice has been highlighted throughout the report; below is a summary and additional case studies to support programmes and interventions targeted at reducing health inequalities for men.

The Local Government Association (LGA) recommends that councils adopt approaches that are community-based, inclusive and tailored to men's needs. They highlight that 'what works' includes creating male-friendly spaces, partnering with trusted community groups and co-designing services with men themselves. Councils are encouraged to use physical activity and social engagement as entry points to support mental and physical health, and to target specific groups of men with culturally relevant interventions. The LGA also urges councils to advocate for a national men's health strategy and the reinstatement of local suicide prevention funding to support these efforts more sustainably.[117]

POLICY GUIDANCE: DESIGNING MEN'S HEALTH POLICY: THE 5R FRAMEWORK [118]

Addressing disparities inequalities experienced by men requires a strategic, evidence-informed approach to policy design. The 5R Framework, published in October 2025 in The Lancet, offers a best-practice model for creating inclusive and effective men's health policies that tackle gender health inequalities.

THE 5R FRAMEWORK FOR MEN'S HEALTH POLICY

1. RECOGNISE

It is important to recognise that men are not a homogenous group—policy must reflect this diversity. Acknowledge the diverse and intersecting factors that shape men's health, including gender norms, socioeconomic status, race, sexuality and geography.

2. RESPOND

Develop tailored interventions that proactively address the specific health needs of different groups of men. Shift from reactive, crisis-driven care to preventive and strengths-based approaches.

3. REFRAME

Challenge deficit-based narratives that portray men as disengaged or problematic. Promote positive masculinity and position men as active partners in their health and wellbeing.

4. RESEARCH

Invest in inclusive, gender-sensitive research to fill data gaps and inform policy. Prioritise research that includes marginalised male populations and explores barriers to care.

5. RESTRUCTURE

Reform health systems to be more accessible, welcoming and responsive to men's health behaviours. Train health professionals in gender-responsive care and cultural competence.

The 5R Framework provides a comprehensive and adaptable model for designing men's health policy that is equitable, inclusive and responsive. By applying this framework, policymakers can more effectively address the structural and social determinants that contribute to gender health inequalities and improve health outcomes for all men.

Throughout the report, examples of effective interventions have been highlighted. Below are some further examples of effective interventions for men's health.

ACOCK'S GREEN MEN'S SHED: COMMUNITY-LED INITIATIVE IN BIRMINGHAM [119]

Acocks Green Men in Sheds is a community-led initiative in Birmingham that supports older men through social connection and skill-building. Established in 2019 by two retired residents, the project provides a space for men to engage in woodworking and other practical activities while fostering friendships and reducing isolation. Although aimed at men, the group is inclusive and welcomes women. The shed operates twice weekly and is supported by Fox Hollies Community Association, which provides rent-free space, administrative support and access to funding. The project has received grants from Ageing Better in Birmingham and the City Council, enabling it to expand its remit to environmental and community work.

Participants report improved mental wellbeing, reduced loneliness and a renewed sense of purpose. The shed has also benefited the wider community by supporting local schools, residents' groups and environmental initiatives. Members contribute to the upkeep of the community centre and have built items such as bird boxes and benches for local use. The group has become a hub for intergenerational and intercultural engagement and is exploring links with healthcare providers to support social prescribing. Key success factors include strong leadership, community partnerships, visibility and initial funding to establish the workshop and sustain activities.

ISLINGTON'S YOUNG BLACK MEN AND MENTAL HEALTH PROGRAMME [120]

Launched in 2022 with a £2.5 million investment, Islington's Young Black Men and Mental Health Programme aims to improve mental health outcomes for young Black men, who face significantly higher risks of serious mental illness and detention under the Mental Health Act. The programme includes school-based psychological support through the Becoming a Man initiative, which operates in three secondary schools and supports nearly 180 students over two years. Community outreach is delivered by the Elevate Innovation Team, which provides trauma-informed, one-to-one support and has engaged over 60 young men, with a 98% engagement rate. A barbershop initiative has trained five barbershops in mental health first aid and safeguarding, with plans to expand to 25 locations to encourage informal conversations and referrals. Over 600 public sector workers have received cultural competency training, with a target of 1,000 by the end of the year. The programme was co-designed with the community to address stigma, lack of role models and mistrust in services. By embedding support in schools, community spaces and trusted networks, it creates sustainable change and strengthens connections between young Black men and mental health services. It is recognised as a model for tackling structural inequalities and improving long-term wellbeing and life opportunities.

WOLVERHAMPTON CITY COUNCIL: COMBINING RECREATIONAL ACTIVITIES AND MENTAL HEALTH SUPPORT [121]

The City of Wolverhampton Council collaborated with Mandem Meetup, a grassroots charity, to deliver a community-led initiative that supports men's mental health through recreational activities. Funded by the Household Support Fund, the programme offers hikes, football, gym sessions, and talking therapy groups. It is peer-led, creating a safe and non-judgmental space for men to connect and support each other.

The initiative has reached over 200 members and recorded 800 attendances in 18 months. It has helped men facing addiction, isolation, and poor mental health to access support, employment and training. The approach reduces reliance on formal services and demonstrates the value of early intervention. Key learning includes the importance of empowering grassroots organisations, combining physical activity with mental health support, and using flexible funding to remove barriers to participation.

MELTON BOROUGH COUNCIL: TAKING HEALTH CHECKS OUT TO FARMERS [122]

Melton Borough Council partnered with the Lincolnshire Rural Support Network to deliver health checks directly to farmers at the Melton Mowbray Livestock Market. Recognising the challenges farmers face in accessing health services due to isolation and demanding work schedules, the council funded twice-monthly clinics offering physical health checks and mental health support. Nurses provide blood pressure, cholesterol, and blood sugar checks, along with lifestyle advice, and one nurse specialises in diabetes care. The service is informal and community-based, helping build trust among farmers. Over 500 farmers, mostly men, have used the service in the past year, with 44 referred to further support. One farmer credited the service with saving his life after a routine check led to a serious diagnosis. The initiative, initially a pilot, is now funded through the UK Shared Prosperity Fund until March 2025, demonstrating the value of accessible, preventative health care in rural communities.

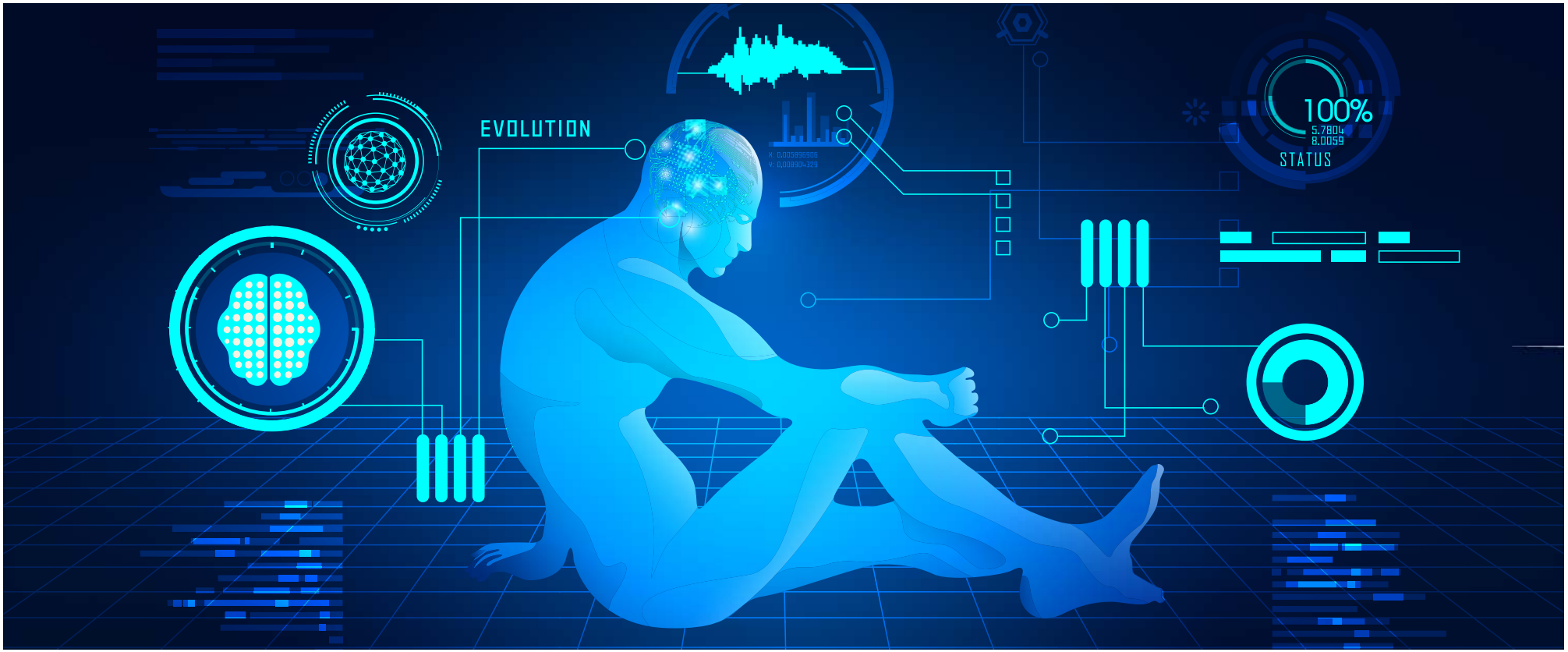
6. NEXT STEPS

This report provides a robust foundation to guide and inform local implementation of the national priorities in relation to men's health, as the national strategy on men's health is due to be published in 2026.

- The Inclusion Health team aim to disseminate this report with the hope that it will help to inform the development of a local strategic action plan on men's health, to be delivered under the auspices of the Birmingham Health & Wellbeing Board and with the ownership and support from the integrated care system partners.

Therefore, the next steps include:

- Ratification by the Birmingham Health & Wellbeing Board.
- Dissemination of the report findings and recommendations across the BSol ICS and other relevant partners.
- Identification of a strategic lead to champion and drive the implementation of the recommendations from this report across the system.
- Establishment of a taskforce to progress the implementation of the recommendations from this report.



7. SUMMARY OF RECOMMENDATIONS

THEME 1: CARDIOVASCULAR DISEASE		
Ref #	Recommendation	Lead Organisation(s)
1	Prioritise Action on Modifiable Risk Factors: Develop targeted interventions for preventing and reducing cardiovascular disease in men that should prioritise modifiable risk factors, particularly hypertension and smoking.	Birmingham & Solihull ICB
2	Improve Local Data Availability: Address critical gaps in local data, especially smoking prevalence by gender across Birmingham's localities.	Birmingham & Solihull ICB
3	Enhance Hypertension Case Finding: Evaluate existing programmes such as Million Hearts and NHS Health Checks to identify inequalities in access and uptake among sub-groups of men.	Birmingham & Solihull ICB supported by Public Health
4	Evaluate Workplace CVD Check Pilots: Explore the effectiveness of workplace-based CVD checks, with a focus on reaching under-served male populations, particularly those who do not typically attend NHS Health Checks.	Birmingham Public Health
5	Assess Smoking Cessation Services for Equity: Review current smoking cessation offers to determine their effectiveness in engaging men—especially those who are at a higher risk.	Birmingham Public Health
6	Ensure Cultural Appropriateness of Interventions Recognise and address the disproportionate impact of CVD on Black and South Asian men by ensuring all interventions are culturally appropriate. This includes exploring community-based initiatives, such as delivering health checks in mosques or through initiatives like the Black barber shop programme.	Birmingham Public Health

THEME 2: CANCER		
Ref #	Recommendation	Lead Organisation(s)
7	Improve data collection and insight for male screening programmes • Commission detailed analysis of uptake for the four male screening programmes (AAA, bowel, lung, and prostate-related case finding). • Disaggregate data by gender, ethnicity, deprivation, and smaller geographies. • Use findings to identify gaps and inform targeted interventions. • Follow up with qualitative research to explore reasons for disparities in uptake.	Birmingham & Solihull ICB & Birmingham Public Health
8	Expand Prostate Cancer Awareness and Case Finding • Recognise the absence of a national screening programme and prioritise local action. • Scale up successful local interventions targeting high-risk men (e.g. Black men, those with a family history). • Use community-based approaches such as trained ambassadors, culturally tailored messaging, and trusted venues (e.g. churches, barbershops).	Birmingham & Solihull ICB, WM Cancer Alliance

Ref #	Recommendation	Lead Organisation(s)
9	Extend Mobile Outreach Models • Build on the success of the ICB Cancer Bus and Targeted Lung Health Checks. • Explore other services that could benefit from mobile delivery (e.g. prostate awareness, AAA promotion). • Ensure strategic location selection, focusing on areas of low uptake and high deprivation. • Incorporate innovative venues such as mosques, sports clubs, and community centres to reach traditionally underserved groups.	Birmingham & Solihull ICB, Community Organisations
10	Tackle Stigma and Build Trust • Develop targeted communication campaigns that address stigma, myths and mistrust. • Involve community voices and lived experience to make messaging authentic and impactful.	Birmingham Public Health, Community Leaders
11	Mobilise Primary Care Networks • Engage the six Cancer Clinical Lead GPs in Birmingham in all relevant initiatives. • Activate Cancer Champions within GP practices to support outreach and reduce barriers. • Address perceived access issues, such as difficulty booking appointments, through staff training and patient navigation support.	GP Practices, PCNs, Birmingham & Solihull ICB

THEME 3: DIABETES & OBESITY

Ref #	Recommendation	Lead Organisation(s)
12	Develop and Maintain a Directory of Services • Create an up-to-date, accessible directory of diabetes and weight management services across Birmingham. • Include details on target audiences, referral pathways, eligibility criteria and contact information. • Promote the directory to GPs and other professionals to support social prescribing and improve service navigation.	Birmingham & Solihull ICB & Birmingham Public Health
13	Improve Data Collection and Monitoring • Strengthen data collection on service uptake, including NHS Health Checks and digital tools like the Healum app. • Ensure data is disaggregated by gender, ethnicity and language spoken. • Use insights to identify gaps in access and inform targeted outreach strategies.	Birmingham Public Health and NHS Health Checks Providers
14	Adopt a Nuanced Approach to Obesity Terminology and Intervention • Reflect emerging evidence by distinguishing between preclinical obesity (risk factor) and clinical obesity (chronic disease). • Tailor public health and NHS interventions accordingly, recognising the different needs and risks of each group. • Avoid stigmatising language and promote inclusive, evidence-based messaging.	Birmingham Public Health

Ref #	Recommendation	Lead Organisation(s)
15	Ensure Equity in Referral Criteria and Clinical Practice • Promote awareness among clinicians of NICE guidance on adjusted BMI thresholds for ethnic minority groups (e.g. 27.5 for Black, Asian and minority ethnic populations). • Monitor referral patterns to assess whether these adjustments are being applied in practice. • Provide training and resources to support equitable decision-making	GP Practices, PCNs, BSol ICB
16	Assess the Impact of GLP-1 Agonist Drugs on Health Inequalities • Monitor uptake and outcomes of new weight loss medications (e.g. semaglutide, tirzepatide) across different population groups. • Evaluate gender differences and potential disparities in access, adherence and effectiveness. • Use findings to inform equitable rollout and support strategies.	Office for Health Improvement & Disparities
17	Increase Male Engagement in Physical Activity Programmes • Investigate low male referral rates to BeActive+ across Birmingham. • Conduct qualitative research to understand barriers and preferences. • Re-shape programme design and promotion to better appeal to men, including through male-focused messaging and community partnerships.	Birmingham Public Health, Physical Activity
18	Address Structural Drivers of Obesity • Ensure obesity strategies go beyond individual behaviour change to address systemic factors. • Advocate for policies that regulate unhealthy food environments and tackle commercial determinants of health. • Collaborate across sectors to create healthier environments and reduce the impact of the obesogenic landscape.	Birmingham Public Health, Birmingham & Solihull ICB

THEME 4: MENTAL HEALTH

Ref #	Recommendation	Lead Organisation(s)
19	Develop Peer Support Networks in Community Settings • Use activities men already engage in — such as sports clubs, gyms, creative arts or local community hubs — as vehicles for mental health engagement. • Facilitate peer support networks that encourage open conversations, reduce isolation and provide mutual encouragement. Partner with grassroots organisations to deliver programmes in trusted, non-clinical spaces.	VCSE organisations supported by BCC Public Health and the Bsol Mental Health Collaborative
20	Strengthen Training and Education for Mental Health Professionals • Strengthening understanding of mental health professionals in specifically men's mental health. • Develop mandatory cultural competency training for mental health staff to address the specific needs of Black, South Asian, and other ethnic minority groups, co-designed by these groups.	Birmingham & Solihull Mental Health NHS Foundation Trust supported by Public Health and community partners

Ref #	Recommendation	Lead Organisation(s)
21	Improve Outreach to Ethnic Communities • Identify barriers such as language, stigma, lack of awareness and mistrust that prevent individuals from seeking support. • Introduce flexible service options (e.g. extended hours, community-based provision e.g. black barbershop programme, multilingual staff) to improve accessibility.	Birmingham Public Health
22	Enhance Community Engagement and Co-Design of Campaigns and Services • Partner with community leaders, faith groups, and grassroots organisations to co-design culturally sensitive mental health campaigns. • Use trusted channels (e.g. community radio, local influencers, places of worship) to share messages that normalise seeking support and highlight diverse role models to reduce stigma.	Birmingham Public Health
23	Monitor outcomes and embed accountability to reduce disparities in treatment experience and outcomes.	Bsol Mental Health Collaborative

THEME 5: ALCOHOL & SUBSTANCE MISUSE		
Ref #	Recommendation	Lead Organisation(s)
24	Expand Integrated Community-Based Support • Deploy recovery coordinators to provide personalised case management, linking individuals with employment, housing, debt advice and training opportunities. • Deliver services in accessible community venues such as libraries, fire stations and local hubs to reduce stigma and barriers to engagement. • Strengthen pathways between recovery services and mainstream public services to ensure joined-up, holistic support.	Birmingham Drug & Alcohol Partnership (BDAP) & Public Health
25	Develop Culturally Tailored Interventions • Commission providers with expertise in supporting ethnic communities to deliver multilingual, culturally sensitive programmes. • Focus delivery in high-prevalence, high-BAME areas to address disproportionate impacts of addiction and substance misuse. • Engage faith leaders and community influencers to support outreach, challenge stigma and improve trust in services.	Public Health & Providers
26	Enhance Peer and Family Support • Recruit and train former service users as peer mentors to provide lived-experience guidance and role-modelling for current clients. • Create structured opportunities for family involvement in recovery planning to rebuild relationships and strengthen long-term resilience. • Provide family-focused interventions that address intergenerational cycles of substance misuse.	Providers supported by Public Health and community partners

Ref #	Recommendation	Lead Organisation(s)
27	Expand Outreach to Homeless Populations • Delivering enhanced support through the Integrated Support for Extremely Excluded (ISEE) Project to deliver rapid, coordinated responses to vulnerable males experiencing substance misuse and homelessness. • Integrate health, housing and substance misuse support into outreach to tackle immediate risks alongside longer-term needs. • Develop clear referral routes between homelessness services and recovery programmes to prevent revolving-door patterns of crisis intervention.	Public Health & Providers
28	Develop a Stigma and Shame Competency Framework for Inclusion Health Groups • Design and implement a stigma- and shame-competency framework to guide frontline staff, ensuring services are trauma-informed, compassionateand non-judgemental. • Provide targeted training for staff working with extremely excluded and socially isolated groups (e.g. rough sleepers, sex workers, people leaving prison, and those with complex trauma histories). • Embed the framework into commissioning standards and service evaluation to improve engagement, trust and recovery outcomes.	Birmingham Public Health

THEME 6: HEALTH LITERACY

Ref #	Recommendation	Lead Organisation(s)
29	Expand Community-Based Outreach for Men's Health • Deliver culturally tailored health education initiatives through trusted spaces such as mosques, community centres, sports clubs and workplaces. • Use male community leaders and role models to promote health literacy and encourage engagement. • Focus outreach on conditions with high male inequalities (e.g. cardiovascular disease, diabetes, mental health).	Birmingham Public Health
30	Strengthen Workplace Health Interventions • Develop workplace wellness programmes that promote men's health awareness, preventive checks and mental wellbeing. • Partner with large employers and trade unions to embed occupational health initiatives. • Provide tailored resources for industries with high male workforces (e.g. construction, manufacturing, transport).	Public Health & Providers
31	Localise and Diversify Male-Focused Health Campaigns • Expand awareness initiatives such as Movember by embedding them within Birmingham's diverse communities. • Feature local male voices, including those from Black, Asian and diverse ethnic backgrounds, to ensure cultural relevance. • Address topics beyond cancer - including mental health, suicide prevention and healthy lifestyles - to broaden impact.	Birmingham Public Health

Ref #	Recommendation	Lead Organisation(s)
32	Improve Digital and Visual Health Communication • Produce health resources in multilingual, visually accessible formats such as infographics and short videos. • Prioritise digital communication strategies that reach men with lower literacy levels or limited healthcare engagement. • Disseminate resources through community-based digital platforms and social media trusted by local men.	Birmingham & Solihull ICB supported by Public Health

APPENDIX 1. MEN'S HEALTH STAKEHOLDER ADVISORY GROUP

The Birmingham Men's Health Needs Report was overseen and co-produced with the Men's Health Stakeholder Advisory Group.

- The Assistant Director of Public Health (Healthy Behaviours and Communities) and the Director of Public Health
- Cabinet Members for Health and Social Care and Social Justice, Community Safety and Equalities
- Birmingham Health and Wellbeing Board via the Birmingham & Solihull Inclusion Health Forum
- Birmingham and Solihull Health Inequalities, Communities and Economy Committee

The advisory group was comprised of stakeholders working across the system (e.g., third sector organisations, NHS England, Birmingham and Solihull ICS, local/regional public health, local men's health experts). This function helped to shape this report and recommendations, informing the key priority areas by adding their insight and experience of the health inequalities experienced by Birmingham's male populations.

CURRENT MEMBERSHIP OF THE MEN'S HEALTH ADVISORY GROUP

NAME	ORGANISATION	ROLE
Monika Rozanski	Birmingham City Council, Public Health	Service Lead – Inclusion Health
Yasmin Nessa	Birmingham City Council, Public Health	Public Health Officer – Inclusion Health
Becky Pollard	Birmingham City Council, Public Health	Assistant Director – Adults & Older People
Joe Merriman	Birmingham City Council, Public Health	Service Lead, Mental Health
Candice Fairclough-Smith	Birmingham City Council, Public Health	Service Lead, Addictions
Hajrah Khan	Birmingham City Council, Public Health	Senior Officer for Suicide Prevention, Mental Health
David Miller	Birmingham City Council, Public Health	Programme Senior Officer, Adults
Sarah Newton	Birmingham City Council, Public Health	Service Lead, Food system
David Ellis	Birmingham City Council, Public Health	Senior Officer, Population Health Management and Health checks
Patrick Vernon	Integrated Care Partnership	ICP Chair
Nicola Pugh	Birmingham & Solihull Integrated Care Board	ICS Inequalities Programme Manager
Nick Adams	Birmingham & Solihull Integrated Care Board	Midlands Suicide Prevention Lead
Helen Jenkinson	University Hospital Birmingham NHS Trust	Clinical Nurse Specialist

NAME	ORGANISATION	ROLE
Dr Oruj Alam	GP Partner, Burbury Medical Centre	General Practice
Harvir Singh	WM Cancer Alliance	Early Diagnosis Senior Programme Manager
James Whitehouse	Change Grow Live (CGL)	D&A service provider
Michael Brown	MindsEye development CIC	Founding Director
Lubna Latif Curtis	Prostate Cancer UK	Health Influencing Senior Officer
Keith Morgan	Prostate Cancer UK	Associate Director of Black Health Equity
Tim Scott	Cruse Bereavement	Leading on increasing uptake of services for men
Neil De-Costa	Aston Villa Foundation	Senior Programmes Manager – Engagement, Health & Wellbeing
Dr Tonye Sikabofori	Birmingham Community Healthcare Foundation NHS Trust	Deputy Chief Medical Officer

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