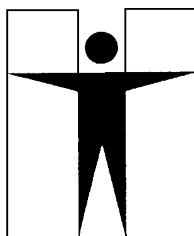

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MALE - THE HEALTHIER SEX?

Ms Lilian Wan[1] Dr C K Li[2]

Introduction

Although men are usually physically stronger than women, they are not always healthier. In fact, men are more likely to die sooner. In 2000, the life expectancy of a newborn boy was 77.0 years, and that of a newborn girl was 82.2 years, with a differential of 5.2 years.[1] This article brings together some facts and figures relating to the morbidity and mortality patterns for men in Hong Kong, and highlights the role of some key determinants affecting their health.

Gender Gaps in Health and Death

Many preventable illnesses occur more frequently in males than in females. In 1997, there were more cancers in men, 1.3 males for every female, and the age-standardized incidence rate for all cancers was 274.9 per 100 000 for male compared to 202.5 per 100 000 for female.[2] The incidence gap was particularly significant in lung, liver and nasopharyngeal cancers (62.6, 32.5 and 19.7 per 100 000 in men vs 25.2, 9.6 and 8.3 per 100 000 in women respectively). Chronic obstructive lung diseases, chronic liver diseases and cirrhosis, hepatitis B and tuberculosis were also more prevalent in men.[3] The majority of road traffic accidents and injuries occurred in men, with a male to female ratio of about two to one in 1999.[4] In terms of sexual health, men outnumbered women significantly in reported cases of primary syphilis (56.8 times), gonorrhoea (6.5 times), genital warts (3.7 times) and herpes genitalis (5.7 times) at the government Social Hygiene Service.[5] Of 213 and 61 reported HIV and AIDS cases respectively in 1999, over three-quarters occurred in men.

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Men not only had higher death rates at all ages compared to women, rising to a peak of 2.3 males for every female in the 25-34 age group (Table 1), they also tended to die younger.[6] As shown in Table 2, the potential years of life lost were substantially higher in men than women in all major categories of death. In 1999, the death rates of boys and girls (age group 0-14) in Hong Kong did not differ greatly in major causes of death. This was in contrast to older age groups in which the disparity became increasingly marked (Table 3).

Whilst injury and poisoning was the prime cause of death of males and ranked second in females for age 15 to 44 years in 1999, men had a 2.7-fold risk of injury death than that of their female counterparts. The mortality gap was particularly marked for poisoning, falls and road traffic fatalities, with a male to female ratio of 10.6:1, 8.2:1 and 3.3:1 respectively. By age 45 to 64, malignant neoplasm and heart diseases emerged as the biggest killers of men and women, but men were about 1.9 and 2.5 times respectively more likely to die from these diseases than women. Much of the excess mortality in men in this age category was due to higher rates of lung cancer and acute myocardial infarction, representing 74.4 and 33.2 deaths per 100 000 men compared to 24.9 and 7.7 deaths per 100 000 women respectively. As importantly, close to 2.4 times as many men than women in this age group died of suicide and self-inflicted injury. Not until old age (65 years and above) the mortality gap between men and women in their major causes of death diminished.[6]

Determinants of Men's Health

The difference in health experiences of men and women in fact results from an interaction of many health determinants which are generally categorized into biological, lifestyle, socio-cultural, occupational and health care aspects.

Biological Factors

Compared to women, males are thought to be biologically disadvantaged and less resistant to a range of conditions. Around the time of conception, external maternal stress may reduce the male to female sex

Table 1 **Number of Deaths and Age-specific Death Rates* (per 100 000 population) by Sex, 1999**

Age Group (Year)	Number of Deaths		Age-specific Death Rate	
	Male	Female	Male	Female
0 - 14	171	137	28.6	24.6
15 - 24	198	114	42.6	24.4
25 - 34	374	189	72.7	30.9
35 - 44	857	476	132.4	70.3
45 - 54	1 485	702	334.3	169.0
55 - 64	2 654	1 030	984.1	446.3
65 - 74	5 403	3 003	2 426.1	1 335.9
75 and above	7 612	8 926	7 347.5	5 617.4
Total†	18 754	14 577	574.4	436.2

* Since August 2000, the "resident population" approach has been adopted in place of the "extended de facto" approach for compiling population estimates. Also, the Population Census which was conducted in March 2001 provides a benchmark for revising the population estimates compiled since 1996 Population By-census. In this table, the population-related figures have been revised accordingly.

† Exclude unknown age and unknown sex.

ratio, suggesting that the male foetus is more vulnerable than the female foetus.[7] As he grows, he will be further disadvantaged by lacking the female sex hormones which protect the female against a range of diseases such as cardiovascular diseases and osteoporosis.

Lifestyle Factors

Differences in lifestyle behaviours also expose men and women to different health risks. Traditionally risk taking behaviour has been used by men to establish masculinity in their own eyes and in the eyes of others. Men are more likely to have lifestyle risk factors such as smoking, hazardous drinking, poor dietary habit and drug abuse that are detrimental to health. A recent survey showed that rates of daily smokers (aged 15 and above) were 22.0 per 100 men and 3.5 per 100 women.[8] In the age group of 18-64 years, more men than women drank four days or more per week. Men also tended to eat less vegetables and fruits, but ate more fat than women.[9] In 2000, 84% of 18 275 persons reported to the Central Registry of Drug Abuse were male.[10]

Although the biological and behavioural aspects of ill health are important contributors to men's poorer health status in Hong Kong, they should not be seen in isolation from the dominant cultural values and determined roles that society ascribes to the two sexes, and the socio-economic context within which men live and work.

Socio-cultural Factors

Many of the health issues facing men can be linked back to how our boys are socialized and raised. Support from families, friends and community is important in helping people deal with adversity. The perceived notions of "maleness" or "boys don't cry" mentality incapacitate many men to express themselves and seek family or social support when they are distressed. Instead of admitting their vulnerability and talking about how they feel, men tend to internalize their feelings or resort to

Table 2 **Potential Years of Life Lost Prior to Age 75 by Cause of Death* and Sex, 1999**

Cause of Death (ICD-9 Code)†	Number of Potential Years of Life Lost	
	Male	Female
Malignant neoplasm (140-208)	64 938	37 332
Unintentional injury‡ (E800-E949)	18 703	3 589
Heart diseases (390-429)	17 168	7 178
Suicide and self-inflicted injury‡(E950-E959)	14 885	8 370
Cerebrovascular disease (430-438)	8 990	5 566
Pneumonia and influenza (480-487)	6 564	3 262
Chronic liver diseases and cirrhosis (571-572)	4 946	1 211
Chronic obstructive pulmonary disease (491-492, 496)	4 300	825
Infectious diseases (001-139)	3 490	1 098
Renal failure (584-586)	2 628	2 237
Diabetes mellitus (250)	1 519	1 457

* Exclude unknown age and unknown sex.
† International Classification of Diseases, Injuries and Causes of Death (ninth revision).
‡ Refers to those cases with "injury and poisoning" as main cause of death.

smoking, using alcohol and drugs, or other destructive behaviours.[11]

Society's expectation and stereotyping of men also create an environment in which men are less able or willing to seek health information, to recognize physical and emotional distress and to seek professional help. It has been shown that many men felt constrained by social taboos and embarrassment from admitting feeling sick, being concerned about some aspects of health, or discussing their health openly with physicians. This pattern has been shown locally in the lower level of health knowledge among men, their lower

Table 3 Age-specific Death Rates*† (per 100 000 population) of the Five Leading Causes of Death by Sex and Age Group, 1999

Age Group (Year)	Cause of Death (ICD-9 Code)‡	Male	Female
0 - 14	Congenital anomalies (740-759)	6.9	6.1
	Perinatal condition (760-779)	4.8	4.1
	Injury and poisoning (800-999)	4.8	3.2
	Malignant neoplasm (140-208)	2.5	2.2
	Pneumonia and influenza (480-487)	2.3	2.5
15 - 44	Injury and poisoning (800-999)	37.3	13.6
	Malignant neoplasm (140-208)	25.1	18.7
	Heart diseases (390-429)	6.3	1.9
	Cerebrovascular disease (430-438)	2.8	1.7
	Chronic liver diseases and cirrhosis (571-572)	2.2	N.A.
	Pneumonia and influenza (480-487)	N.A.	1.4
45 - 64	Malignant neoplasm (140-208)	276.1	145.5
	Heart diseases (390-429)	69.3	27.2
	Injury and poisoning (800-999)	55.6	18.6
	Cerebrovascular disease (430-438)	36.3	23.7
	Pneumonia and influenza (480-487)	23.3	N.A.
	Renal failure (584-586)	N.A.	8.7
65 and above	Malignant neoplasm (140-208)	1 331.9	770.4
	Heart diseases (390-429)	633.2	606.2
	Cerebrovascular disease (430-438)	410.4	432.6
	Pneumonia and influenza (480-487)	403.0	359.4
	Chronic obstructive pulmonary disease (491-492, 496)	385.2	167.1

* Exclude unknown age and unknown sex.

† Since August 2000, the "resident population" approach has been adopted in place of the "extended de facto" approach for compiling population estimates. Also, the Population Census which was conducted in March 2001 provides a benchmark for revising the population estimates compiled since 1996 Population By-census. In this table, the population-related figures have been revised accordingly.

‡ International Classification of Diseases, Injuries and Causes of Death (ninth revision).

N.A. Not applicable as the listed cause is not among the top five leading causes of death for that sex category.

consultation rates with general practitioners, and their lower utilization of preventive health services compared to women.[3,9]

Occupational Factors

For adult men, a major influence on health is the workplace because they as a whole spend longer periods in the workforce. Paid work provides men not only financial security, but also offers social networks and a sense of worth in supporting a family. For many employed men, work conditions and demands increase their risk of ill health. Men tend to predominate in occupations that are identified as hazardous and expose them to more physical risk than their female counterparts. For example, all 21 accidental deaths associated with machinery in 1999 occurred in men.[6] A recent survey on men in Hong Kong reviewed that 37% of them worked ten hours or more per day. Among those who did not sleep well in the past 12 months, 45% reported work problem as the major reason.[12] Certainly, effects of unemployment and work stress are unlikely to affect men all uniformly. Those having a good social support network or a higher socio-economic status would cope better.

Health Care Factors

While great strides have been made in Hong Kong towards highlighting the special health needs of women and in establishing services for a range of screening and well women checks, there are generally fewer health programmes targeted at men. For many men, accessing health services during working hours may be difficult. A recent survey on a cohort of men aged 26 to 70 revealed that three-quarters of them had not undertaken body check-up in the past 12 months, with a higher proportion seen among the working age group.[12]

Conclusion

The fact that men generally live a shorter and less healthy life than women is not new to us. Equally ingrained in many of us, however, is the idea that this is a "fact of life" - as natural as men being different from women. Unfortunately, this traditionally-accepted view has also often been accompanied by the unhealthy notion that nothing much could be done about it.

To tackle men's health issues effectively, we need to first acknowledge and understand the underlying determinants of men's health, and integrate these factors into our intervention strategies. Although individual choices in lifestyle behaviours are important, many contemporary health problems facing men (and women) have their basis in the social, cultural and economic environments and the health care system that are beyond individual control, especially among those socio-economically disadvantaged.

If a men's health programme is to achieve significant improvement in the health of men in our community, it must go beyond the health issues that are sex-specific to men only such as prostate diseases, sexual dysfunction and baldness; it must tackle the major health problems facing men in our community such as smoking, cancer, heart disease and mental health. As importantly, efforts must also be made to tackle the various environmental and health care factors in our society that affect men's health.

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SALMONELLA SURVEILLANCE IN HONG KONG

Dr Samuel T K Yeung[1] Dr K M Kam[2]

Introduction

Salmonellae are common foodborne pathogens which are widely distributed in nature, including intestine of mammals and birds. They can cause food poisoning, acute enterocolitis as well as non-gastrointestinal symptoms. There are more than 2 000 serotypes of the bacteria.[1] The best known serotypes are *Salmonella (S)* Typhi and *S*. Paratyphi which cause the invasive diseases, typhoid fever and paratyphoid fever respectively. Food is the main vehicle of transmission.

Salmonella has been amongst the top three agents causing food poisoning outbreaks in recent years.[2,3,4] The number of these outbreaks and number of persons affected due to *Salmonella* were on the increase in the past decade.

Methods

A laboratory-based surveillance programme for *Salmonella* was started in Hong Kong in 1974.[5] Its objectives include monitoring the circulating strains of the organism in the community and detecting emerging strains in both the community and hospitals. At present, eight laboratories in public hospitals[a] and the Public Health Laboratories of the Department of Health (DH) participate in the programme. Data on *Salmonella* isolations, which include age and sex of patient, date of collection of specimen, the serotype and clinical symptoms, are collected regularly from these laboratories. The data are then compiled and analysed by the DH, and the results are fed back to the laboratories and relevant parties.

Food poisoning, typhoid fever and paratyphoid fever are notifiable diseases. Data on food poisoning notifications due to *Salmonella*, together with those on the enteric fever notifications are also analysed to complement the laboratory information obtained from the Salmonella Surveillance Programme (SSP).

Results

A total of 2 039 human isolations of *Salmonella* were reported to the SSP in 2000, the majority (84.5%) of which were

[a] **Participating laboratories**: laboratories in Kwong Wah Hospital, Prince of Wales Hospital, Princess Margaret Hospital, Queen Elizabeth Hospital, Queen Mary Hospital, Tuen Mun Hospital, Tung Wah Hospital and Tung Wah Eastern Hospital.

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from hospital laboratories. Information on serotyping was specified in 1 375 (67.4%). Eighty-two different serotypes were identified and the top ten serotypes most commonly isolated are listed in Table 1. These ten serotypes represented 73.4% of the isolations for which the serotypes were specified.

Children under five years accounted for 42.2% of the isolations. This probably reflects their susceptibility to infection and prolonged carrier state. The overall male to female ratio is 92:100. The bacteria were more commonly isolated in male in all age groups under 20 years whereas they were usually more commonly isolated in female for age groups 20 years and above (Figure 1). Salmonellosis occurred more often in the summer months and the number of isolations peaked in August (Figure 2).

Table 1 Top Ten Serotypes Isolated in 2000

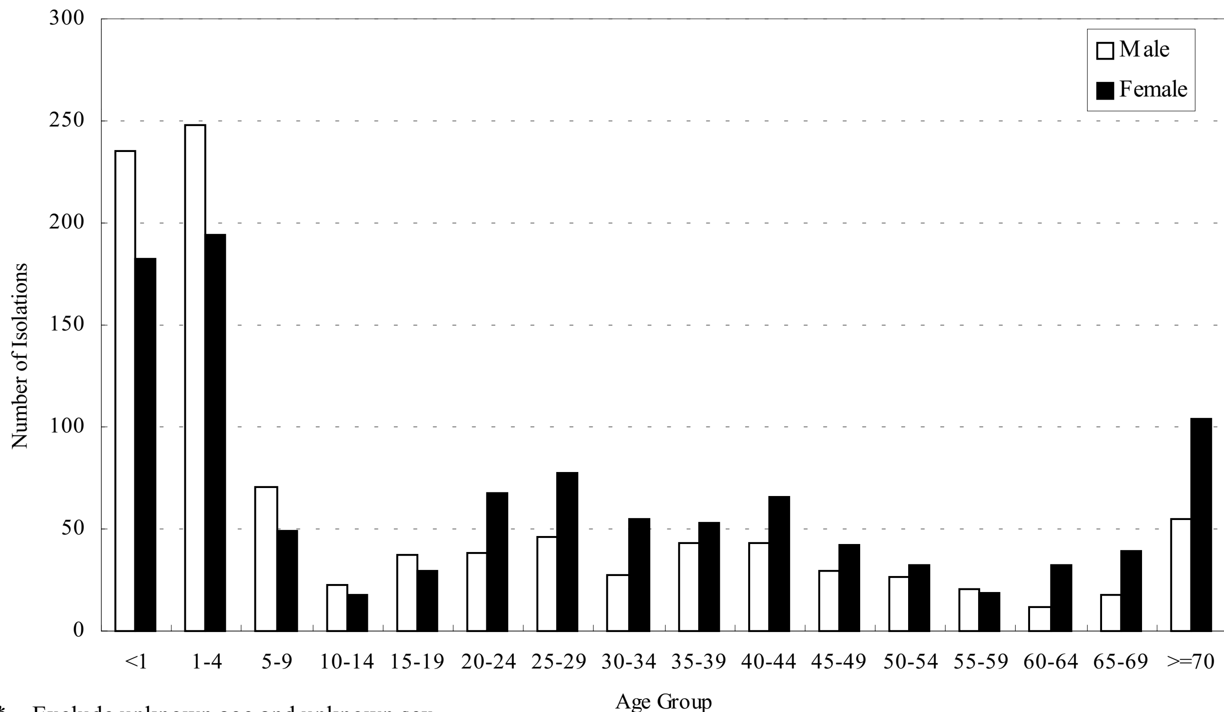
Serotype	Number of Isolations
S. Enteritidis	346
S. Typhimurium	189
S. Derby	175
S. Infantis	51
S. Stanley	45
S. Typhi	45
S. Agona	41
S. Haardt	41
S. Virchow	40
S. Rissen	36

New and Emerging Serotypes

The nine serotypes that had more than five isolations reported in 2000 and showed more than double the number isolated in 1999 are listed in Table 2.

S. Ardwick was not reported in 1996-1999 but 11 isolations were reported in 2000, ten of which were from one hospital in the second half of 2000. *S.* Haardt was first reported in 1996 and the number of isolations reported was two per year from 1996 to 1999. Forty-one isolations were reported in 2000 which showed a 20-fold increase. No clustering in age and sex of

Figure 1 Number of *Salmonella* Isolations* by Age and Sex, 2000



* Exclude unknown age and unknown sex.

patients, month of reporting or reporting hospital was noted among the cases. There may be considerable fluctuation in the number of serotypes isolated from year to year. Confirmation of emergence of some serotypes may require longer term evaluation.

Phage Typing of Salmonellae

A total of 91 non-duplicating strains of *S*. Enteritidis isolated from stool specimens of clinical diarrhoeal cases in 1998 and 1999 were phage typed according to the scheme of the Public Health

Figure 2 **Number of *Salmonella* Isolations by Month, 2000**

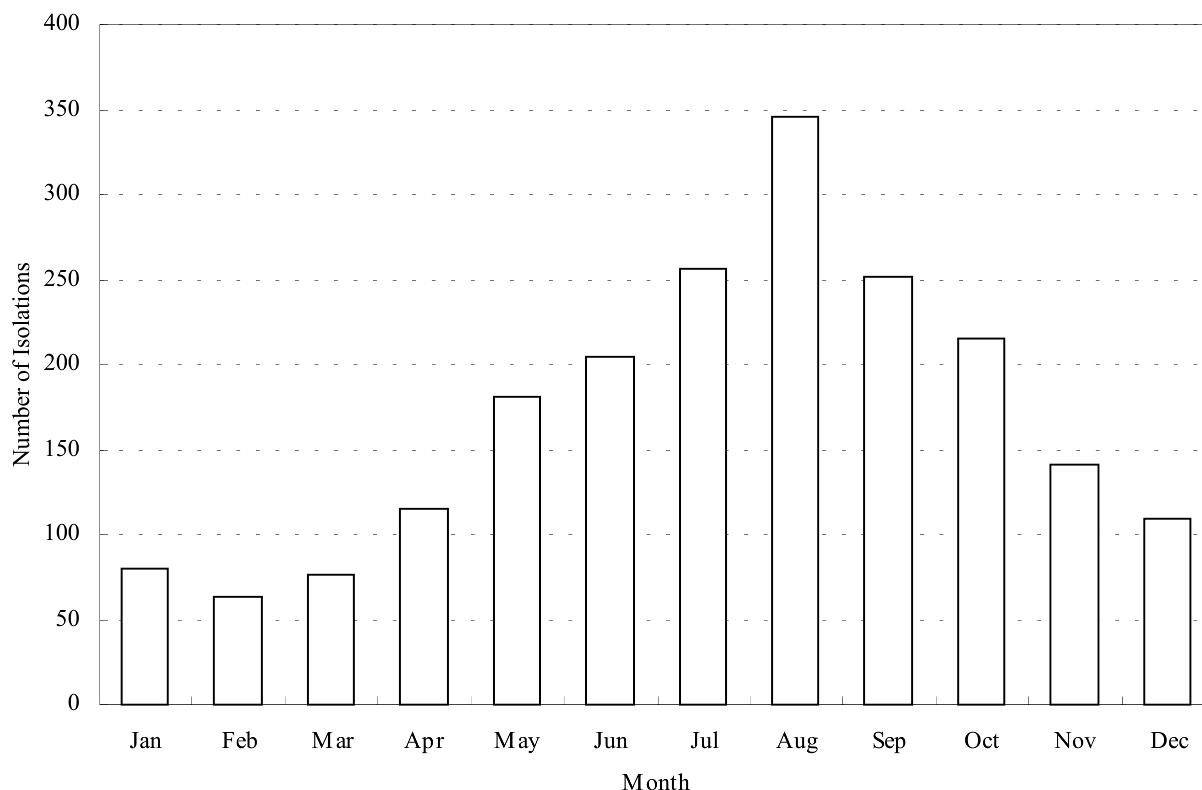


Table 2 **New and Emerging *Salmonella* Serotypes in 2000**

Serotype	Number of Isolations		% Increase (rounded to the nearest ten)
	1999	2000	
S. Ardwick	0	11	-
S. Haardt	2	41	1 950%
S. Infantis	7	51	630%
S. Indiana	2	14	600%
S. Give	1	6	500%
S. Hadar	7	28	300%
S. Schwarzengrund	4	13	230%
S. Uganda	8	26	230%
S. Virchow	14	40	190%

Laboratory Service (Colindale, United Kingdom (UK)). The distribution of phage types (PT) of these *S.* Enteritidis strains isolated from different age groups is shown in Table 3. It was found that PT4 was the commonest among all age groups. This PT4 was responsible for the significant increase in *Salmonella* infections in the 1980s and 1990s in the UK and Western Europe.[6] Epidemiological and microbiological investigation suggested that contaminated hen's egg was the source of infection.[7] PT4 was the commonest phage type isolated in UK in 1999.[8]

Trend

The number of *Salmonella* isolations reported to the SSP increased during 1991 to 1995 and then decreased in the following years (Figure 3). *S.* Enteriditis had remained the most common serotype isolated since 1997. The number of isolations with unspecified serotype increased generally.

The trend for the top six serotypes (ranked according to data in 2000) over the past ten years is shown in Figure 4. *S.* Enteritidis isolation showed an increasing trend and peaked in 1998. Increased number of isolations for *S.* Typhimurium was seen in 1995 and 1996.

Salmonella Food Poisoning Outbreaks

The number of food poisoning due to non-typhoidal salmonellae had shown an increasing trend, both in terms of number of outbreaks and number of persons affected. The increase was more obvious in the non-domestic settings.

In 2000, a total of 618 food poisoning outbreaks affecting 2 452 persons were reported to the DH, of which 89 outbreaks and 407 affected persons were due to salmonellae. *Salmonella* is the second commonest causative agent in terms of number of persons affected. Egg was identified as the incriminated food item in 15.7% of the outbreaks, chicken in 13.5%, siu mei and lo mei in 10.1% and pudding in another 10.1%. These four food items accounted for about half of the

Table 3 Results of Phage Typing of *S.* Enteritidis Obtained from Human Infections in Hong Kong, 1998 - 1999

Age Group (Year)	Phage Type (PT)*												
	4	21	47	1	8	13a	6	24	25	5b	RDNC†	Un-typable	Total
0	5	2	2	2	3							2	16
1 - 10	10				1	1	1					1	14
11 - 20	7	2				1		1					11
21 - 30	10	2	4	2	1		1						20
31 - 40	5		1	1							1	1	9
41 - 50	4	1		1					1			1	8
51 - 60	2									1		2	5
> 60	3												3
Total‡	46	7	7	6	5	2	2	1	1	1	1	7	86
%	53.5	8.1	8.1	7.0	5.8	2.3	2.3	1.2	1.2	1.2	1.2	8.1	100.0

* Phage typing scheme according to Public Health Laboratory Service, Colindale, UK.
† RDNC stands for 'Reaction Does Not Conform' to a typical pattern.
‡ Exclude five isolates (four PT4 and one PT13a) with unknown age.

Figure 3 Distribution of Major *Salmonella* Serotypes Reported, 1991 - 2000

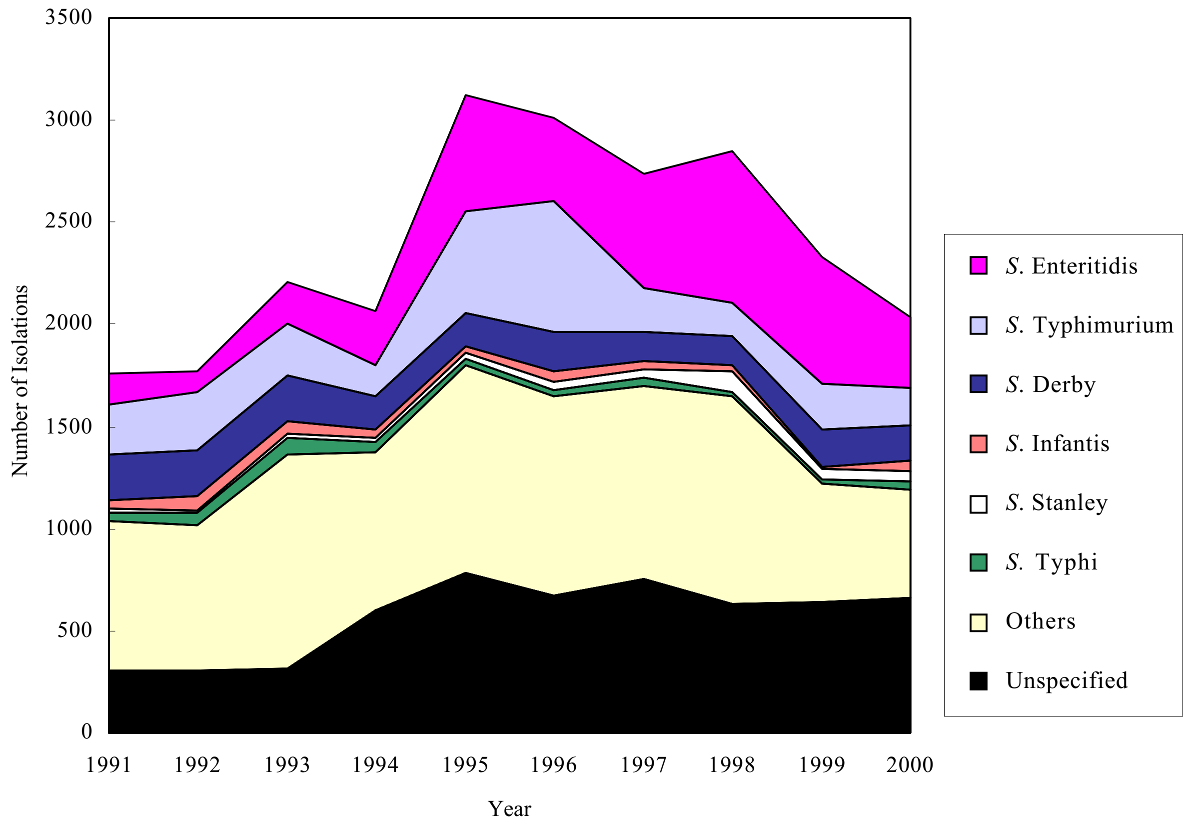
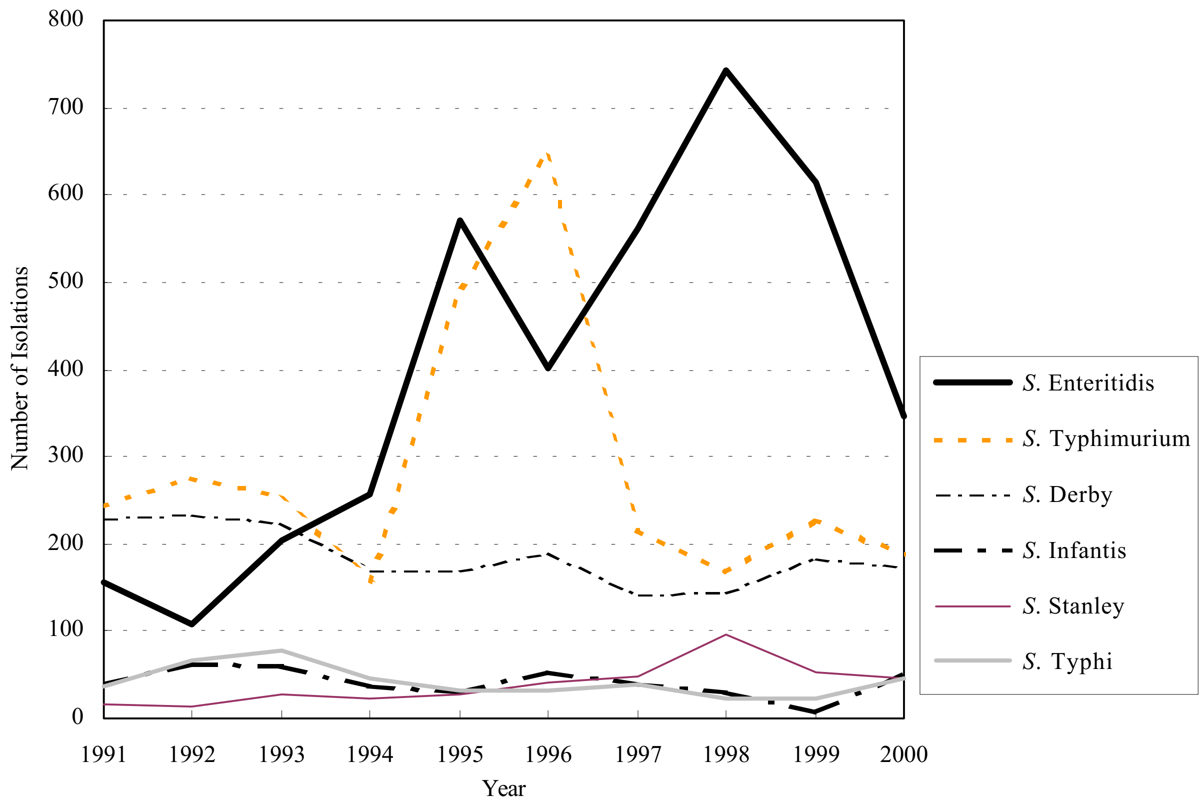


Figure 4 Trend of Top Six Serotypes, 1991 - 2000 (Ranked According to 2000 Data)



outbreaks. In terms of number of persons affected, the major contributing factors identified included improper holding temperature (24.1%), contaminated processed food (17.7%), inadequate cooking (16.7%) and contamination by raw food (11.3%).

Typhoid and Paratyphoid Fever

There were 45 isolations of *S.* Typhi, eight isolations of *S.* Paratyphi A and one isolation of *S.* Paratyphi B reported to the SSP in 2000. On the other hand, 106 and 13 cases of typhoid and paratyphoid fever respectively were notified in the statutory notifiable diseases registry. Of the 119 enteric fever notifications, 16 (13.4%) were imported cases. Typhoid and paratyphoid fever notifications were most commonly reported in young adults. One third of the cases were 20-29 years of age. Only 3.4% were children under 3 years old. There was one death due to typhoid fever in 2000.

Discussion

Because of the wide distribution of the bacteria in our food chain, the changing patterns of food consumption, changes in food industry and demographic changes in the population, salmonellosis is becoming an increasingly important public health concern.[9] As only a small proportion of salmonellosis cases are recognized clinically and another small proportion are reported,[1] the figures presented in this report represent a fraction of the actual occurrence of the disease in the community. Despite this limitation, laboratory-based surveillance of salmonellae with serotyping provides valuable information in monitoring disease pattern in the community to assess the health needs, to identify clusters and outbreaks, and to evaluate interventions.

Use of phage typing can further characterize and track the outbreak strain more accurately. Breakdown of subtypes using different methodology may help further distinguish cases, and aid in investigation of their epidemiological linkage. Comparison of PT found in neighbouring areas would be useful to analyse the spread of the organism. The PT dataset acts as a baseline of PT of *S.* Enteritidis found in Hong Kong, so that future changes in PT can be monitored when the tests are repeated, and public health preventive actions are taken in time.

Acknowledgment

The authors would like to thank the hospitals participating in the SSP which have provided data for this report, and acknowledge the assistance given by Laboratory of Enteric Pathogens, Public Health Laboratory Service, Colindale, UK, for the phage typing work.

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NUMBER OF NOTIFICATIONS OF INFECTIOUS DISEASES*

DISEASE	Aug 2001	Sep 2001	Jan - Sep 2000	Jan - Sep 2001
	Cases	Cases	Cases	Cases
1) Cholera	4	18	6	36
2) Plague	-	-	-	-
3) Yellow Fever	-	-	-	-
4) Acute Poliomyelitis	-	-	1†	-
5) Amoebic Dysentery	3	1	1	6
6) Bacillary Dysentery	40	36	245	278
7) Chickenpox	856	667	5 741	10 462
8) Dengue Fever	1	2	6	10
9) Diphtheria	-	-	-	-
10) Food Poisoning : *Outbreak*	88	53	471	554
Persons Affected	292	233	1 924	2 349
11) Legionnaires' Disease	-	-	1	1
12) Leprosy	-	1	6	8
13) Malaria	7	3	32	32
14) Measles	18	9	56	168
15) Meningococcal Infections	1	-	9	10
16) Mumps	8	9	62	58
17) Paratyphoid Fever	5	3	11	19
18) Rabies : *Human*	-	-	-	-
Animal	-	-	-	-
19) Relapsing Fever	-	-	-	-
20) Rubella	3	4	2 315	45
21) Scarlet Fever	17	14	109	124
22) Tetanus	1	-	5	4
23) Tuberculosis	692	587	5 769	5 491
24) Typhoid Fever	4	6	92	56
25) Typhus Fever	1	1	2	6
26) Viral Hepatitis :	29	37	548	610
- *A*	*16*	*19*	*435*	*460*
- *B*	*11*	*9*	*82*	*101*
- *Non-A Non-B*	*1*	*-*	*26*	*32*
- *Unclassified*	*1*	*9*	*5*	*17*
27) Whooping Cough	2	1	9	13

* The first two columns are numbers of two latest months whilst the other two columns are cumulative totals of the current and previous years.

† A case of vaccine-associated acute poliomyelitis occurred in 1995 but was notified in August 2000.

AIDS/HIV Surveillance

Cumulative Number of Cases	as at 30.6.2001	as at 30.9.2001
AIDS	524	544
HIV	1 636	1 693