In August 1999, “extreme” kayaker Tao Berman plunged over the 32-metre Upper Johnston Falls in Banff National Park, setting a world record and bringing some onlookers to tears. There were some tough variables: the pool was 7 metres deep, at best; a bad landing could have crushed his spine; and the waterfall flowed through a crack in the cliff face barely 2 metres wide.

Death wish or lust for life?

Statistics show that people are becoming increasingly involved in high-risk sports (Greenfeld, 1999; Groves, 1987). The rising numbers can, in part, be associated with technological advances and accessibility. However, there is also value to be gained in personal development. Previously, explanations for involvement in high-risk activities included the following:

- the Freudian death wish;
- fear displacement – attempting to deny one fear by directing attention to another, more manageable one;
- acting out psychopathic fantasies;
- demonstrating a misguided sense of immortality;
- anger from deep feelings of inadequacy.

Over the past few years, the scientific community has reversed its thinking. These days, it is difficult to find an expert who will state flatly that high-risk participants are driven by negative psychological motives. Yet, the popular view of the impulsive and careless thrill seeker/extremist still persists.

According to Ogilvie (1973), there appears to be no correlation between participation in high-risk sports and emotional instability. High sensation seekers simply need varying, novel and complex experiences for which they are willing to take physical and social risks.

High Sensation Seeker Personality Traits

Zuckerman (1991) suggests that high sensation seekers prefer hard rock music, skin flics, and Taco Bell (versus McDonald’s). They are more creative, but don’t necessarily receive high grades possibly because they don’t function well in structured classrooms. They are extroverted and may become leaders in less structured groups. They regard life as play; tend to injure themselves more often, but rarely succumb to depression. In fact, they often seem on the verge of hypermania: talkative, optimistic, full of new plans and ideas. Subjects are success-oriented, above average in abstract ability, superior in intelligence, and rarely reckless in risk-taking, preferring instead the calculated approach.

Farley (1986) claims that anywhere from 10 to 30% of society are risk-takers. He distinguishes between people who seek risks primarily in the mental realm (painting, writing, or the stock market), and those who seek thrills primarily in the physical realm, e.g. skydiving, white-water boating, ice climbing or BASE jumping (Building, Antenna, Span (bridge), and Earth (cliffs) parachute jumping). He postulated the existence of “a type T category” into which high-risk participants would fit.

Type T tends to seek thrills or arousal. He explains, “A T-plus personality takes risks in positive, healthy, and constructive ways; this category includes many of the great adventurers, scientists, and artists. The T-minus type tends to seek risks in negative ways, through delinquency, crime, violence, unrestrained drug experimentation, or drinking and driving.”

There is no doubt that we all have a natural desire to do adventurous, risky things at some time in our lives. With children and adolescents, this desire is particularly strong. Their natural curiosity leads them to seek out challenges. Pringle (1986) points out that if their needs are not met in positive, healthy ways, some may turn to anti-social behaviour.

The true adventurer takes life so seriously that he cannot bear to fritter it away on mere comfort, safety and respectability.
This issue of WellSpring focuses on a wide range of men’s health issues. When I was asked to write the opening article for this issue, it seemed like a reasonable request at the time, because all of us on the Editorial Committee are trying to share the workload. However, when I sat down to write this piece, I began to wish I had not been so agreeable. It’s difficult to know when to become excited about men’s health. It’s just not the thing to do. This topic is just a best seller on the magazine racks. Actually, I should caution that if you look at the magazine racks, you will see topics discussed which seem to address men’s health. Exercise, bodybuilding and sports are all featured there. These magazines capitalize on our society’s interest to achieve or excel. But one needs to ask of these magazines, “Is the information given in the interest of building health or is it given with the slant to achieving a physical goal?” If it is being given with the slant to achieving a goal, then does the information it contains support principles of healthy living? Even more, does the information encourage practices that do not enhance well-being? As health and well-being professionals, we need to be aware of our own health and the risks for my health. I have a better opportunity than many to open the door to discuss these issues and to model healthy behaviour – for those I meet or you’ll get hurt.”

There are topics in men’s health that just aren’t sexy. They don’t lend well to coffee talk. For example, how do brain chemistry and exercise relate? Why would people rock climb? Stefan (1999) noted that “99% of those who climb regularly are just normal(ish) people, like me, who like to see the world from the bottom up.”

Perhaps, “extremeness” exists simply in the eye of the beholder. I

**References**


We Dare You to Take This Quiz

Can you look at a person and tell whether he or she is a risk taker? There may be clues when you meet them: some risk takers have high energy levels and display impulsiveness. How can you size up your capacity for risk? Here’s an informal quiz. Although some of the questions seem obvious, your final score reflects the range of risk that you’re comfortable with, not just whether you like taking risks or not. Answer true or false:

1. I don’t like my opinions being challenged.   T
2. I would rather be an accountant than a TV anchor.   F
3. I believe that I control my destiny.   T
4. I am a highly creative person.   T
5. I like a lot of varied sex.   F
6. I don’t like trying exotic foods.   F
7. I would choose bonds over growth stocks.   F
8. Friends would call me a thrill seeker.   T
9. I like to challenge authority.   F
10. I prefer familiar things to new things.   T
11. I’m known for my curiosity.   T
12. I would not like to be an entrepreneur.   F
13. I’d rather not travel abroad.   T
14. I am easily bored.   T
15. I wouldn’t like to be a stand-up comedian.   T
16. I’ve never got speeding tickets.   F
17. I am extremely adventurous.   F
18. I need a lot of stimulation in my life.   T
19. I would rather work for a salary than a commission.   T
20. Making my own decisions is very important to me.   T

Give yourself one point each time your answer agrees with the key.

If you score 16-20, you’re probably just back from hang gliding in the Himalayas. 10-15: you’re a sushi eater who’d skip the trip to Japan. If you score 11-15: your score is a little too low—or too high! 5-10: don’t forget the umbrella. It might rain. 0-5: So, how long have you been on the tourist trail? 0-5: If you score 1-4, you don’t have to go to Japan. You’re probably just back from hang gliding in the Himalayas. 5-10: you might want to buy a new umbrella. 10-15: you’re a sushi eater who’d skip the trip to Japan. If you score 16-20, you’re probably just back from hang gliding in the Himalayas.

Why do some people get fat while others don’t? The simple answer is that the overweight eat too much and exercise too little. There’s more to it than that, however. Why do some people struggle to lose weight and fail? And why do some people never seem to gain weight, no matter what they eat or how little they exercise?

A recent study conducted at the University of Vermont suggests that overeaters who don’t gain weight may be more efficient fidgeters. They freely indulge in what the researchers call “nonexercise activity thermogenesis,” or NEAT (a ten-dollar term for burning calories through fidgeting). As reported in Science, researchers fed 16 non-obese volunteers an extra 1,000 calories daily and told them not to exercise. Then they noted weight gain over eight weeks. Those who did not gain weight, it appears, unconsciously increased leg-crossing, squatting, standing up and sitting down, and other movements that did not add up to exercise. It would be a mistake to make too much of a study so limited and with so many hard-to-measure variables. “Fidgeting” may not have been all there was to it. But if overeating stimulates your nervous system and makes you jumpy, count yourself lucky.

—Berkeley Wellness Letter, January 1999

Exercise and the colon: benefits beyond dispute

Exercising regularly, as has long been observed, is associated with a lower risk of colon cancer. Indeed, high activity levels can reduce the risk by half. Though “high activity levels” are admittedly hard to define and measure, most scientists go along with the idea that walking, jogging, cycling, and other kinds of exercise are good for the colon. According to a study in the Journal of the National Cancer Institute in June, “the only debatable issue is whether strenuous and non-strenuous activity are equally protective.” This question cannot be answered for sure right now, but chances are that both kinds are beneficial. But no one understands exactly why. Obesity increases the risk for colon cancer, and regular exercise helps prevent obesity. Researchers have been looking into other explanations. For example, people who regularly take aspirin and other nonsteroidal anti-inflammatory drugs (such as ibuprofen) appear to have a lower risk of colon cancer. Thus it’s theorized that high levels of certain prostaglandins (the hormone-like substances in the body that aspirin combat) in the colon may have something to do with tumor development.

But what does exercise have to do with prostaglandins? Interestingly, it seems that being both inactive and overweight increases levels of prostaglandins in the colon. The study cited above, which was conducted at the University of Arizona Cancer Centre in Tucson, did find that high levels of leisure-time activity and regular exercise helps prevent obesity. Researchers have been looking into other explanations. For example, people who regularly take aspirin and other nonsteroidal anti-inflammatory drugs (such as ibuprofen) appear to have a lower risk of colon cancer. Thus it’s theorized that high levels of certain prostaglandins (the hormone-like substances in the body that aspirin combat) in the colon may have something to do with tumor development.

Other ideas about the colon

Some researchers theorize that exercise promotes regular bowel movements. If so, this might mean the feces are moved out the large intestine more quickly, thus protecting tissues from cancer-causing substances. This theory is controversial, and not all studies have ever shown that exercise increases colonic contractions. But a recent small study at the University of Iowa focused on 11 healthy people (not athletes) with normal bowel habits. When they exercised at strenuous levels, normal movements of the colon actually slowed down, possibly because blood was being shifted to other parts of the body. (Technology for taking accurate measurements of this kind is now so sophisticated that it can be done without discomfort to the subjects.) Later, when the subjects were at rest, colonic contractions increased. Thus vigorous exercise does have measurable effects on the colon. These preliminary findings may support the idea that exercise reduces colon cancer risk by reducing constipation.

The benefits of regular exercise are beyond dispute. Reducing your colon cancer risk is one good reason to stay active, whatever the explanation turns out to be.

—Berkeley Wellness Letter, January 2000
Male Menopause – does it exist?

The following are excerpts from “Male Menopause – how to define it, how to treat it” by D. A. Schow, B. Redmon and J. L. Pryor, MDs.

Does an analogue to menopause in women occur in men? Although reproductive function in elderly men remains relatively intact, the physiologic and psychological changes that occur in some middle-aged men produce symptoms that are quite similar to those experienced by women during menopause. The manifestations of male menopause include hot flashes, depression, insomnia, mood swings, irritability, impotence, decreased libido, weakness, lethargy, and loss of both lean muscle and bone mass.

The relationship between this symptom complex and gonadal function in men is controversial. Nonetheless, male menopause will become an increasingly important issue because the number of men in the United States between ages 45 and 70 years is expected to grow from 46 million in 1990 to 81 million by 2020.

Changes with Aging

Among the changes that many men may expect as they age are declining androgen levels, decreased sperm motility, impotence, and frailty. These changes are not universal and do not occur during any set time span.

Androgen levels

The issue of whether aging causes a reduction in serum testosterone levels is controversial. It is generally believed that aging in men is accompanied by decreased serum testosterone levels. In addition, levels of sex steroid-binding globulin increase with age, reducing testosterone bioavailability even further. As a result, a significant number of men older than 50 years of age have bioavailable testosterone levels that are lower than those of young men.

Thus, testicular function in the male, like ovarian function in the female, declines with age, although the decline is more gradual and less dramatic. As with female menopause, declining gonadal function does not affect all men to the same degree, and many do not experience the adverse effects of lower testosterone levels during their lives.

Reproductive function

Despite the decline in hormonal function of the testicle with aging, reproductive function, unlike that in female menopause, remains relatively intact. There have been reports of men in their 90s fathering children. Sperm motility appears to be the primary parameter that is significantly decreased. However, at least one study has shown a decrease in sperm production with aging. The decline in semen quality is accompanied by numerous histologic changes in the testicles, including seminiferous tubular fibrosis (formation of fibrous tissue in the tubules of the testis).

Sexuality

Perhaps the most important change that men encounter with aging is a decline in or loss of sexual function. Recent estimates are that 10 to 20 million US men have erectile dysfunction, which is defined as the inability to achieve or maintain an erection sufficient for satisfactory sexual performance. In the Massachusetts Male Aging Study, 52% of men between 40 and 70 years of age reported impotence.

Impotence, which is perceived by the public as a sign of aging, can have a dramatically negative impact on a man’s sense of well-being. To quote one popular lay publication, male menopause strikes “at the core of what it is to be a man … his youthful sexual drive and performance.” The inability to achieve an erection can have profound effects on the male psyche, and impotence itself may contribute to the lethargy, depression, increased irritability, and mood swings associated with male menopause.

Declining sexual function may be the result of many factors, including a decrease in both erectile response and penile sensitivity. Thus, as a man gets older, achieving an erection takes longer and requires more direct physical stimulation. Medical illness, medications, and psychosocial factors such as a loss of one’s spouse or waning spousal interest in sex may also contribute to impotence.

Testosterone, on the other hand, probably plays an insignificant role in the decline of sexual activity with aging. The Massachusetts study cited above, as well as other studies, has shown no correlation between impotence and testosterone levels.

Androgens, in fact, are not essential for penile erection. Despite these facts, many men seek androgen replacement therapy for their impotence, hoping to “boost” their sexual prowess. Although studies in hypogonadal young men have shown an improvement in libido and spontaneous erections with testosterone replacement therapy, use of testosterone replacement in most elderly males for treatment of impotence has been unsuccessful. However, other forms of therapy for impotence are available, including psychotherapy, vacuum-suction devices, penile injections, and penile prostheses.

Frailty

Another important issue is the possible relationship between declining testosterone levels and increasing frailty in the aging man. Osteoporosis, loss of muscle mass, and an increase in body fat with aging have all been attributed to this decline. Men with chronically low testosterone levels have an increased risk of osteoporosis, and elderly hypogonadal men are at greater risk of hip fracture. Testosterone replacement therapy in young hypogonadal men results in increased calciumion levels and improved bone density.

Aging in men is also associated with anatomic and histologic changes in skeletal muscle, namely, a decrease in the number and bulk of muscle fibres along with an increase in body fat content. Hypogonadal men similarly lose lean body mass, decreased muscle strength, and increased adipose tissue. The changes in body composition have been ascribed to lower testosterone levels in both hypogonadal and elderly men, but conclusive evidence for causality does not exist.

Conclusion

Does male menopause exist? If the term implies a physiologic event analogous to female menopause, that is, complete cessation of gonadal reproductive function over a rather limited and relatively well-defined time span that is essentially universal by the sixth decade of life, the answer is no. However, many symptoms often associated with female menopause can occur in middle-aged men, even though the incidence, age of onset and extent of changes are more variable. Using a looser definition, male menopause does exist and may be defined as a gradual, age-related decline in gonadal function, which by the fifth or sixth decade of life, may span a continuum from frankly hypogonadal to clearly eugonadal. Also male menopause may have a role in age-related changes in body composition, bone mass, and sexual function.

Reference:
Physical Activity and Bone Strength in Men

Brendan Humphries, PhD
Central Queensland University

Bone strength, osteopenia (low bone mass), porous bone, or osteoporosis are all terms used to characterize the condition known as osteoporosis. It is important to understand that osteoporosis is not a disease (in the clinical sense) but rather a condition. Osteoporosis typically commences with an unnoticed decrease in bone mass that leads to structural deterioration of bone tissue and an increased susceptibility to fractures of the hip, spine and wrist. Fortunately, any bone can become susceptible to a change in its strength, particularly as we age.

Typically we regard human bone tissue as an inert substance, being little more than a support structure for our other tissues and organs, and probably not much more than a clothes hanger for our muscles. Luckily for us this is not the case. Human bone is a complex living tissue that can either atrophy or hypertrophy. It possesses both a blood and nerve supply, stores calcium and is constantly undergoing change. The constant changes in bone provide bones with the unique ability to heal or to be affected by diet and exercise. Until the age of about 30 to 35 years, our bones are in a unique state of building, however, the strength of bone can be affected by such things as heredity, diet, sex hormones, physical activity, lifestyle choices, and the use of certain bone or brittle bones. Osteoporotic symptoms occur earlier and last longer in women (40-65 years) than men (65 years onwards).

Osteoporosis in Women

Osteoporosis is less common in men than in women for several reasons. Men have larger skeletons, bone mass starts later in life and progresses more slowly, and they do not experience the rapid bone loss that affects women when their estrogen production drops as a result of menopause. Despite these differences, men can be at high risk for osteoporosis as well. Bone density loss, and the risk of a bone fracture in men, is associated with age, race, fracture history, weight, smoking, and alcohol intake. Active men are at lower risk for osteoporosis and fractures than inactive men.

Osteoporosis in Men

The prevalence of osteoporosis in Canada is estimated at 1.4 million Canadians suffer from osteoporosis:

- 1 in 8 men over 50 have osteoporosis (1 in 4 women over 50 years old)
- 25,000 hip fractures in Canada each year (1 in 3 will be men)
- 20% of hip fractures result in death, High levels of physical activity, especially in early life, can help maintain bone health and therefore reduce the risk of fractures.  In my view, male alienation is a serious well-being issue. The largely cultural introduction of sport and promotion of alienation between men and other men (in the form of competition), drives many individual maladaptive behaviours (addictions), degrades the environment to be friendly physical activity information to researchers and practitioners.

The effects of physical activity on bone health are generally positive and can help to prevent bone loss. Regular physical activity, especially if combined with weight-bearing exercise, can help to maintain bone density and reduce the risk of fractures.  The effects of physical activity on bone health are generally positive and can help to prevent bone loss. Regular physical activity, especially if combined with weight-bearing exercise, can help to maintain bone density and reduce the risk of fractures.  The effects of physical activity on bone health are generally positive and can help to prevent bone loss. Regular physical activity, especially if combined with weight-bearing exercise, can help to maintain bone density and reduce the risk of fractures.
Physical Activity and Prostate Cancer

Kerry S. Courneya, PhD
University of Alberta

Epidemiology of Prostate Cancer

Prostate cancer is the most common cancer in Canadian men and its incidence has been increasing in the past two decades (National Cancer Institute of Canada, 2000). Approximately 16,900 new cases of prostate cancer will be diagnosed in Canada in the year 2000 — about 1,100 of them in Alberta. The number of deaths in Canada due to prostate cancer is expected to be around 4,200 in 2000 with 390 in Alberta. Over their lifetime, Canadian men have about an 11%, or 1 in 9, probability of developing prostate cancer and about a 4%, or 1 in 25, probability of dying from prostate cancer. In terms of demographics, the probability of developing prostate cancer increases dramatically with age, making it a disease that primarily affects older men. Specifically, over 90% of prostate cancers are diagnosed in men over age 60, and over 60% are diagnosed in men over age 70 (National Cancer Institute of Canada, 2000).

Fortunately, early detection and improved treatments for prostate cancer have resulted in increased survival rates over the last few decades. The deaths-to-cases ratio for prostate cancer, a crude estimate of disease severity, is approximately .25 (National Cancer Institute of Canada, 2000). This figure compares favourably to other cancers (ratio for all cancers combined is .49) and indicates that men diagnosed with prostate cancer have a very good prognosis for survival. Increased incidence rates, combined with improved survival rates, means that there are thousands of Canadian men alive today who have survived prostate cancer. Consequently, health and fitness professionals can expect to serve a large and increasing number of prostate cancer patients and survivors.

Physical Activity and Prostate Cancer Prevention

One potential role of physical activity may be in the prevention of prostate cancer. Physical activity is a risk factor for prostate cancer has received increased research attention over the past few years based on a number of plausible biological mechanisms. The most plausible biological mechanisms include the role of physical activity in helping men cope with, and/or recover from, prostate cancer and its treatments (e.g., surgery, radiation therapy, hormone therapy). We have recently reviewed this literature and identified 36 studies on exercise in cancer patients (Courneya & Friedenreich, 1999; Courneya, Mackey, & Jones, 2000).

Unfortunately, only one of these studies included prostate cancer patients (most have examined breast cancer). Nevertheless, the studies have consistently demonstrated that exercise has beneficial effects on a wide variety of quality of life outcomes (e.g., cardiovascular and muscular fitness, self-concept, mood states, and fatigue) in cancer patients and survivors.

We have recently initiated a large-scale randomised clinical trial to examine the effects of a 12-week supervised weight training program on physical fitness and quality of life in prostate cancer patients receiving androgen blockade (i.e., surgical or chemical depletion of testosterone). This study is being conducted in conjunction with Dr. Roanne Segal of the Ottawa Regional Cancer Centre and is funded by the National Cancer Institute of Canada through their Prostate Cancer Research Initiative program. Our goal is to enrol 120 men in total (60 in Edmonton and 60 in Ottawa). To date, we have enrolled 25 men at the Edmonton site and 9 have completed the study. Preliminary results show that the men in the weight training group have doubled their upper body strength whereas the men in the control condition have shown no change.

Moreover, comments from men who have completed the weight training program have indicated significant positive psychological benefits as well. We caution, however, that these results are preliminary and we will not have final results until we complete the study in about one year.

In conclusion, research on the role of physical activity in both prostate cancer prevention and rehabilitation is beginning to emerge. At this early stage, the research is promising but very limited. We are hopeful that in the very near future our research programs, as well as others, will have more definitive information to report on this topic.

Myron Lusk pushes weights as part of a weight training study of men with prostate cancer at the University of Alberta Behavioral Medicine Fitness Centre.

What is one significant health issue facing men today?

Young men today lack inner strength and a sense of balance between their physical body and emotional/mental/spiritual self. They are constantly in a hurry and do not take the time to build their inner strength.

Personally, what do you do to stay healthy?

Everyday I practice Tai Chi for two or three hours to improve my psychological and physical well-being in order to live a harmonious life. Often I will practice with others and help others to learn Tai Chi. Although I am retired, I still volunteer three days a week because it motivates me when my students tell me how much their health or aliments have improved. Many of my former students are still exercising and have become Tai Chi teachers. Recently I have taught many seniors to be teachers of other seniors. It is very gratifying to see older people, who were once constantly sick, be lively and energetic; or who were barely able to walk, now be able to move without a cane or assistance. With perseverance, determination, patience, humility and faithfulness, regular practice, Tai Chi will ensure awareness and good health.

References


WellSpring
Why Men Exercise

A study done for the International Health, Racquet & Sportsclub Association (IHRSA) by American Sports Data found that 36% of Americans considered weight control to be the most important incentive to start an exercise program. It was more important to women (44%) than men (27%). However, the reasons for exercising change gradually as people age.

Men, age 18-24
Primary motivation is to build strength, followed closely by weight control. Developing and toning muscles are also important to this group. Cardiovascular conditioning plays a minor role. As with their female counterparts, primary motivation appears to be to improve physical appearance.

Men, age 25-34
Weight control takes over the number one spot, while strength training and cardiovascular conditioning virtually tie for second place, with toning and developing muscles not far behind. Primary motivation to exercise still seems to be improving physical appearance. There is a high likelihood that they are also motivated by the desire to train for and compete in sports.

Men, age 35-44
The strongest motivator appears to be growing concerns about health, particularly heart health. Interest in weight control and cardiovascular conditioning along with concerns about health problems increase along parallel lines, occupying the top three spots as motivators. Toning and developing muscles are in last place.

Men, age 45-54:
Reasons for exercising are the same as for age 35-44.

Men, age 55+:
Interest in cardiovascular conditioning soars, taking over the number sport from weight control. Concerns about health problems are the third highest motivator. Overall health appears to be the primary motivator for starting and staying with an exercise program.
Sources for more information on men's health

Tracy Chalmers Kitagawa

On-line versions of the popular American consumer health publication—Men's Health Magazine, and Men's Health Monthly—are available at www.mensfitness.com and www.menshealth.com. Both sites feature articles from previous newstand issues. However as the name implies, Men's Fitness Magazine is narrower in scope, focusing on topics like "training," "nutrition," "gear" and "sport and adventure." They also offer a web conference discussion group and chat room. A highlights of the Men's Health site is their monthly "exclusive" feature. The June 2000 issue, for example, provided heart health information and links to additional resources. Another commercial site, MenWeb, at www.vix.com/memmag/menshealth-feat.html features articles, interviews and book reviews from various consumer health sources. Topics addressed include "Conditions Men Get Too" (osteoporosis, eating disorders and22 Menopause), "Men and Anger," and "Why Don't Men Go to the Doctor?" (written by Dr. Kenneth Goldberg, founder of the Male Health Center in Dallas, Texas). This site, the first of its kind in the U.S., has its own Internet education site (titled "Not For Men Only") at www.malehealthcenter.com. Their web site is an excellent introduction to men's health issues with information mapped out by topic and then organized under three sub-headings: About male health, Symptoms, and Self-care.

Also worth visiting is the U.S. Department of Health and Human Services section on men's health at www.healthfinder.gov justoformen. Sub-sections within “just for you: men” include hot topics (don’t look for physical activity information here though), news, tools for you, and communities. The news section provides reputable links to leading health headlines and stories on the treatment and prevention of many well-known medical conditions. Under tools, see "Dr. Koop’s Community Resource Guide,” "Conditions Men Get Too" (osteoporosis, eating disorders and Menopause), "Men and Anger," and "Why Don't Men Go to the Doctor?" (written by Dr. Kenneth Goldberg, founder of the Male Health Center in Dallas, Texas). This site, the first of its kind in the U.S., has its own Internet education site (titled "Not For Men Only") at www.malehealthcenter.com. Their web site is an excellent introduction to men's health issues with information mapped out by topic and then organized under three sub-headings: About male health, Symptoms, and Self-care.

What’s Your Waist Size?

Measure your waist to find out if you are at risk for weight-related health problems. In 1998, a Dutch study found that this simple measurement may be as narrow in scope, focusing on topics like "training," "nutrition," "gear" and "sport and adventure." They also offer a web conference discussion group and chat room. A highlights of the Men's Health site is their monthly "exclusive" feature. The June 2000 issue, for example, provided heart health information and links to additional resources. Another commercial site, MenWeb, at www.vix.com/memmag/menshealth-feat.html features articles, interviews and book reviews from various consumer health sources. Topics addressed include "Conditions Men Get Too" (osteoporosis, eating disorders and Menopause), "Men and Anger," and "Why Don't Men Go to the Doctor?" (written by Dr. Kenneth Goldberg, founder of the Male Health Center in Dallas, Texas). This site, the first of its kind in the U.S., has its own Internet education site (titled "Not For Men Only") at www.malehealthcenter.com. Their web site is an excellent introduction to men's health issues with information mapped out by topic and then organized under three sub-headings: About male health, Symptoms, and Self-care.

Also worth visiting is the U.S. Department of Health and Human Services section on men's health at www.healthfinder.gov justoformen. Sub-sections within “just for you: men” include hot topics (don’t look for physical activity information here though), news, tools for you, and communities. The news section provides reputable links to leading health headlines and stories on the treatment and prevention of many well-known medical conditions. Under tools, see "Dr. Koop’s Community Resource Guide,” "Conditions Men Get Too" (osteoporosis, eating disorders and Menopause), "Men and Anger," and "Why Don't Men Go to the Doctor?" (written by Dr. Kenneth Goldberg, founder of the Male Health Center in Dallas, Texas). This site, the first of its kind in the U.S., has its own Internet education site (titled "Not For Men Only") at www.malehealthcenter.com. Their web site is an excellent introduction to men's health issues with information mapped out by topic and then organized under three sub-headings: About male health, Symptoms, and Self-care.

Also worth visiting is the U.S. Department of Health and Human Services section on men's health at www.healthfinder.gov justoformen. Sub-sections within “just for you: men” include hot topics (don’t look for physical activity information here though), news, tools for you, and communities. The news section provides reputable links to leading health headlines and stories on the treatment and prevention of many well-known medical conditions. Under tools, see "Dr. Koop’s Community Resource Guide,” "Conditions Men Get Too" (osteoporosis, eating disorders and Menopause), "Men and Anger," and "Why Don't Men Go to the Doctor?" (written by Dr. Kenneth Goldberg, founder of the Male Health Center in Dallas, Texas). This site, the first of its kind in the U.S., has its own Internet education site (titled "Not For Men Only") at www.malehealthcenter.com. Their web site is an excellent introduction to men's health issues with information mapped out by topic and then organized under three sub-headings: About male health, Symptoms, and Self-care.

Also worth visiting is the U.S. Department of Health and Human Services section on men's health at www.healthfinder.gov justoformen. Sub-sections within “just for you: men” include hot topics (don’t look for physical activity information here though), news, tools for you, and communities. The news section provides reputable links to leading health headlines and stories on the treatment and prevention of many well-known medical conditions. Under tools, see "Dr. Koop’s Community Resource Guide,” "Conditions Men Get Too" (osteoporosis, eating disorders and Menopause), "Men and Anger," and "Why Don't Men Go to the Doctor?" (written by Dr. Kenneth Goldberg, founder of the Male Health Center in Dallas, Texas). This site, the first of its kind in the U.S., has its own Internet education site (titled "Not For Men Only") at www.malehealthcenter.com. Their web site is an excellent introduction to men's health issues with information mapped out by topic and then organized under three sub-headings: About male health, Symptoms, and Self-care. —Berkeley Wellness Letter, March 1999

2000 – Canada

Information Technology in Community Health 2000 August 23 – 27, Victoria BC Contact: (250) 721-8576 National Physical and Health Education Conference October 12 – 14, Victoria ON Hosted by CAHPERD and OPHEA. The conference attracts delegates who have an interest in the physical and health education needs of children and youth including: physical educators, recreation professionals, and public health professionals. Contact: OPHEA, Ph: (616) 426-7120, Web: www.ophea.org Health for All in the Year 2000 October 25 – 22, Ottawa, ON The CPAH 91st Annual Conference and the OPHEA 51st Annual Conference. Themes are health for aboriginal peoples, equity and health for all, innovative approaches to health for all, and international health. Contact: CPAH Conference Secretariat, Ph: (613) 725-7169, Web: www.cpaha.ca Health, Work & Wellness October 25 – 22, Toronto, ON Balancing Values with Economics. Conference streams are: The Canadian Healthy Workplace Criteria, Integration, Balancing Personal & Organizational Well-Being, International Exchange, and Economic and Health Outcomes of Organizational Health. Contact: Conference 2000 Program Committee, Ph: (604) 605-0922, Em: deb@healthworkandwellness.com 29th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology October 26 – 29, Edmonton, AB Aging with attitude. Contact: CAG Conference Secretariat, Ph: (613) 728-9347, Web: www.cagge.ca

2001 – Canada

Advances in Qualitative Methods Feb 22 – 24, Edmonton AB Contact International Institute for Qualitative Methodology, University of Alberta, Ph: (780) 492-9041, Web: ualberta.ca/~iqm/methods01.html 17th World Congress of Gerontology July 1-6, Vancouver BC Contact: Dr. Gloria Gutman, Chair 2001 World Congress Organizing Committee, Gerontology Research Centre, Simon Fraser University, Ph: (604) 291-5062, Web: www.hubbour.df.ca/cag

Showing Our Past: Creating Our Future June 21-22, Red Deer AB The Alberta Public Health Association Conference. Deadline for submission of abstract is October 5, 2000. To receive a copy of the abstract, email: info@apha.ab.ca

2000 – International

World Federation of Public Health Associations September 2 – 6, Beijing, China Challenges for Public Health at the Dawn of the 21st Century, International Congress. Join health practitioners, policymakers, development workers, and researchers. Hosted by the China Preventive Medicine Association and the Chinese Academy of Preventive Medicine. Contact: WPHPA secretariat, c/o APHP 809 1 St NW, Washington, DC 20001-3710. Ph: (202) 777-2554 Em: allen.jones@apha.org

Worksite 2000: Advancing Business, Enhancing Health September 13 – 16, Orlando, Florida You’ll learn the fundamentals of health promotion, discover new programming ideas and collect the latest research on the economic benefits of worksite health promotion. Contact Association for Worksite Health Promotion, Ph: (847) 480-9574, Fax: (847) 480-9282, Em: awhp@awhp.com Society of Preventive Medicine 2000 Conference September 23 – 26, Pittsburgh, Pennsylvania The conference is looking to address this critical time in preventive medicine by bringing together researchers, educators, and ethics targeting special populations. It will be a dynamic collaboration of local, national, and international health professionals, students, and researchers. Contact: The Society of Preventive Medicine, Ph: (412) 647-1087 Ph: (412) 657-7374 Em: spsjanet@psst.net Web: www.spm.org

12th National Health Promotion Conference October 29 – November 1, Victoria, Australia This conference aims to encourage the health promotion field to be radically more effective in improving health and well-being, and in reducing inequalities in the 21st Century. It will stimulate this through thinking critically about both our past and our future, a combination of wisdom from the last 25 years, and international health. Contact: www.icms.com.au/health , Fx: +61 3 9682 0288, Em: health@icms.com.au

2001 – International

XVIIIth World Conference on Health Promotion and Health Education July 15-20, Paris, France The conference themes are Evidence, Investment, Advocacy, and Ethics. The goals are 1.) To contribute to the scientific and technical base for health promotion and education; 2.) To advocate for the development and application of national, regional and international policies to promote health; 3.) To identify effective investment options in health promotion and education; and 4.) To identify ethical principles upon which to base health promotion and education. Contact: The International Union for Health Promotion and Education at iuhpemcl@worldnet.fr