



Getting Inside
Men's**Health**

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Foreword



Foreword

It gives me great pleasure to see the publication of *Getting Inside Men's Health*. This report provides us with valuable and wide-ranging insights into many of the key issues pertaining to men's health. The report is very timely, in that it will have an important function in terms of informing the development of a National Policy on Men's Health.

Whilst there has been an increased awareness of the statistics surrounding men's health in recent years, this report addresses in a very meaningful way, the issues that underpin these statistics. The report is highly comprehensive, both in terms of the range and depth of questions that it addresses, and in the use of both quantitative and qualitative methodologies. As the report shows, the culture in which a man finds himself has a crucial bearing on his health status.

Getting Inside Men's Health will appeal to a wide audience – policy makers, service providers, health and allied health professionals, and to those who work with men in the community and voluntary sectors. The recommendations contained in the report offer a clear blueprint for developing policy and service-delivery measures for Irish men in the years ahead.

Pat McLoughlin

Chief Executive Officer South Eastern Health Board

Foreword



I very much welcome the publication of this important research project on men's health. Action 15 of the Health Strategy states that a policy for men's health and health promotion will be developed. It further states that the Department of Health and Children will take the lead role in preparing and driving a policy for men's health in partnership with the health boards and other agencies. The Health Promotion Strategy 2000-2005 also identified the development of a national plan for men's health as an important initiative.

The development of any national policy should be based on extensive consultation and comprehensive research in order to ensure that all relevant stakeholders commit to the policy and that any resulting recommendations are evidence based. It is also essential, in the case of a men's health policy, that men are an integral part of the policy development.

As an important first step in this process the Health Promotion Unit supported the appointment of a men's health research officer in the South Eastern Health Board and commissioned this research report in 2002 with a remit to research the role of gender and masculinity on Irish men's concept of health, document their knowledge, beliefs and attitudes to health and illness, health behaviours and risk behaviours and identify the barriers that Irish men perceive in accessing the health services.

The Unit has also commenced a consultation process and established a national steering committee to oversee the development of a men's health policy and action plan.

The findings of this research "Getting Inside Men's Health" will inform the development of the new men's health policy and action plan which we hope to publish in 2005. I would like to thank all involved in this important project, particularly the men who gave of their time to participate in the process.

Chris Fitzgerald
Principal Officer Health Promotion Unit



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INTRODUCTION

1.1 Introduction **Section 1**

Despite men's very prominent and powerful presence throughout the ages at the centre of health discourse, men have been conspicuously silent and largely non-reflective about defining or highlighting 'men's health' issues. Whilst men have been the predominant players in the decision-making process affecting health research and health service policy and provision, men themselves have not argued, lobbied or campaigned in the same way that women have, for improvements to their health at a personal or individual level. There has been a tendency in the literature to focus on the 'health' issues of 'men's health', with comparatively less focus on 'men', or more specifically, men as gendered beings (Connell et al, 1998). For example, Courtenay (2000b) states that although male bodies are often used to research the aetiology and treatment of wide-ranging diseases, men are rarely studied as patients, or as men. This historical context is in marked contrast to the relatively recent upsurge of interest in men's health in the academic and popular press, and more tentatively at a policy level.

The first World Congress on men's health was held in Vienna in 2001, and there have been a number of National Conferences on men's health in Australia, the United States and Europe. Other international initiatives in recent years include the launch of the International Society for Men's Health, the commencement of an International Men's Health Week, the launch of the European Men's Health Forum (EMHF), and the introduction of two academic journals devoted to men's health (The International Journal of Men's Health and The Journal of Men's Health and Gender). The launch of the EMHF's report in 2003 (White and Cash, 2003) provided for the first time, a comprehensive overview of statistics on men's health across Europe. Australia has been to the forefront during the 1990s in advancing men's health at a policy level, as well as being driven by local men's groups and community service organisations, and private sector men's health services. As well as hosting a number of National Men's Health Conferences, there has also been a draft national men's health policy for Australia, and the development of taskforces, advisory groups and policy and strategy documents within individual states. Closer to home, the UK Men's Health Forum has recently launched its draft policy for men's health ('Getting it Sorted' - Wilkins and Baker, 2004), and acts as the secretariat for an all-party parliamentary group on men's health.

Some welcome men's health initiatives have also emerged within Ireland in recent years. For example, the North Western Health Board (North Western Health Board, 1998) was the first board to co-ordinate a dedicated conference on men's health, whilst the Western Health Board (Western Health Board, 2000), became the first Board to devise a regional men's health promotion strategy. The North-Eastern Health Board (2001) conducted qualitative research on the beliefs, attitudes and perceptions of men in relation to health, and has since been actively involved in promoting men's health within the region. The present study evolved from the work of a men's health steering group in the south-east region, which includes members from both statutory and community sectors and is chaired by the Health Promotion Manager, South Eastern Health Board. The study is a joint Health Promotion Unit/South Eastern Health Board initiative. It should also be acknowledged that many statutory and voluntary organisations nationally, have been working towards a broad agenda of men's health and men's health-related issues. For example, the Irish Cancer Society launched an innovative campaign in 2003 directed at increasing awareness and early detection of cancers among men, and is shortly to commission research around cancer prevention and early detection of cancer in adult men in Ireland. The Crisis Pregnancy Agency has in recent times funded a number of research initiatives with a focus on men, including fathers' experiences of crisis pregnancies, and the barriers around men's use of sexual health services. Since the early 1990s, the Men's Development Network in Waterford has been engaged in wide-ranging developmental work with men from socially disadvantaged areas, that seeks to positively impact on men's health. Other organisations such as **AMEN** (support for male victims of domestic violence) and **Parental Equality** (support for separated/divorced fathers) are issue based, and with a specific focus in the broader context of 'men's health'. The Men's Health Forum in Ireland (www.mhfi.org) has been engaged in men's health work at an advocacy level since 2002, and in January 2004 launched the most comprehensive report to date on men's health statistics in Ireland (McEvoy and Richardson, 2004). The recent publication of an **All-Ireland Men's Health Directory** (The Institute of Public Health, 2004) provides a very worthwhile database of activity in the area of men's health on the island of Ireland.

Whilst these initiatives are evidence of a very welcome and significant shift towards an increased awareness around men's health issues, men's health at an overall strategic and service delivery level remains fragmented and ad-hoc. From a very limited knowledge base and in the absence of a clear set of guiding principles to direct policy and practice, those



individuals and organisations that are interested in men's health continue to operate largely in a vacuum. Whilst the issue of women's health, both nationally (Department of Health and Children, 1997) and within each health board area (e.g. *Women's Health in the South East 2000 and beyond* – South Eastern Health Board, 2000), has been the source of extensive consultation and careful strategic planning, the same cannot be said for men's health. Indeed, men have not until very recently (Department of Health and Children, 2000; 2001), been identified as a target population group for the strategic planning of health care. Other policy documents such as those on alcohol (Department of Health and Children, 1996) and cardiovascular disease (Department of Health and Children, 1999) highlight specific health statistics relating to men, but stop short of identifying the reasons underlying the disproportionate representation of men within the statistics, or of forming gender-specific action plans to deal with the issues raised. The state of inertia towards men's health at a strategic planning level seems to be linked to an overall lack of development of men's health policy and practice at a local level. It is against such a backdrop that the relevance of this research report becomes most apparent, particularly in terms of helping to inform the development of a national policy for men's health in Ireland.

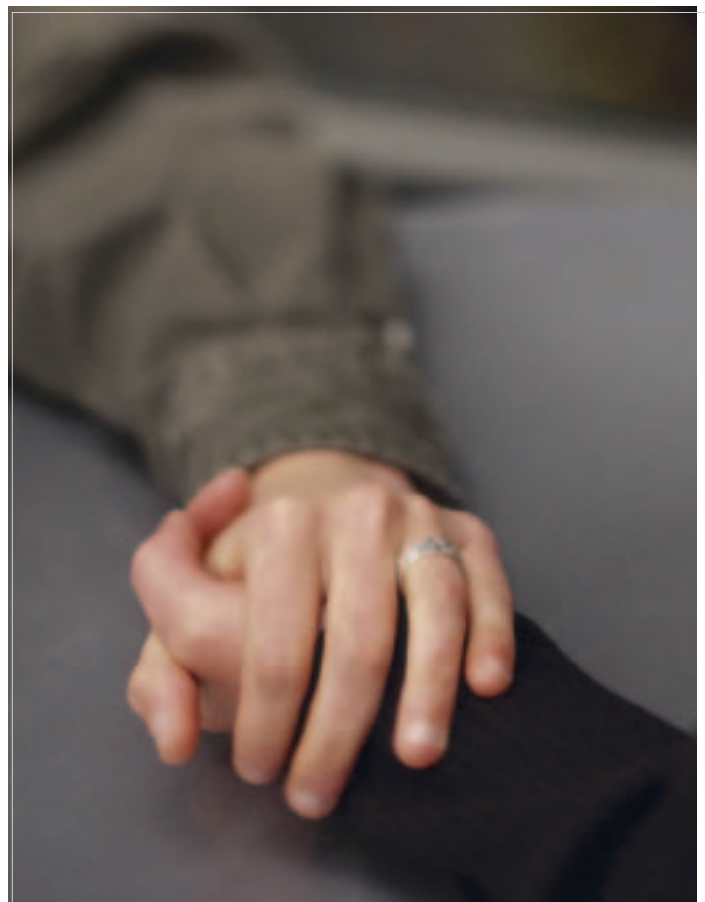
1.2 'Men's Health' Background and Origins

Whilst the flagging of men's health 'for action' in *Quality and Fairness* (Department of Health and Children, 2001) is a welcome first step, it must be said that there remains a fundamental lack of understanding and clarity about what is meant by 'men's health'. In particular, the over-simplistic use of the term is indicative of a single, homogeneous set of men's health issues which fails to take account of the diversity that exists between different groups of men. There is a tendency in the literature to focus on the margins of difference between men's and women's rates of morbidity and mortality from different illnesses, diseases and lifestyle issues, with particular reference to sex specific diseases (especially prostate and testicular cancer). To focus solely on this 'sex-differences' literature may have shortcomings (see Section 2.8), and in particular, men's health needs to be defined as an issue in its own right. The 'value' of this literature is perhaps most pronounced in terms of lobbying for more resources to be allocated to men's health. However, careful and cautious analysis of such statistics is necessary, particularly where policy or service delivery issues may be under consideration.

It must be stressed that a number of other factors - age,

social class, sexual orientation, race, marital status and urban/rural issues - all have a significant bearing on health status for men and indeed for women. For example, the leading causes of death among older men are very different from those of younger men. The incidence of sexually transmitted infections (STI's) and HIV is disproportionately higher among gay men compared to heterosexual men. The statistics in relation to health and social class are particularly damning (Public Health Alliance, Ireland, 2004), with those from lower social classes suffering disproportionate levels of ill-health. A number of other important and well documented factors also contribute to health and longevity, including education (Pekkanen et al, 1995), access to health care (Humphreys, Mathews-Cowey & Weinard, 1997), and employment status (Mathers and Schofield, 1998).

In light of the profound impact that these factors relating to social disadvantage have on health, the question may well be asked as to what extent men's health is in fact sex-specific. At one level, this question is answered by seeking out studies on health measures that control for level of disadvantage, the vast majority of which still show better health outcomes for women (Schofield et al, 2000). Such studies provide telling evidence that simply 'being male' accounts for the margins of difference in health outcomes between women and men. Whilst the focus of attention typically turns to biological differences, there is now a



growing realization that inherent biological influences are but one aspect of this complex issue. Men's health discourse has begun to evolve around the interaction of social disadvantage with the process of being a male and developing one's maleness. An examination of how social behaviour, cultural patterns, and social institutions lead to socially constructed gender differences can provide a more holistic understanding of men's health (Schofield et al, 2000; North Eastern Health Board, 2001). Indeed the debate and initiatives surrounding women's health in the 1990s confirm that gender is an issue that matters in relation to health care, health education and disease prevention. Sabo and Gordon contend that,

...gender influences the patterning of men's health risks, the ways men perceive and use their bodies, and men's psychosocial adjustments to illness itself

Sabo and Gordon (1995, p2)

There has been a tendency in the literature to focus on the "health" issues of "men's health", with comparatively less focus on "men", or more specifically men as gendered beings (Connell et al, 1998). Courtenay (2000b) refers to the individual lenses through which we view men's health, and emphasizes the need to look beyond the predominant and narrow biomedical perspective to a broader 'biopsychosocial approach'. This means putting 'the men into men's health', and not trying to separate or isolate men's health from all of the other aspects of men's lives. The emphasis therefore should be on a corroborative, interdisciplinary and team approach; opening up lines of communication with other professionals allied to men's health, trying out new approaches and new work practices, taking advantage of the Internet to form professional links, and reaching out to work in co-operation with the women's health movement. There is clearly a need for a greater understanding of 'men's health' in light of the fragmented and inconsistent use of the term in the past. The 'naming of men as men' is a critically important element of an emerging debate around men that is

...more explicit, more gendered, more varied and sometimes more critical

(Hearne et al, 2003, p6)



1.3 PRINCIPLES UNDERPINNING 'Men's Health'

1.3.1 The World Health Organisation defines health in broad and holistic terms, recognising that health is a 'complete state of physical, mental, spiritual and social well-being, and not merely the absence of disease or infirmity' (Nutbeam, 1998). It is vital that men's health is understood in the context of the broader determinants of health (Figure 1.3.1), and within a broad conceptual framework (Figure 1.3.2). The focus must be on the differences in men's health status and health outcomes, which arise in particular as a consequence of age, social class, education, employment status, the effects of marginalisation, and from the construction of masculinities.

Figure 1.3.1

Factors that influence health

Source: Dahlgren and Whitehead (1998)

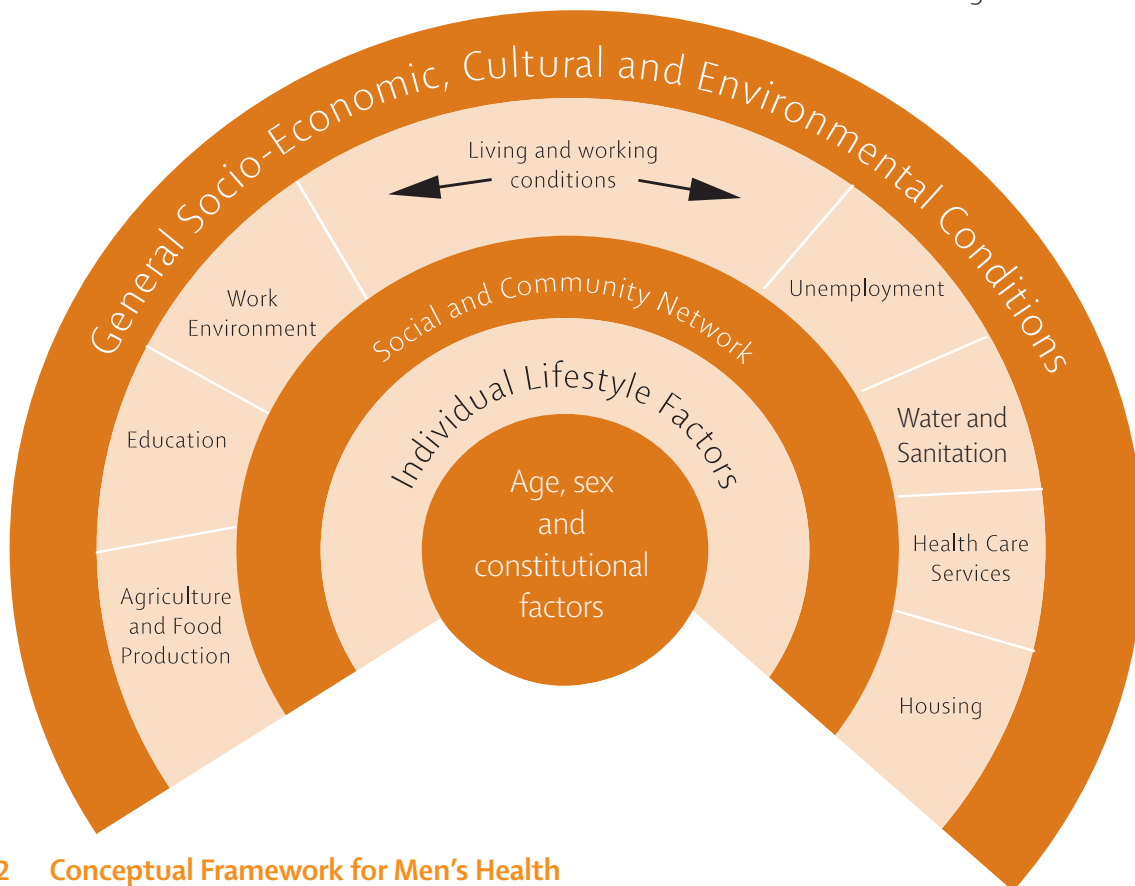
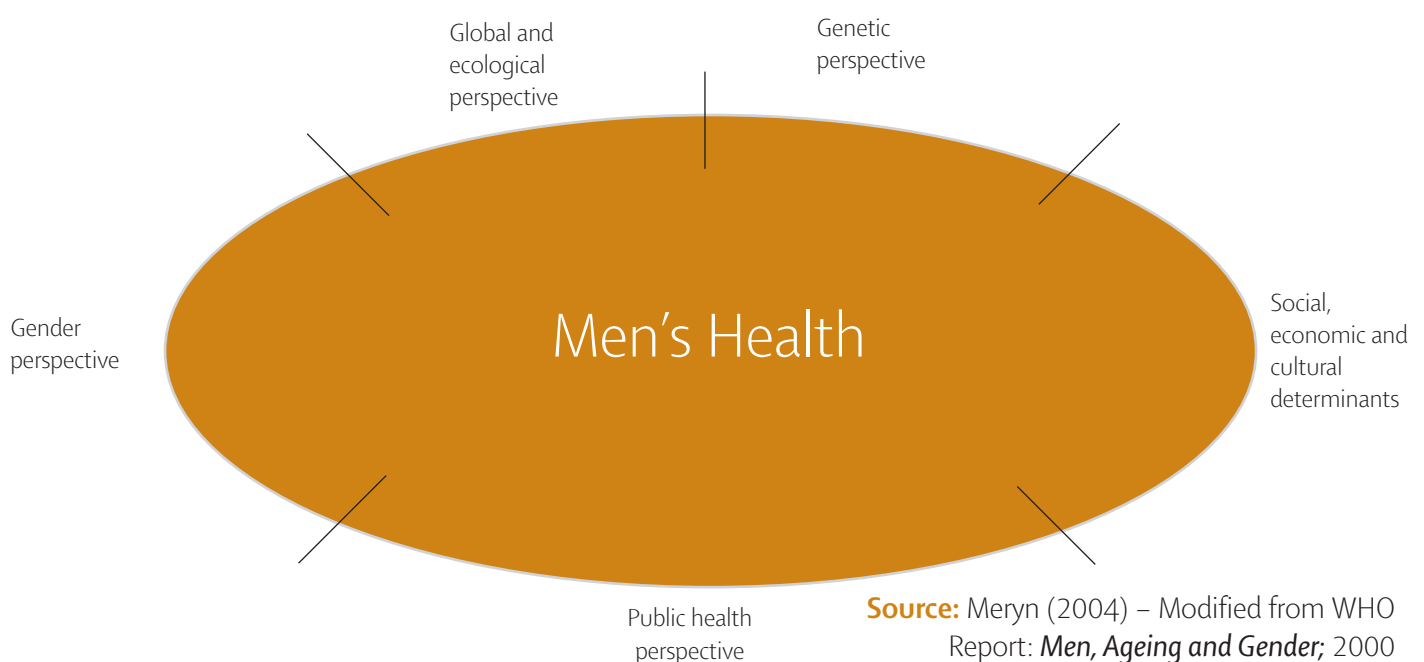


Figure 1.3.2 Conceptual Framework for Men's Health



Source: Meryn (2004) – Modified from WHO Report: *Men, Ageing and Gender*; 2000

- 1.3.2** Strategies and initiatives aimed at addressing men's health must acknowledge the diversity of men's health needs, and take into account the views and attitudes of men themselves about health and healthcare provision. A stronger and more critical evidence base, and a more creative approach to health-care policy and provision, are necessary to engage with men across all sectors of society in caring for their own health.
- 1.3.3** The pursuit of a 'men's health agenda' must not be at the expense of women's or children's health, but developed in the context of a gendered approach to health that recognises the reciprocity between men's and women's health.
- 1.3.4** The term 'men's health' is taken to mean the health of men and boys.
- 1.3.5** Health strategies and policies, and health care providers, must distinguish between 'sex' and 'gender'. Whilst sex refers to the biological characteristics by which human beings are categorised as 'male' or 'female', gender refers to culturally imposed 'masculine' or 'feminine' traits that are deemed to be socially appropriate to the sexes (Collins Dictionary of Sociology, 1995). Men's health therefore must not be solely defined as a set of male-specific, biomedical problems, but also in the way that men perceive themselves and live as masculine within a specific culture. Of particular importance is the way in which different subgroups of men see themselves as being male, and how this directly affects their health, health behaviours and risk behaviours.
- 1.3.6** A partnership approach, based on consultation and inclusiveness with all of the agencies that potentially impact on men's health, must form the basis of any future men's health policy. This consultation process should be with men themselves, health care providers, community groups, appropriate statutory and voluntary organisations and with employers.

1.4 'Men's Health' Defined

The earlier attempts to define men's health were largely based on the premise that men's conformity to what became known as 'traditional masculinity' (see Section 3.3) produced certain health deficits and increased men's physical health risks. However, the quite dramatic social, economic and cultural changes that marked the second half of the last century deeply unsettled traditional male/female roles, and began to challenge conventional 'manliness' from a number of different directions. The

emergence of feminism, rapid industrial and technological growth, and the destabilisation of the Catholic Church were key factors in challenging and unsettling a patriarchal Irish society. In the editorial of the first ever British Medical Journal (BMJ) edition devoted to men's health, Meryn and Jadad (2001, p1014) draw attention to the dramatic redefinition of men's roles, and the proliferation of products and services for men that would have traditionally been regarded as 'women's stuff'. As a result, the 'rules' or norms governing the way in which men were expected to behave in for example, the workplace, as fathers or as husbands/partners, were (and perhaps in many respects still are) in a state of flux. This has led some commentators to the assertion that men are 'in crisis' (e.g. Clare, 2000). Indeed, one of the major challenges facing men's health at a policy or health promotion level is to contest the hijacking of 'men's health' by the popular press. *Men's Health* the magazine for example consistently presents the message that men's health is based on an idealised, mesomorphic male body, that is a prerequisite for attracting women, and that can be acquired by the consumption of an array of products, supplements, gadgets and cosmetics. The Internet hosts thousands of 'men's health' web sites with a similar agenda, and many others that are driven by the pharmaceutical industry, primarily to promote treatments for male-specific health issues (e.g. erectile dysfunction).

Connell (2000) attributes the evolution of a 'men's health' concept to:

...the critique of patriarchal medicine by the women's movement, the emergence of a debate about women's health, and the questioning of masculinity and male roles which the new feminism provoked" Connell (2000, p177)

However, whilst the discourse around women's health in the 1970's evolved from a very definite feminist challenge to patriarchy and to male-dominated health services, Schofield et al (2000) reflect on a much more 'blurred rationale' for developing a sex-specific public health policy and service response for men. At the level of policy and delivery, the question arises as to whether men's health should be considered in a separate box to women's health, or in a way that accommodates the relations between the sexes. A gender relations approach examines

...health concerns in the context of men's and women's interactions with each other, and their positions in the larger, multidimensional structure of gender relations. Schofield et al (2000, p247)

There is now a growing body of research, loosely described by Sabo and Gordon (1995) as 'men's health studies', which evolved from critical feminist analyses of men, masculinity and health. This relatively new field places men firmly at the centre of the gender research process, and presents a number of perspectives from which to examine the fields of gender, gender health equity and men's health. It also acknowledges the complex and ongoing interaction between the structures of gender, class and ethnicity.

There remains however an absence of explicit definitions of men's health, and the concept has tended to be constructed by a contrast with women's health, and consequently constituted by

men's diseases of the reproductive organs (primarily prostate and testicular cancer) and by the margins of difference between men's and women's rates of death, disease, and so on.

(Schofield et al, 2000, p248)

Indeed, one of the more popular definitions that is quoted in relation to men's health (e.g. McEvoy and Richardson, 2004) is the following, which somewhat ironically is an adaptation of an American women's health definition rearranged to focus on men.

A men's health issue is a disease or condition unique to men, more prevalent in men, more serious among men, for which risk factors are different for men or for which different interventions are required for men

Fletcher (1996, pl)

In the context of a more holistic approach to men's health, the New South Wales Health Department, Australia defines a men's health issue' as

any issue, condition or determinant that affects the quality of life of men and/or for which different responses are required in order for men (and boys) to experience optimal social, emotional and physical health New South Wales, Health Department (1999, p7)

The Australian definition draws on the broader determinants of health as well as recognising that gender-specific as distinct from generic responses and interventions are required to enable men (and boys) to experience optimal health.

Taking a broader and more holistic approach, it is proposed that men's health in Ireland be understood as much more than the sum of male-specific illnesses or diseases such as

prostate cancer or erectile dysfunction. Men's health at both a policy and service delivery level must address the risks that men take with their health, the high level of health damaging behaviours in which men engage, the apparent reluctance of men generally to engage in preventative health behaviours, and the tendency for far too many men to present late during the course of an illness.

1.5 Men's Health in Ireland

Developing a Research Framework

The predominant source from which men's health statistics have emanated in Ireland has been from a biomedical research framework. It is obviously beyond the remit of this report to review the entire spectrum of research that has involved and impacted on Irish men's health. The following observations however may provide a context from which a men's health research framework, which can inform policy and practice, should emerge in the future.

1.5.1 Underlying causes of sex differences must be addressed

In general, the pattern has been for research to be disease or illness-driven, usually with reference, where appropriate, to sex differences within the data. Whilst there is a certain convenience at a policy, research or conceptual level in labelling 'men's health' and 'women's health' separately, this segregation tends to give rise to a focus on margins of difference between men and women, and may indeed invite conflict and rivalry (see Section 2.8). What appears to be an obvious gap in the research, is a general failure to probe the underlying causes of sex differences that are associated with health and longevity. In essence, the findings and conclusions tend to stop short of highlighting sex differences, without examining the role of gender as a complex and dynamic concept in actively constructing behaviours that directly or indirectly impact on health. The failure to recognise gender as an interactive system is fundamentally a failure to come to grips fully with the underlying causes for men's and women's health issues. The general absence of research in Ireland on gender relations and masculinities means that our understanding of the causation of men's health problems is largely vague and speculative.

1.5.2 Sex v Gender

The lack of a clear distinction between 'sex' and 'gender' in much of the literature is also a limitation. In most of the existing Irish health policy documents, gender tends to be defined in terms of sex and sexuality, rather than as a dynamic social structure. For example, the section on men's health in *Quality and Fairness* (Department of Health and

Children, 2001, P154) makes reference to 'gender differences in mortality', whereas the examples that are subsequently cited are in fact sex differences. Indeed, one of the key challenges posed by the development of a men's health policy, will be to critically review the degree of gender awareness that permeates the plethora of existing health/health-related policy and strategy documents, particularly from the point of view of 'men' as a diverse category of subgroups. A cursory overview would indicate that a gender-neutral approach is taken. For example, while the National Taskforce on Suicide (Department of Health and Children, 1998) documents an extensive set of recommendations for tackling suicide in Ireland, it appears to overlook the issue of suicide as a highly 'gendered' phenomenon that underpins the stark male/female differences in completed suicides. Future health policy documents should include a gender dimension that is specific to the health needs of men, and linked to specific health goals for men. The impact of health policy on men must also be carefully monitored and evaluated, so as to safeguard against the specific needs of men being overlooked.

1.5.3 Multidisciplinary approach to men's health research

The lack of any substantial body of social scientific, or interdisciplinary research on men's health in Ireland is disappointing, and needs to be addressed at a number of different levels. Principally, there is a need to develop more multidisciplinary research teams that can link biomedical research with social scientific research. This means a broadening and diversification of research methods, and appropriate multidisciplinary programmes to facilitate the research. For example, the specific needs and coping strategies of male cancer patients might be issues that the Ireland/Northern Ireland National Cancer Institute and the Irish Cancer Society might consider in the future. Likewise an examination of the role of gender and masculinities in the relatively high cardiovascular disease mortality rate among men should also be an integral part of the ongoing research in this area. The Department of Health and Children's commitment to the development of a policy on men's health that is informed by the current work is laudable. It is to be hoped that this report will be succeeded by future Department-funded research initiatives that will help to both inform men's health policy and to evaluate its effectiveness on an on-going basis. Men's health 'activists' must reciprocate by canvassing for existing sources of governmental research funding, through for example the third level sector, the health boards and the Health Research Board. Organisations such as *The Institute of Public Health in Ireland*, and the *Men's Health Forum in Ireland* have in the past played an important role through research and other

initiatives, in highlighting men's health issues, and can continue to play such a role in the future. There is also a case to be made for the soliciting of research funds around men's health from appropriate branches of both the public and private industrial sector. It is to be hoped that a greater volume of research initiatives will in the future develop within academic institutions from the ground up. For example specialist centres already exist at Trinity College (The Centre for Women and Gender Studies), and UCD (Women's Education Research and Resource Centre), where gender is the focal point of research initiatives (albeit not in the context of health specifically), but almost exclusively in relation to women. Given the relational nature of gender, the development of a centre for gender and health studies may well be the way forward for the advancement of health issues for both women and men in the future. In particular the linking of research on gender studies and gender relations with biomedical research would be most welcome in developing a greater understanding of the causation of both women's and men's health issues. Education and training initiatives bringing 'health' and 'gender' experts around the same table would greatly facilitate the breaking down of traditional barriers between these fields.

1.5.4 Funding and dissemination of research findings

In light of the predominant focus on biomedical research, it may well be appropriate to review existing structures and policies for the dissemination of health research funds in Ireland, and to question if particular biases exist towards the more tried and tested quantitative, biomedical research. The question of how research findings are disseminated at the coalface is also worth exploring. The criteria set by academic journals (which ultimately define the fate of the researchers), may well be in stark contrast to the more practical and 'bottom line' needs of health workers, community activists and even policy makers. There may well be justification for a type of filtering mechanism, whereby the findings from academic work are disseminated through other publications or through the general media. Connell et al (1998) recommend a policy of building in funding for dissemination, and that in order for grant applications for men's health to be successful, that specific proposals and budgetary requirements for dissemination should be included in the grant application.

1.5.5 Framework to connect research to policy and practice

Connell et al (1998) conclude that much of the research on men's health in an Australian context is not cumulative, and not well connected with the needs of policymakers and practitioners. The authors highlight the need to develop an overall framework in which different aspects of men's health can be linked together, and in which research can be

better connected to health care policy and provision. This also has implications for research funding to be built into the strategic planning of healthcare and health services, while training and resources also need to be identified to facilitate community participation. Within an Irish context, there is clearly a need to develop a national men's health research framework and network that will drive a more vibrant and cohesive men's health research agenda, that will support practical action with relevant community-based organisations, and that will in turn shape men's health policy into the future.

1.5.6 Identifying key research questions for men's health

One of the more immediate tasks of any future men's health research group would be to develop a priority of men's health research questions. This study investigates the role of gender and masculinities on Irish men's lay concept of health, their knowledge, beliefs and attitudes in relation to health and illness and health practices, and on the barriers that Irish men perceive in accessing health services (see Section 4.1/4.2). Effective policy will ultimately be based on a more comprehensive understanding of some of the broader social, economic, cultural and environmental determinants of health. Examples include the impact of social disadvantage on health, the relationships between work and health, and between work and family responsibilities; the impact of unemployment on health; and men's status as fathers in the context of Irish family law. Research into effective health promotion practices with men should also be included.

1.5.7 Locating research in community and work settings

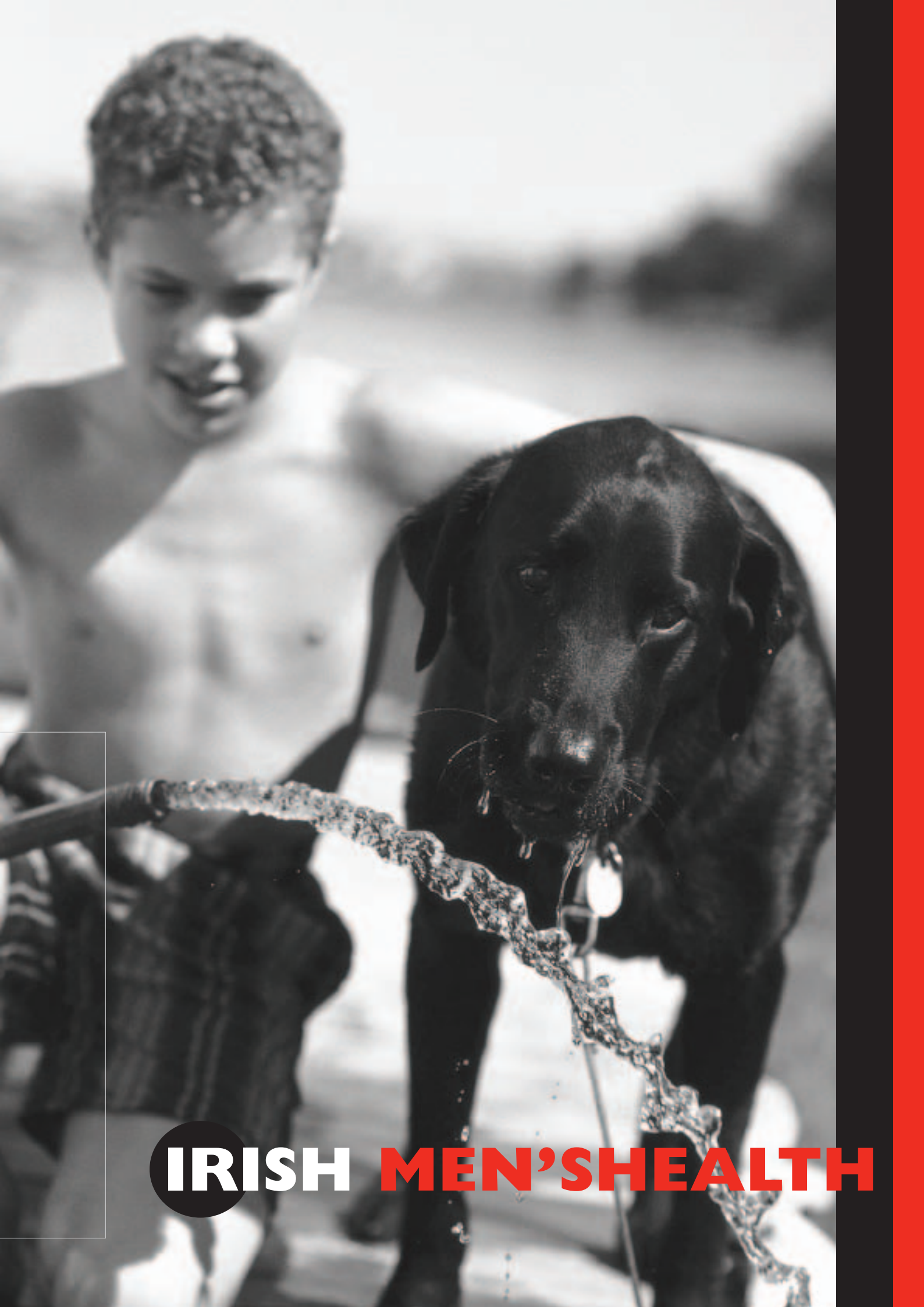
Among the most striking features from the existing literature on men's health is the overall problem of 'getting through' to men, and the disproportionate representation of many aspects of ill health and disease among certain subgroups of men. It is therefore critically important to locate and construct future research initiatives in community, work, and other settings where men feel at ease, and where those men in most need are targeted. A very appropriate example is the 'action research' model, where community-based workers and researchers work side-by-side, and where research actively unfolds in tandem with community-based initiatives. Research that is practically based rather than abstract, and in which there is a perceived degree of ownership in terms of research design, outcomes and recommendations, is more likely to have positive long-term effects. A model of good practice within the South East region is the close working relationship that exists between The Centre for Health Behaviour Research at Waterford Institute of Technology

(WIT) and The Health Promotion Department of the South Eastern Health Board. The building in of research budgets to the overall funding of Community Development Projects would be one practical way of moving this issue forward. In order to promote community-based and community-driven research, Connell et al (1998) recommends the provision of small 'seeding' grants that are not conditional on overly strict eligibility criteria nor on bureaucratic application procedures, and that could make a valuable contribution to community definition of need.

1.5.8 Policy development

The commencement of the consultative process that will lead to the development of a national men's health policy in Ireland will begin in the near future, and represents a unique opportunity to bring men's health forward in a strategic and holistic way. That the consultation process is proposed to include liaison with health care providers, statutory and voluntary organisations that work with or on behalf of men, academic institutions, and men themselves, is to be welcomed. It is also critically important that such research as is contained in this report (and others cited in this report), should inform the development of policy. A valuable reference point will obviously be to learn from the existing model for women's health, and to consult with The Women's Health Council. Not to do so runs the risk of segregating men's and women's health in a way that may be counter-productive to both sexes (see Section 3.2).





IRISH MEN'S HEALTH



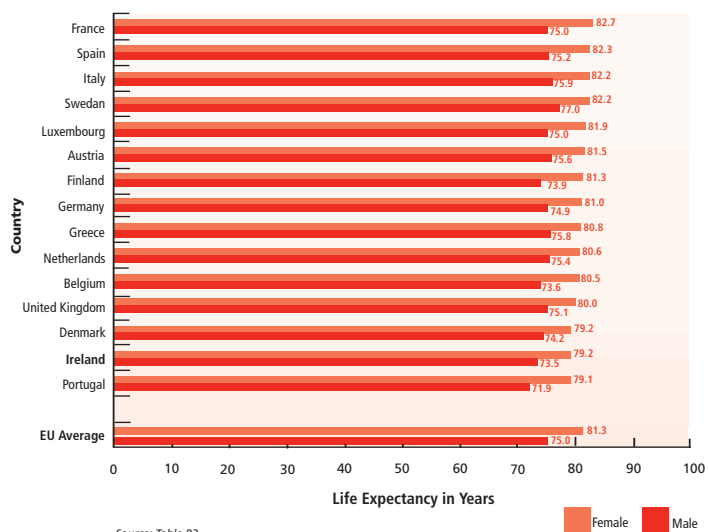
Summary of Key Statistics on Irish Men's Health Section 2

Whilst the statistics on Irish men's health have already been well documented (The Men's Health Forum in Ireland, 2004; Department of Health and Children, 2003; The Institute of Public Health in Ireland, 2001), they do serve as an important backdrop to the current study and will be summarised in this section. A critical overview of this 'sex-differences' literature will also be presented.

2.1 Life Expectancy

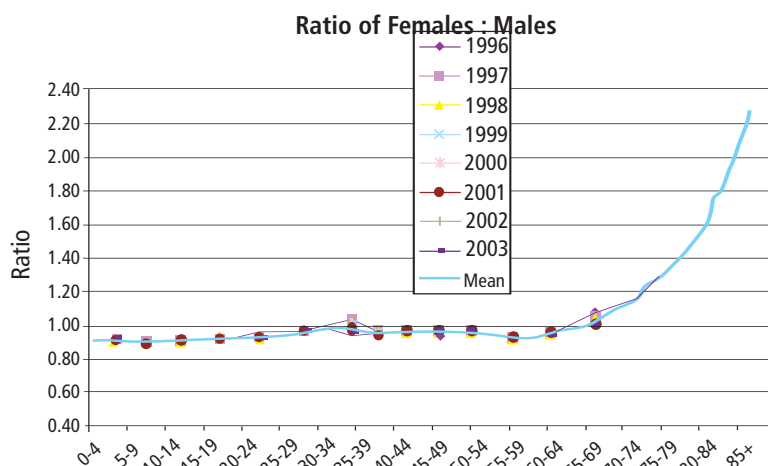
Irish men die on average nearly 6 years younger than Irish women do, and have the second lowest life expectancy in the European Union (Figure 2.1.1) Although more males are born in Ireland each year than females (Ratio 2003, 1.05), there is a marked discrepancy in the ratio of females to males after the age of 65 (Ratio 2003, 0.77; Figure 2.1.2). The gap between the sexes has resulted in a marked female dominated population amongst those over 65 years (Figures 2.1.2 & 2.1.3).

Figure 2.1.1 Life expectancy at birth for males and females in EU Countries



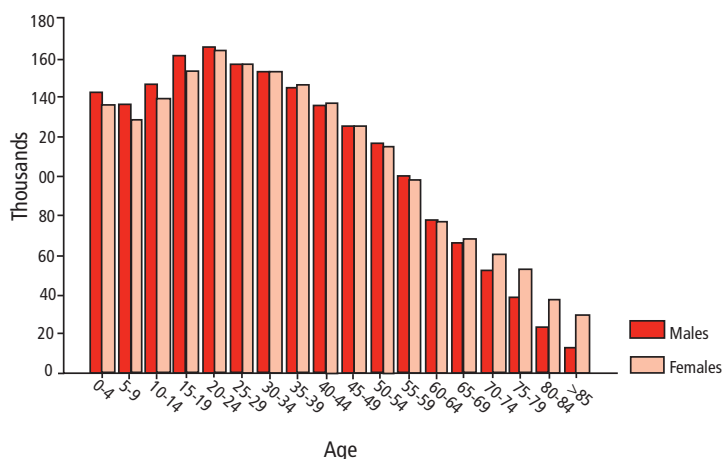
Source: Health Statistics 2002, Department of Health and Children (2004)

Figure 2.1.2 Ratio of females to males 1996-2003



Source: Central Statistics Office, ROI 2004

Figure 2.1.3 Population by gender and age 2002

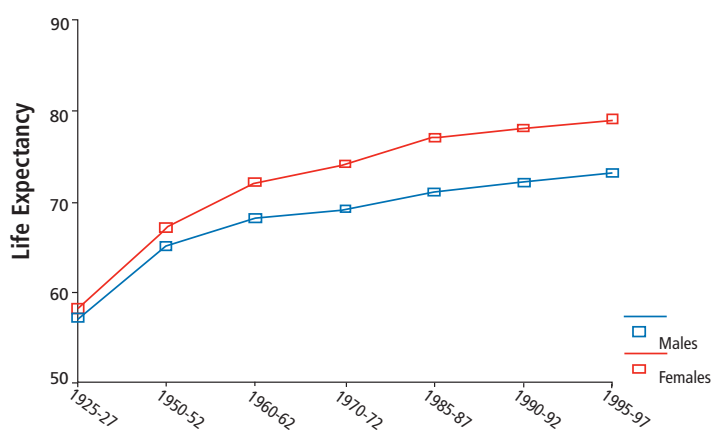


Source: Central Statistics Office, ROI, 2004

It should be acknowledged that life expectancy has increased very considerably (see Figure 2.1.4) for both men and women during the course of the last century and in an international context, Ireland can be considered to be among the healthiest countries in the world. The increased elderly population is not so much a function of old people living longer, but rather from a reduction in death rates at earlier ages, resulting in a much higher proportion of the population surviving to old age. Indeed, the younger the age group, the greater has been the reduction in death rates, with the biggest decline being in infant mortality and childhood mortality respectively (Wilkinson, 1996). It is since the 1920s that the gap in life expectancy between the sexes has emerged (Figure 2.1.4). The magnitude of this

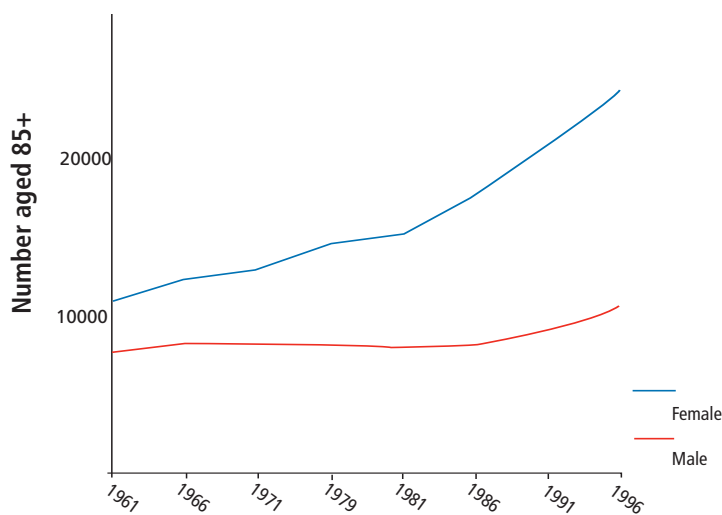
gap is most evident in the population aged over 85 years, a gap which has more than quadrupled between 1961 and 1996 (Figure 2.1.5).

Figure 2.1.4 Changes in life expectancy by gender Since 1920 in Republic of Ireland



Source: Central Statistics Office, ROI 2004

Figure 2.1.5 Number of Males/Females aged 85+ in Ireland, 1961-1996



Source: Health Statistics 2002

Source: Health Statistics 2002, Department of Health and Children (2004)

Furthermore, the gap in terms of female/male life expectancy internationally has been widening, most notably in much of central and Eastern Europe. During the

1990s in Russia for example, life expectancy at birth fell to a low of 58.2 years for men, compared to 73.4 years for Russian women (UNICEF, 1996).

2.2 Mortality

Underpinning men's lower life expectancy is the fact that in Ireland men have higher death rates for all leading causes of death (Table 2.2.1) and at all ages (Figure 2.2.1). The annual standardised mortality rates (per 100,000) during the period 1989-1998 for men and women was 1046 and 680 respectively (Balanda and Wilde, 2001). This represents a 54% higher level for men, and has been described as 'a fundamental inequality in health' (ibid, p11). Indeed, even in the case of sudden infant death syndrome, the all Ireland annual directly standardised mortality rate during the period 1989-98 was significantly higher (53%) for males than it was for females (The Institute of Public Health in Ireland, 2001). As Table 2.2.1 outlines, the male/female mortality differential is consistent for all the principal causes of death, and is particularly pronounced in the case of external causes of injury and poisoning. A closer examination of this category (Figure 2.2.2) reveals grave sex differences in mortality for transport accidents (three times higher) and suicide and intentional self-harm (four times higher). In 2002, 72% of all deaths by RTAs were male, and 60% of those in RTAs were male (National Roads Authority, 2003). Whilst the gap in male/female mortality is consistent across all age groups, it is most pronounced between young men and young women, with men in their 20s being three to five times more likely to die than their female counterparts (Figure 2.2.1).



Table 2.2.1 Annual directly standardised mortality Rates (DSMR) and Directly Standardised Mortality Rate Ratios for Females and Males in the Republic of Ireland, 1989-1998

	Number		DSMR		DSMR Ratio
	Female	Male	Females	Males	Male:Female
All Causes of Death	22,622	24,219	680.3	1,046.4	154%
Diseases of Circulatory System	10,281	10,732	290.8	467.3	161%
Neoplasms	5,199	5,903	179.3	260.4	145%
Diseases of Respiratory System	3,658	3,530	101.0	149.9	148%
External Causes of Injury and Poisoning	633	1,450	21.6	58.0	269%
Diseases of Digestive System	711	620	21.3	27.1	127%
Diseases of Nervous System and Sense Organs	414	392	12.9	16.6	128%
Mental and Behavioural Disorders	189	170	5.5	7.3	131%

Source: Balanda and Wilde, 2001

Figure 2.2.1 Ratio of mortality rates male:female due to all cause of death

Source: Central Statistics Office, 2004

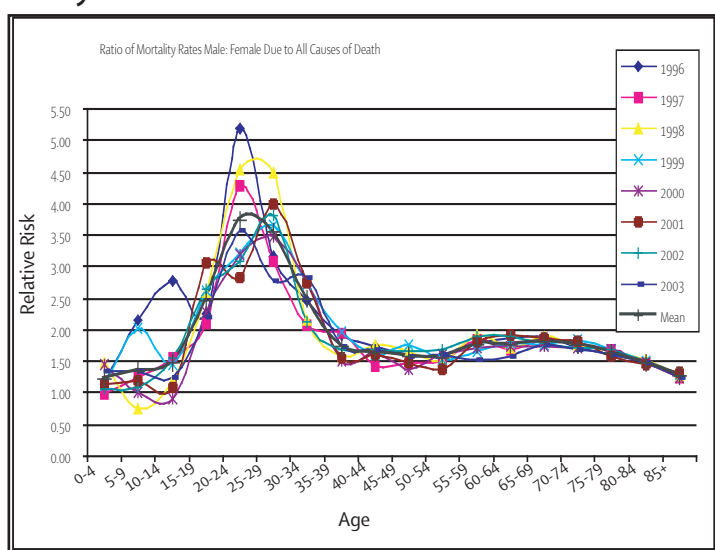
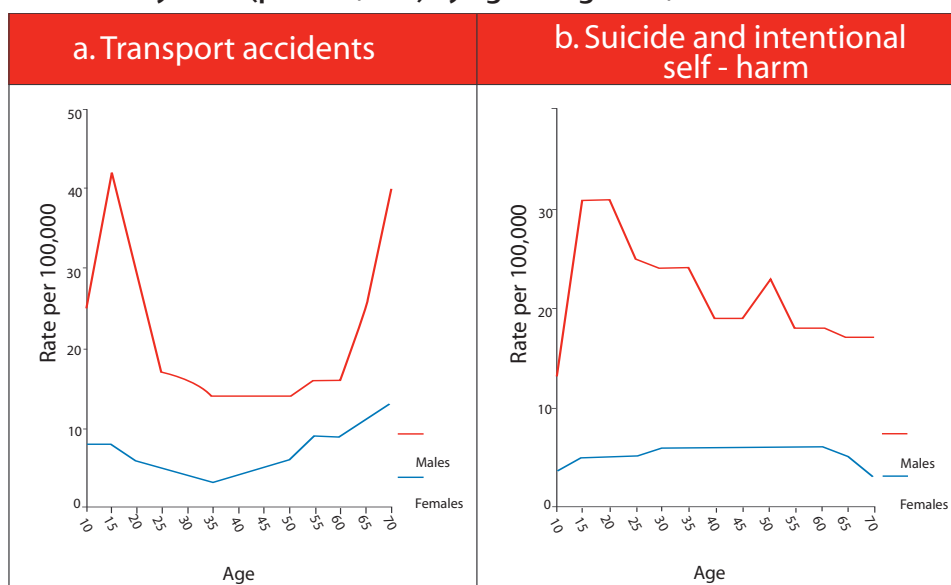


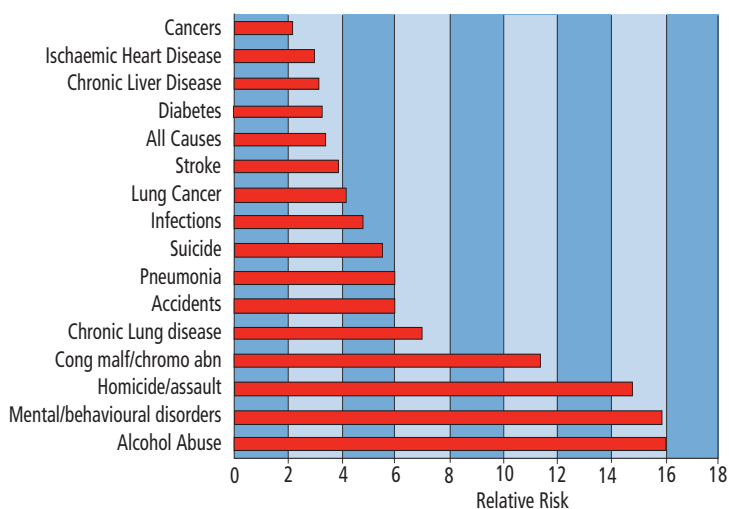
Figure 2.2.2 Annual mortality rates (per 100,000) by age and gender, 1989-98



Source: The Institute of Public Health in Ireland, 2001

Differences in mortality rates between lower and higher socio-economic groups (both men and women) offer the most striking evidence of the impact of social disadvantage on health (Figure 2.2.3). For example, men from the lowest occupational group are over five times more likely to die from suicide and sixteen times more likely to die from alcohol abuse, compared to men from the highest occupational group.

Figure 2.2.3 Relative risk of dying from various causes, comparing highest occupational group with lowest occupational group

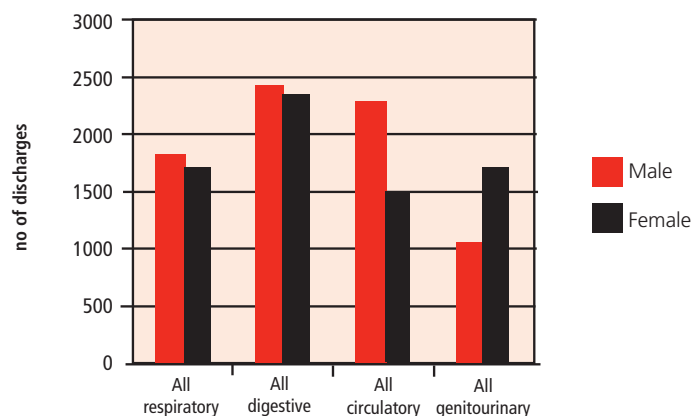


Source: Balanda and Wilde (2001)

2.3 Morbidity

Evidence of sex differences in the incidence, symptoms, and prognosis of a wide range of health problems is also well documented. Kraemer (2000), highlights the comparative 'biological fragility' of males, citing evidence to indicate that the male embryo is more vulnerable than the female, and that developmental and behavioural disorders are much more common among males. Later in life, the incidence in particular of cardiovascular diseases, respiratory diseases and neoplasms are all higher among men (The Institute of Public Health in Ireland, 2001; McEvoy and Richardson, 2004). As a result, males are admitted to hospitals more often than females for all the major diagnostic categories, with the exception of genito-urinary disease (Figure 2.3.1).

Figure 2.3.1. Acute hospital discharges by gender



Source: Cited by McEvoy and Richardson 2004

While it is widely accepted that genetic and hormonal differences protect women, while making men more vulnerable to certain diseases (Christianson et al, 2000), there has also been a growing recognition of the role of gender in terms of increasing men's risk (See Section 3.3). It is noteworthy that despite their relative lower life expectancy and higher rate of mortality, men see themselves as having better health than women, and are less likely to have recently consulted a doctor (Table 2.3.1). Indeed in a comparative study of 15 European countries (White and Cash, 2003), Irish men had the second highest level of perceived 'good health', despite having the lowest life expectancy of all countries surveyed. Less stress (44%) and a change in weight (34%) were cited by Irish men as the most important requirements for bettering health (Kelleher et al, 2003).

Table 2.3.1 Perceived general health by gender

	% Male	% Female
Excellent	31	27
Very Good	35	36
Good	23	25
Fair	9	10
Poor	2	2
GP visit in previous two weeks	15	23

Source: Central Statistics Office (2002, Quarterly National Households Survey, Third Quarter, 2001)

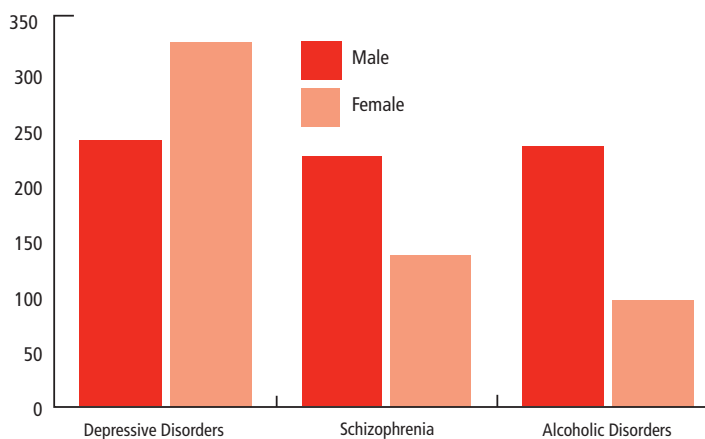
Mental health

Daly and Walsh (2003) report a consistent pattern of higher admission rates to psychiatric hospitals for males compared to females. In 2001 for example, the differences between males and females (rates per 100,000) were 978.3 v 838.6 (~1.2 all admissions) and 308.1 v 235.1 (~1.3 first admissions). In the 25-34 year age group the male rate of admissions was one and a half times that of the female rate.

It was noteworthy that married females had a higher rate of admission compared to married males (593.4 v 442.4; ~1.3), but widowed males had higher rates than widowed females (801.8 v 673.9; ~1.2) and divorced males had higher rates than divorced females (1,906.2 v 1,157; ~1.6). While males had higher rates of admissions for schizophrenia and alcoholic disorders, the rate of admission for depressive disorders was higher for females (Figure 2.3.1). In the context of prevalence rates for depression, Courtenay cites a gender-bias in the diagnostic decisions of mental health clinicians, and argues that men's own unwillingness to seek help reinforces the social construction of their invulnerability to depression.

...denial of depression is one of the means men use to demonstrate masculinities and to avoid assignment to a lower status position relative to women and other men Courtenay (2000a, p1397-8)

Figure 2.3.2 All admissions to psychiatric hospitals in Ireland 2001 – selected diagnostic groups and gender (rates per 100,000)



(Source Daly and Walsh, 2003)

Moller-Leimkuhler also reports that much of the observed differences in prevalence rates for depression may be produced by gender-related bias such as

...differences in help-seeking behaviour, symptom reporting patterns, quality of symptoms, recalling of depressive episodes, self-ratings, diagnostic trends because of gender-biased perceptions, definitions of cases in epidemiological studies, and a better detection of illness among women since scales do not include symptoms which predominate in men Moller-Leimkuhler (2002, p2)

Brookes (2001) also cites evidence to indicate that male depression is far greater than previously suspected, being suppressed and manifested through more 'acceptable' male outlets, such as alcohol abuse and aggressive

behaviour. These 'gender' differences in relation to mental health raise an important question around 'gender-fair' measures (Fuhrer and Stansfeld, 2002, p812), and whether the definition and measurement of health constructs should be identical for men and women.

2.4 Lifestyle/Health Behaviours

The growth in recent years in the fields of preventative medicine and health promotion, bears testimony to the contention that health behaviours are critically important in terms of influencing health. This has been confirmed by a growing shift in health care policy both internationally (United States Preventive Services Taskforce (USPSTF), 1996) and nationally (Department of Health and Children, 2001), towards the importance of individual health behaviours, disease prevention and lifestyle in determining health outcomes. These policy statements clearly implicate cigarette smoking, excess alcohol consumption, physical inactivity, raised total cholesterol, hypertension and poor diet in the aetiology of many of the principle causes of mortality and morbidity, including cardiovascular and respiratory diseases, and some cancers. Indeed, it has been estimated that one half of all deaths in the United States could be prevented through changes in personal health practices (USPSTF, 1996). Underpinning the relationship between gender and health behaviours is an acknowledgement of the wide range of influences on health behaviours, which

...should be studied not simply as individually determined but rather as social products which are subject to complex structural and interactional constraints

(Beckett, 1989: P141 in Watson, 2000)

2.4.1 Alcohol

Overall alcohol consumption and alcohol related harm

The 'tiger economy' that has raged in Ireland in recent years seems to have spawned a simultaneous and dramatic increase in alcohol consumption. Between 1989 and 1999, alcohol consumption per capita increased by 41%, compared to an overall slight decline in thirteen other European Union member states (Department of Health and Children, 2002; Strategic Taskforce on Alcohol, Interim Report). The increase has been most pronounced since 1995, with the total alcohol consumption per adult reaching 14.2 litres of pure alcohol in 2000, the second highest in the European Union after Luxemburg (ibid). There have been parallel increases over the past decade in

the incidence of cancers related to alcohol consumption, cirrhosis of the liver and a range of other alcohol-related conditions, such as alcohol psychosis and alcohol dependency (ibid). Alcohol is also a major contributory factor in relation to mortality from accidental falls, suicide, homicide and accidents, all of which disproportionately affect males (Rossow, Pernaenen and Rehm, 2001). As outlined earlier (Figure 2.3.1), Daly and Walsh (2003) reported that alcoholic disorders accounted for 18% of all admissions to psychiatric hospitals in the Republic of Ireland in 2001, and were two and a half times higher among males.

It is also well documented that increased alcohol consumption is associated with increased alcohol-related problems, including drunkenness arrests, street violence, assaults, domestic disturbances and accidents (Garda Siochana, Annual Report 2000/02; Edwards et al, 1994; Rossow, Pernaenen and Rehm, 2001). Purser (2001) also reported an association of high levels of risk taking behaviour amongst men with alcohol consumption. These included taking drugs they would not otherwise have taken, engaging in unprotected sexual intercourse, becoming involved in an argument or fight, or drink driving. Excess drinking has also been strongly associated with lower levels of socio-economic status and social exclusion (Acquire, 2002). Lindsay (2001) reported that the consumption of 'harmful' levels of alcohol and binge drinking were of particular concern in the case of young, working class men.

There is now strong evidence linking increased alcohol consumption at the aggregate or population level with increased alcohol related harm (Department of Health and Children, 2002a; Strategic Task Force on Alcohol – Interim Report). While volume of alcohol consumed directly influences harm, the extent of the harm is strongly influenced by drinking patterns in the culture. Episodes of drinking that lead to rapid intoxication, or 'binge drinking', typically result in a greater amount of alcohol related harm. Ramstedt and Hope (2003) reported that the rate of harmful drinking-related consequences amongst Irish men was approximately twice that reported in other European countries. Coupled with this are the huge economic costs associated with alcohol related problems, estimated in a recent European Comparative Alcohol study to be approximately €2.4 billion per year, or 1.7% of Irish GDP in 1999 (Byrne, 2001 in ibid, P 11)

Patterns of excess drinking in Ireland

The most recent evidence in Ireland confirms that 30% of males compared to 22% of females consumed more than the recommended weekly limits for alcohol (Kelleher et al,

2003), and that overall, men drink about three times as much alcohol as women (Ramstedt and Hope, 2003). However, it is the pattern of excess drinking that is of particular concern (Table 2.4.1; Ramstedt and Hope, 2003).

Table 2.4.1 Drinking patterns among men and women in Ireland (2002) in comparison with the ECAS-countries (All respondents aged 18-64)

	Mean Drinking Occasions Last 12 months	Drinking Occasions relative to Irish	Mean Binge Drinking Occasions last 12 months	% Occasions Binge drinking	Binge drinking relative to Irish drinkers
Men					
Ireland	78	-	45	58	-
Finland	70	1.1	20	29	2.0
Sweden	37	2.1	12	32	1.8
Germany	97	0.8	13	13	4.3
UK	118	0.7	47	40	1.4
France	121	0.6	11	9	6.3
Italy	179	0.4	23	13	4.5
Women					
Ireland	46	-	14	30	-
Finland	35	1.3	6	17	1.8
Sweden	24	1.9	4	17	1.8
Germany	54	0.9	4	7	4.1
UK	73	0.6	16	22	1.4
France	62	0.7	3	5	6.3
Italy	121	0.4	14	12	2.6

Mean drinking occasions last 12 months % Occasions binge drinking

	Men	Women	% Diff	Men	Women	% Diff
Ireland	78	46	70	58	30	93
Finland	70	35	100	29	17	71
Sweden	37	24	54	32	17	88
Germany	97	54	80	13	7	86
UK	118	73	62	40	22	82
France	121	62	95	9	5	80
Italy	179	121	48	13	12	8
Mean	100	59	73	28	16	73

Source: Ramstedt and Hope (2003)

- Men drink more frequently (73% more) and binge drink more frequently (90% more) than women
- The number of binge drinking occasions during the past 12 months is 3-4 times higher in Ireland (and UK) than it is in other countries surveyed.
- The percentage of occasions that end up in binge drinking for Irish men is considerably higher than other European countries (e.g. over four times that of Italian

men and six times that of French men), and also twice that of Irish women. Despite the fact that Irish men drink on just 40% of the occasions of Italian men, they are over four times more likely to binge drink when they do drink. This does suggest as Ramstedt and Hope point out that binge drinking is the norm for Irish men.

- As outlined earlier, the total alcohol consumption per adult in Ireland was 14.2L in 2000 (the second highest in Europe). One can conclude therefore that Irish men drink an overall greater volume of alcohol per year but on fewer occasions than their European counterparts. In order to consume such masses of alcohol on such few occasions, they must binge drink on 58% of those occasions.

Based on the evidence from Table 2.4.1, it is hardly surprising that abuse of alcohol and alcohol-related problems are associated more with men than with women. In a recent study of prevalence and detection of alcohol abuse in a large general hospital in Ireland, Hearne and Connolly (2002) reported that 30% of male patients and 8% of female patients (selected randomly from all hospital admissions) met the criteria for alcohol abuse or dependency (n=1133). In a subsequent review of 255 case records of patients who had met the criteria for alcohol abuse or alcohol dependency, only 46 cases were recognised by the admitting team as having a problem. This suggests that four out of five cases of alcohol abuse or alcohol dependency may be going undetected in the hospital setting, and that men are almost four times more likely than women to belong to this category. A British survey (National Statistics, 2001) revealed that 38% of adult males aged 16 to 74 years were 'hazardous drinkers', in that their drinking was associated with risky behaviours. These included getting involved in arguments, injuring themselves or another, or failing to turn up for work the morning after. The highest proportion of 'hazardous drinkers' was in the 16 to 24 years age category. The same survey revealed that one in nine adult men in Britain is dependent on alcohol, with men being three times more likely than women to be dependent on alcohol. The 16 to 24 years age category is also the age category, which has most strongly been associated with increasing alcohol consumption in recent years (Office for National Statistics, 2000).

In a survey of Australian secondary school children (n=2144), 53% of males and 47% of females agreed that 'getting occasionally drunk is no problem' (Australian Capitol Territory, 2002). A much higher percentage of males agreed that 'drinking is the best way of relaxing' (45%) and that 'drinking is the best way to get to know people' (43%), compared to 27% and 23% respectively for

females. It has been found that over half of Ireland's young people began experimenting with alcohol before the age of 12, and that in each age group, a higher percentage of boys drink compared to girls (Kelleher et al, 1999; 2003). Brooks (2001) argues that many male settings, such as military units or college fraternities, encourage men to abuse alcohol as a common male rite of passage. Lemle and Mishkind (1989) in Brooks (2001) argue that alcohol use is in fact symbolic of being male, and is part of the male sex role and of being manly. At a time of growing concern in Ireland about the strong links between alcohol advertising and sport (e.g. Guinness and hurling; Carlsberg and soccer; Heineken and rugby), there is a strong case for exploring what many would deem to be a 'drink culture' in Irish sport, and in particular to investigate the possible relationship between alcohol advertising, sponsorship and marketing practices, and the nurturing of this 'drink culture', particularly among Irish men. There appears for example to be very strong and very traditional masculinity overtones used in some recent advertising slogans ('not men but giants'; 'not choosing but inheriting your team' and 'its part of what we are'). It is noteworthy that beer accounts for 84% of the total alcohol consumption for men, compared to 43% of the consumption for women (Ramstedt and Hope 2003). Section 7.5.1 offers some exploration of how alcohol consumption is used in the construction of masculinities, which may shed some light on the way alcohol is both portrayed and perceived to be part of what it is to 'prove' one's manhood or to be a 'man' in Ireland.

2.4.2 Smoking

Cigarette smokers have more acute and chronic illness, more restricted activity and disability days and more absenteeism from work than those who do not smoke.

Annual Report of Chief Medical Officer 2002
(Department of Health and Children 2003, p17))

Approximately 7,000 people die from smoking related diseases in Ireland every year, making smoking the single most important preventable cause of death. (Department of Health and Children, 2003). Smoking causes 90% of lung cancers, while 50% of all smokers will die from smoking related diseases (ibid). It is also now well documented that the influence of passive smoking can lead to an increased risk of lung cancer (up to 20-30%), heart disease (up to 25-50%), stroke (up to 80%), and an increased frequency of chronic respiratory symptoms such as cough, phlegm production, shortness of breath and chest colds (Department of Health and Children 2003, p17)). There has been an overall decline in smoking in recent years, for both men and women, and across all age groups (Table 2.4.1). Whilst the gap in prevalence of

reported smoking has narrowed between men and women, men continue to smoke more than women (28% v 26% overall). Encouragingly from a men's health perspective, the most notable decline in smoking rates between 1998 and 2002, was among 12-14 year old boys. This does suggest that preventative measures targeting children have been effective in reducing the incidence of smoking in young boys. It is also to be expected that the recent introduction of a ban in smoking in public places will lead to further reductions in overall smoking rates in the years ahead.

Table 2.4.2 Prevalence (%) of cigarette smoking by sex and age

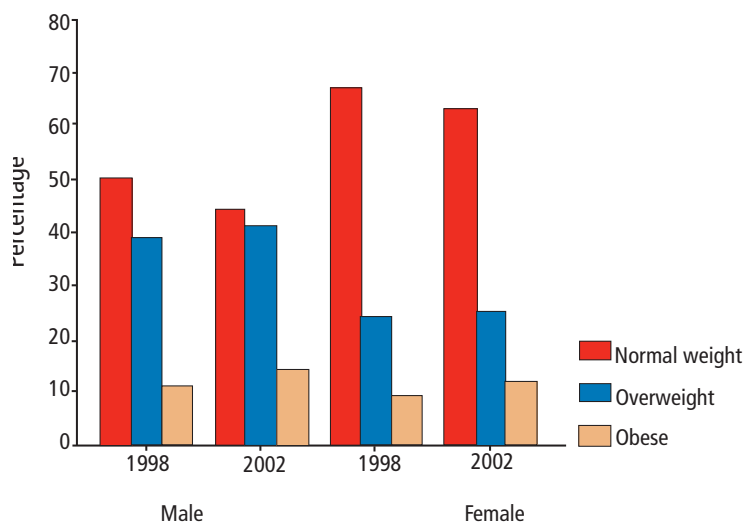
Age	1998		2002	
	Male	Female	Male	Female
18-34	38	40	35	33
35-54	32	29	26	25
>55	22	18	19	16

Source: The National Health and Lifestyles Survey 2002 (Kelleher et al, 2003)

2.4.3 Overweight/obesity & dietary habits

It is now well recognized that overweight and obesity are associated with an increased risk of developing a wide range of medical conditions, and with increased mortality (Mokdad et al, 2001). It has also been established that health risks increase, even within 'healthy ranges' that are frequently recommended at the level of public health (Liu and Manson (2001)). The most recent SLAN figures confirm that overall overweight and obesity levels have risen since 1998, and that both levels are higher amongst men (Figure 2.4.3). Of Irish men, 56% are now either overweight or obese.

Figure 2.4.3 Levels of overweight and obesity among Irish men and women



Source: National health and Lifestyles Survey 2002 (Kelleher et al, 2003)

Male/female differences in the level of overweight/obesity are particularly noteworthy in light of the following (Kelleher et al, 2003): (i) men are less likely than women to be compliant with consuming 3 or less servings per day of meat/fish/poultry; (ii) men are three times more likely than women to consume fried foods more than 4 times per week; (iii) men are much less likely than women to be on weight reducing diets – five times less likely (4% v 20%) in the case of men aged 18-34 years. There is also some evidence to suggest that an anomaly exists between what men may perceive as 'normal weight' or underweight compared to how these are defined at the level of public health. In a US study for example, McCreary and Sadava (2001) found that one in four normal weight men perceived themselves to be underweight, while almost half of overweight men felt that their weight was normal. In a study of body image satisfaction amongst lower SES and middle-aged Scottish men (n=80), it was found that both normal weight and moderately overweight men wanted to gain weight and enlarge body shape (McPherson, 2004). Toomey (2004) reported that male students were significantly less likely (p=000) than female students to access weight control/weight loss programmes. The scale of obesity in Ireland, and the dramatic pattern of increasing obesity particularly among children, has prompted the recent establishment of a national taskforce on obesity (Department of Health and Children, 2004a).

2.4.4 Exercise/physical activity

There is a long established positive relationship between physical activity and health, particularly in relation to the role of physical activity in preventing cardiovascular disease (Department of Health and Children, 1996). Physical inactivity is now widely recognised as an important risk factor for coronary heart disease, as well as being associated with other health risks. Coupled with increasing levels of overweight/obesity amongst Irish men is an overall increase in the percentage of Irish men reporting no activity at all (Kelleher et al, 2003). Between 1998 and 2002, the percentage increased from 21% to 30% (compared with 20% to 25% for women). Rates of increased inactivity are particularly pronounced amongst men with less formal education: up from 27% to 40% amongst 35-54 year old men and 37% to 56% amongst men aged 55+ years. These figures are somewhat surprising in light of the relatively high level of young men (18-34years) engaged in strenuous exercise, where the rates are much higher for young men than for young women, as indeed they are for 15-17 year old boys compared to 15-17 year old girls. More recent data (Balanda and Wilde, 2004, p143) indicates that

45% of men on the island of Ireland do no 'adequate exercise' (i.e. less than three times per week of any type of exercise). This figure compares to 54% of women.

2.5 Risk Behaviours

Section 2.4 has outlined the extent to which men are at greater risk than women in relation to lifestyle issues such as smoking, alcohol consumption and dietary patterns. It is also well established that men engage in a variety of other risk behaviours and at much higher rates than women.

2.5.1 Convictions for various offences

Many of the 'risks' that men take with their health are associated with breaking the law. Table 2.5.1 illustrates the hugely disproportionate incidence for which Irish men are convicted compared to Irish women in relation to a range of criminal offences. The first four offences reinforce the well-established fact that men are much more likely to be both the perpetrators and the victims of violent-related crime. The exception is sexual violence, where girls (7.6%) and women (7.4%) are more likely to have been subjected to serious sexual crimes than boys (4.2%) and men (1.5%). The data in relation to speeding, drink driving and failure to wear seat belts is also noteworthy in the context of the comparatively high mortality rates from road traffic accidents among men. Indeed, Kelleher et al (2003) reported that men were more than twice as likely as women to report driving a car after drinking two or more alcoholic drinks, and less likely to wear seat belts. It is hardly surprising therefore that men are much more likely than women to receive prison custodial sentences, with 97% of prisoners in 2001 (n=2705) being male (Central Statistics Office, 2002).

2.5.2 Accidental injury

Kelleher et al (2003) reported that men are more likely than women (21% v 14%) to have experienced an injury in the past two years that interfered with their daily activities. Men were most likely to sustain injuries related to sport (31%), work (28%) and home (21%) (ibid).

2.5.3 Drugs

The most recent data on the (mis)use of drugs in Ireland, confirms that men are approximately twice as likely as women to have used illegal drugs (National Advisory Committee on Drugs (NACD), 2004; Kelleher et al 2003). The NACD data (Table 2.5.3) also indicates that men are less likely than women to have used anti-depressants. 94% of convictions for unlawful possession of drugs in 2002 were male (Garda Siochana Annual Report, 2002). Of those who presented for treatment, in relation to problem drug use in 1997/98, 70.2% were male (Health Research Board, 2002).

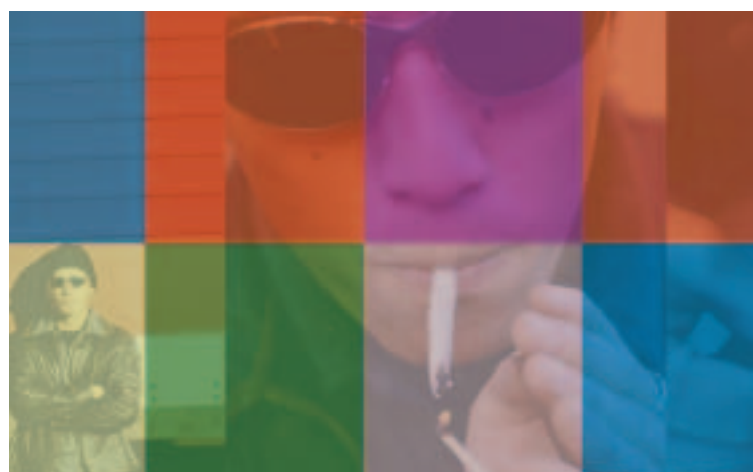


Table 2.5.1 Persons convicted of various offences in 2002, Republic of Ireland

Offence	Convictions brought against person		Male convictions as % of total convictions
	Male	Female	
Assaults	578	45	93%
Intoxicating liquor offences	827	273	75%
Public order offences	9,725	1,090	90%
Possession of offensive weapon offences	556	29	95%
Unauthorised taking/ interference with vehicle offences	904	30	97%
Speeding Offences	833	73	92%
Intoxicating driving and in charge offences	4,604	517	90%
Dangerous driving	2,920	510	85%
No seat belt	802	131	86%
Traffic lights- non conformity with	290	48	86%

Source: Garda Siochana Annual Report 2002

Table 2.5.3 Drug use in Ireland 2002/2003

	Lifetime Prevalence (%)		Last Year Prevalence (%)		Last Month Prevalence (%)	
	Males	Females	Males	Females	Males	Females
Any illegal drugs	24.4	13.5	7.7	3.4	4.1	1.8
Cannabis	22.5	12.5	7.1	3	3.4	1.7
Heroin	0.7	0.3	0.1	0.2	0.1	0.1
Cocaine	4.5	1.7	1.7	0.5	0.7	-
Amphetamines	4.1	1.9	0.7	0.2	0.2	0.1
Ecstasy	4.9	2.6	1.5	0.6	0.6	-
LSD	4.6	1.5	0.2	-	-	-
Anti-depressants	9.3	15.1	4.0	7.3	2.9	5.0

Source: National Advisory Committee on Drugs 2004

2.5.4 Sexual activity and sexually transmitted infections (STIs)

Few studies in Ireland have explored in an in-depth way the sexual behaviour among the general population. In a study of post-primary pupils (15-18) in the west of Ireland, 29% of boys compared to 15% of girls reported previous sexual activity (MacHale and Newell, 1997). A Cork study (The Alliance Centre for Sexual Health, 1997) found that 32% of boys compared to 22% of girls reported having sexual intercourse before the age of 16. A recent report commissioned by the Crisis Pregnancy Agency (Rundle et al, 2004) reported that men were significantly more likely than women to report first sexual intercourse before the age of 17 ($p < 0.001$). In the same study, 58% of men (compared to 38% of women) reported that drinking alcohol had contributed to their having sex. Furthermore, 54% of men (and 26% of women) agreed that drinking alcohol had contributed to their having sex without using a condom. In an analysis of 2002 SLAN data (Crisis Pregnancy Agency, 2004), it was found that men were more likely than women to 'sometimes or never use contraception', with 65% of those reporting unprotected sex being men. Alcohol and drug use have previously been associated with early sexual activity, which is more likely to be unplanned and unprotected (Hingson et al, 2003).

There has been an alarming increase in the rate of reported STIs (370% between 1989 and 2002) in Ireland in recent years (National Disease Surveillance Centre 2004). Whilst the overall rate is slightly higher amongst females (51%; Table 2.5.4), concern has been drawn to the recent resurgence of STIs amongst men who have sex with men. In Dublin for example, there was a dramatic increase in syphilis between 2000 and 2002 amongst men who have sex with men (ibid). Syphilis is associated with increased risk of transmitting and acquiring HIV.

Table 2.5.4 Notified sexually transmitted infections by age group (years) and gender

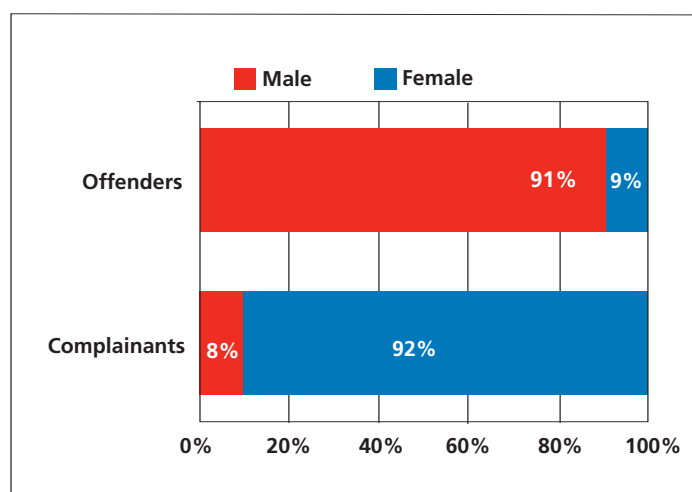
Sexually Transmitted Infections	0-19	20-29	30-39	40+	Age UK¹	Male	Female	Gender UK¹	Total
Ano-Genital Warts	302	1424	330	114	1762	1761	2103	68	3932
Candidiasis	96	456	169	100	530	589	755	7	1351
Chancroid	0	0	0	0	1	0	1	0	1
Chlamydia Trachomatis	151	643	121	30	977	880	1018	24	1922
Genital Herpes Simples	18	88	35	9	208	149	207	2	214
Gonorrhoea	13	68	20	12	101	90	122	2	214
Granuloma Inguinale	0	0	0	0	0	0	0	0	0
Infectious Hepatitis B	2	17	9	4	25	18	39	0	57
Lymphogranuloma Venereum	0	0	1	0	0	1	0	0	1
Molluscum Contagiosum	10	47	7	8	78	76	74	0	1
Non-Specific Urethritis	127	818	281	121	678	1193	831	1	2025
Pediculosis Pubis	10	33	9	3	29	49	35	0	84
Syphilis	6	74	114	86	23	215	87	1	303
Trichomoniasis	1	15	3	8	46	45	26	2	73
Total	736	3683	1099	495	4458	5066	5298	107	10471

UK=Unknown, **Source:** National Disease Surveillance Centre (2004)

2.5.5 Domestic violence

There were 10,248 incidents of domestic violence reported in 2002, representing a pattern of continued increase in recent years (Figure 2.5.5). 91% of offenders were male while 92% of complainants were female. McKeown and Kidd (2002) highlights that the outcomes of domestic violence in terms of physical and psychological injuries tend to be considerably more negative for female victims than for male victims, and that female victims are more likely to acquire and seek outside help. However, McKeown also highlights that male victims of domestic violence are likely to face much greater barriers in accessing services than female victims, and that the range of services is much greater for female victims than male victims.

Figure 2.5.5 Domestic violence complainants and offenders by gender, 2002



Source: Garda Siochana Annual Report 2002

2.6 Men's Health - Knowledge /Awareness/ Attitudes to Health & Health Screenings

A number of recent studies have revealed a high level of ignorance among men about issues pertaining to men's health (Court, 1995). Even where knowledge and awareness of health issues is high among men, the assumption cannot be made that this will impact on health behaviours. In a Danish qualitative study, Meillier et al (1996) interviewed 40-year-old males (n=21) on their use of, attitudes to and reactions to health information targeting coronary heart disease prevention. While the men in the study revealed a considerable amount of background knowledge of the subject, nevertheless they did not follow generally accepted health advice. The authors concluded that strategies aimed at improving men's health might be placing too much optimism in, and forming unrealistic expectations from the impact of more traditional written

health educational material on alterations to health behaviour.

Neither can it be assumed that what is considered a 'health issue' at the level of public health will similarly be understood by men. Courtenay (1998) reports that for most health problems, American men are less likely than women to perceive themselves as being at risk, even for health problems that men are more likely to experience. In a study of adult drinking behaviour and knowledge, it was found that 80% of men had heard of measuring alcohol by units, but only 13% kept a check of their alcohol consumption in this way (Lader and Meltzer, 2001). This highlights the perhaps not so subtle difference between knowledge and awareness, where the latter doesn't necessarily follow if the issue is not seen as a relevant health issue. The effectiveness of written health education and health promotion materials needs to be researched more thoroughly in the context of men, with particular focus to whom and under which circumstances health education is given. It is also imperative that such materials are used not in isolation, but as part of wider and more holistic men's health initiatives.

In the context of body images used in health advertising (e.g.; Health of the Nation advertisement, 1992; 'ideal' male body as a machine, cited in Watson, 2000) Watson (2000) questions the use of stereotypical mesomorphic male images as inappropriate cultural representations of the 'normal bloke's' body. In the same way as many women would express concerns about current images of 'ideal' body shape and weight for women, the men in Watson's study (Scottish, middle-aged working/middle class men) were critical of the extremes necessary to achieve or sculpt such a body, which they felt signified 'fanaticism' and 'taking things to extremes', with no real focus on long-term health outcomes. Indeed, in the context of extreme forms of exercise, many men felt that the demands of achieving very high performance goals could accelerate the onset of bodily injury or breakdown, as well as compromising social, family and other obligations. It was also felt that the notion of the male body as a machine perpetuated existing and unhelpful male perceptions of their own bodies, as well as obscuring implicit health messages. These responses suggest that whilst images used in a health advertising or health promotion context may have the best intent, they may paradoxically constitute a form of resistance among many men to adopt health-promoting behaviours or to develop 'healthy bodies' (Crawford, 1984 in Watson, 2000).

These observations are also noteworthy in the context of the 'body as a machine' men's health literature that has become popular in recent times.

The claim is often made that men are less likely than women to avail of public health screenings. Thompson et al (2001) reported that in the case of cancer screenings, men are overwhelmingly interested in participating in prevention trials. One of the limitations of much of the research to date is that the majority of participants are middle-class, well educated and white. In order to attract minority or marginalised groups of men, the authors propose a number of recommendations. These include the choice of sites that currently target and that have a tradition of targeting minorities, the involvement of people from such minorities in the research work, the provision of aggressive community outreach programmes, and the provision of culturally sensitive public service announcements. Meredith et al (1995) reviewed, from the patient's perspective, the perceived strengths and weaknesses of existing leaflets and fact sheets on prostatectomy given by surgeons to patients. Patients reported a number of shortcomings. These included: a lack of uniformity in the form and content of information given; that certain topics, which were perceived as relevant to the patient, were omitted; that the terminology used was not clear; and that patients' experiences were at odds with what they were told by their surgeons. For example, only 6 of the 25 different fact sheets being used referred to possible changes in sexual sensation after transurethral resection of the prostate, stating that patients would feel no change. However, 35% of patients did in fact report a change, and this was a cause of concern or worry to 12% of patients. The authors concluded that there is much scope for improving the standard of printed information given to patients undergoing prostatectomy. Leydon et al (2000) reviewed the information needs of patients diagnosed with cancer, and provides insights into the reasons underlying patients not seeking information at particular times during their illness. Men compared to women seemed less likely to access additional information services, in the belief that a sense of hope was maintained through "strength in silence". The authors point out the fluctuating information requirements of patients during the course of their cancer, as they oscillate between different emotions, and recommend that more attention be given to the diversity of attitudes and coping strategies among patients. In response to this paper, Lockwood and Manaszewicz (2000) states that lack of information seeking may also be linked to recognition of the system's limitations, or a lack of knowledge of exactly what to ask.

It is clear therefore that a more thoughtful and creative approach needs to be brought to the way in which both the

content and delivery of health and health screening information is presented to men. Traditional generic approaches need to be replaced by 'gender specific' and 'gender-relevant' programmes, which are pitched within appropriate social and cultural contexts. In particular, the priority should be towards the creation of effective methods and approaches of working with those subgroups of men who are affected by social disadvantage or marginalisation.

2.7 Men's Health - Accessing Health Services

Although research is limited in Ireland, it is well documented internationally that compared to women, men have limited contacts with physicians and health care services in general. A recent US report stated that:

Many men fail to get routine check-ups, preventive care or health counselling, and they often ignore symptoms or delay seeking medical attention when sick or in pain"

The Lancet (2001 P1813)



The same report found that many men felt constrained by social taboos and embarrassment from discussing their health openly with physicians. Roter and Hall (1997) reported that female patients are better informed about their illnesses than male patients.

Courtenay (1998) cites a number of studies which confirm that men take much less physician time than women do in their health visits, receiving less information with fewer and briefer explanations.

There is increasing evidence to suggest that choosing to access health services is based not just on need, but on how a given service is perceived, and on the value that patients place on the service (Humphreys et al, 1997). While there would appear to be a strong consensus in the literature that men are unwilling or less able (than women) to access health services (Griffiths, 1996), there is also evidence that many men feel marginalised by the health services (Essex, 1996). In the context of sexual health, many men's initial perception is that their problem is being dismissed (Gregoire, 1999). In terms of accessing the health services, men are slower to notice signs of illness, and when they do, they are less likely to consult their doctor (Kraemer, 2000; *The Lancet*, 2001). Late presentation can result in poorer health outcomes, and has been widely implicated in unnecessary premature mortality for men (Banks, 2001). In a study of homosexual men's perceptions of general practice, Fitzpatrick et al (1994) reported that there was considerable scope for improvement in the acceptability of general practice to homosexual men. Of those subjects, 44% (n=623) had not informed their GP of their sexual orientation, while 44% of the 77 men who were HIV positive, had not informed their GP of this fact. The perception of general practice as unsympathetic to homosexual men influenced whether men declared their sexual orientation or HIV status. These findings were supported by Dawson (1994), who stressed the importance of improving the acceptability of primary health care to gay men, especially GP services. Baker (2002) notes that men also under-use pharmacies, despite their potential as a source of advice, information and self-treatment for men. Whilst the anonymity and relative accessibility of pharmacies offer the kind of service that is potentially attractive to men, there is, in the author's view, much greater scope for improvement by offering space for confidential consultations and by reviewing product displays that are typically female-orientated.

Penchansky and Thomas (1981) in Humphreys et al (1997) identified five key factors underpinning access to GP services in rural Australian communities. These were 'availability' of services in the context of patient's needs; 'accessibility' to services from the point of view of distance, time and availability of public transport; 'accommodation' of patients in such terms as waiting times and appointment times; 'affordability' in economic terms from patient's perspective; and 'acceptability', or how comfortable patients feel with individual doctors. Humphreys et al

(1997) reported on some of the more important factors of accessibility reported by Australian rural patients in their decision to consult a doctor. While geographic proximity was ranked as the most important consideration for men from isolated communities, this was not the case for rural residents in general. Overall, acceptability and continuity of care were deemed to be more important than geographical proximity, both in relation to patients' decision to consult a doctor and their choice of doctor. The authors highlighted the importance of social factors, community issues and communication skills in the development of a curriculum for rural general practice. The issue of acceptability from the patient's perspective, and the identification of those attributes which patients value most highly from their GPs, are areas that require more careful scrutiny. Poulton (1996) investigated various dimensions of patient satisfaction with general practitioners and community nurses, based on a large sample (n=1575) of patients within three practices. Professional care, depth of relationship and perceived time spent with the health professional were identified as the key dimensions of patient satisfaction. It was notable that patients rated satisfaction with professional care significantly more highly for nurses than for general practitioners.

Williams and Calnan (1991) conducted a postal questionnaire of a random sample of adults (response rate 62%, n=454) in the southeast of England, to review consumer satisfaction with general practice. Despite general levels of satisfaction being high (95%), more detailed and specific questions revealed higher levels of dissatisfaction among respondents, of whom 38% felt unable to discuss personal problems with their GP, 26% were dissatisfied with the level of information that they received, and 25% were unhappy with the length of time spent in consultation. The criteria adjudged to be most important in terms of overall satisfaction with general practice were communication skills, the nature and quality of the doctor-patient relationship and GPs' professional skills. An Australian study on consumer satisfaction in a hospital setting revealed that information and communication, concern, respect and personalised attention, attention to the patient's condition, and skill, were the variables which most affected patients' satisfaction with their doctor (Draper and Hill, 1995). Parry-Langdon (1998) examined the extent to which teenagers' (male and female) experiences of and satisfaction with GP service delivery influenced their health behaviours, and their decision-making process regarding responsibility for their own health. While most teenagers believed that GPs did understand and were sympathetic to teenage health problems, they believed that as a group they had very little status as patients. Difficulties in verbal communication

were also expressed, and they felt that GPs were ignoring the opportunity to negotiate a shared responsibility for teenage health.

Williamson and Robertson (1999) stress the importance of integrating gender awareness into the training curricula for all public health professionals, so that health services become more accommodating of men and responsive to their needs. Cooper (2000) in Health Development Agency (2001) emphasizes the need for evening surgery opening hours, information on the Internet, and targeting places men already visit such as the workplace, as important aspects of a men's health targeting strategy. The latter in particular can only be brought about if there is a major shift in the traditional structure and delivery of primary health care, and recognition of the need to 'go to' where men are more likely to be more open and receptive to health care. During the 1990s, 'well man' clinics were established, particularly in the UK, in an attempt to entice more men to access primary care. The majority of clinics failed, which as Baker (2002) suggests may have been due to a concept that worked for women ('well-women' clinics) simply not being appropriate for men. Those that did work tended to offer flexible opening hours, at sites that were separate from primary care.

Fear has also emerged as a reason why many men fail to access the health services (North Eastern Health Board, 2001). Doyal (2001) emphasizes the need for clinicians to recognise the psychological difficulties that some men bring to the medical encounter and the challenges or threats that illness may pose to their self-esteem or sense of their own identity. Leydon et al (2000) suggests that this is particularly apparent with male cancer patients, who may sometimes be fearful of the threat that the cancer poses to their sense of masculinity. This is also of particular importance in the context of sexual health. Gregoire (1999) notes that many men may be hesitant or anxious when they report with a sexual problem, and that their presentation may be disguised in terms of another complaint. It is the pressure exerted by masculinity to conceal emotional vulnerability that results in men being more vulnerable to stress than women (Matthews, 1988 in Rees et al, 1995). Rees et al (1995) note that social norms surrounding men discussing their emotions and problems may restrict and distance the health services from responding to men. Helgeson (1995) in Sabo and Gordon (1995) notes that denial may be a common coping strategy for male patients coping with coronary heart disease (CHD). Whilst this may be associated with some positive outcomes, it can also result in non-compliance with medical advice, such as smoking in the hospital or failing to follow a medical regimen.

Moynihan (1998) notes the irony of health on the one hand being inextricably linked with the image of 'the perfect man', strong and in control, while the whole illness process inevitably means a loss of traditional 'masculinity'. In this context, fear surrounding the potential loss of masculinity may result in a façade of control and stoicism, instead of honesty about reporting symptoms and accepting interventions, or openness about feelings and insecurities associated with particular illnesses. Gordon (1995) in Sabo and Gordon (1995) found that some testicular cancer patients turned to traditional masculinity to interpret their cancer as a struggle that reinforced their courage and toughness. The same author also states that the language used by some male clinicians with testicular cancer patients actually reinforces the way men have traditionally seen themselves as machines, "controllable and controlled". The uses of phrases such as "shooting blanks" (in the case of infertility), or "one cylinder is as good as two" (in the case of a loss of a testicle), are examples of this.

In order to successfully tackle men's health, Connell and Huggins emphasize the need to

...contest stereotypes of masculinity that are widely disseminated and deeply entrenched – in the healthcare system as in other institutions

Connell and Huggins (1998, p296)

Davies et al (2000) reported that despite a high level of awareness and openness among young college men in relation to health concerns, a number of substantial barriers still existed that limited their ability or willingness to take action on these concerns. Principal among these was men's socialisation to be independent and to conceal vulnerability, which had the effect in particular of discouraging or at least delaying young men from seeking help. The authors highlight that independence and intimacy (forming and maintaining inter-personal relationships) are particularly important issues for young men. Help-seeking could be seen by many young men to run counter to appearing independent, whilst peer pressure and adherence to group norms could also militate against seeking out help. An overall lack of knowledge and misinformation about services, and a lack of trust in healthcare providers was also raised. The authors also highlighted a perception that seems to be particularly prevalent among young men (North Eastern Health Board, 2001), which is that long-term health risks are not associated with current habits. Courtenay (1998) recommends the use of gender-sensitive approaches to health, such as telephone hotlines or electronic mail and

chat lines, to overcome college men's reluctance to seek help and their tendency to conceal vulnerability.

Tudiver and Talbot (1999) conducted a qualitative study on the family physician's perspective on why men tend not to access health care for medical problems. Three key themes emerged from their research. In terms of support for health concerns, men rely primarily on their female partners rather than on male friends. The pattern of seeking support also tends to be indirect rather than straightforward. Secondly, perceived vulnerability, fear and denial emerged as the most significant influences as to why men seek help. They also tend to seek help for more specific problems rather than for more general health concerns. The third area related to perceived barriers to accessing health care. Personal barriers revolved around perceived male socialisation issues, including a sense of immunity or mortality, fear of relinquishing control, and a macho rejection of seeking help or adopting preventative health behaviours. Systematic barriers related to time and access issues, and included the lack of a male care provider and having to state the reason for a visit. It is interesting to note that many of these issues were also raised from the male patient's perspective, in research carried out by the North Eastern Health Board (2001).

In the context of the socialisation issues referred to by Tudiver and Talbot (1999), Moynihan (1998) contends that doctors are, perhaps unwittingly, locked into stereotypical roles which epitomise masculine achievement and power, and work in institutions imbued with images of male stereotypes. If both patient and doctor are locked together in perpetuating traditional 'masculinity', then optimum patient care cannot be achieved, nor can the cycle of the damaging impact of traditional 'masculinity' on health be broken. There is however some evidence of a demand for change at the level of health consumer, from the views expressed (by men and women) in the consultation process for the current health strategy (*Quality and Fairness*, Department of Health and Children, 2001) in Ireland (www.doh.ie/hstrat/consult.pdf). These included: openness and involvement in one's own health; courtesy, respect and listening; training for staff in customer care/relations; consultation; and user-friendly procedures. There is a need to fully investigate Irish men's perception of and attitudes towards primary care services in Ireland, in the context of maximising and optimising their uptake of the services. It is not enough to adopt the approach that "the services are there and men can use them", as suggested is often the case, in a recent report from the UK's Men's Health Forum (Baker, 2002, P10). Training needs to be provided for health professionals, particularly in relation to the delivery of effective health

services at a local level for men. There should also be a more creative approach to the provision of primary care services outside of the traditional primary care setting, including the workplace, community, sporting venues and elsewhere. Since primary care is the 'gateway' to most other health services, increasing men's uptake may have additional significance.

2.8 Critique of 'Sex-Differences' Literature

As highlighted in Sections 2.1 to 2.7 of this report, the principle focus within the literature on 'men's health' to date has tended to be on overall mortality differences between men and women, and the predominant conditions, risk factors and causes of death for which men are more likely to die than women. Whilst the sex-differences literature serves as a crucial backdrop to understanding 'men's health', there are a number of limitations and indeed concerns that should be considered in interpreting this literature

Men and women are not simply distinct biological categories

The sex-differences literature reflects what has become a taken-for-granted and popular assertion, particularly in the media, that men and women are simply distinct biological categories, constituted solely by biological differences. Courtenay (2000a) highlights the fallacy of trying to separate men's diseases from the men who experience them. Keeling (1998) notes that there is a tendency in the literature to overlook or abolish the differences in men's lives and experiences, with much of the referenced research having a narrow focus on Caucasian, heterosexual, middle- and upper-middle-class men. Watson (2000) highlights the importance of acknowledging the context of men's lives when interpreting research findings, not just as a background, but also as a core element to the findings. Connell argues that 'doing sex-difference research' has somehow become automatic, in the same way as differences are reported by age, ethnicity or nationality:

To do this does not require any specific thought about the nature of gender or the meaning of gender difference – that is typically taken for granted, or vaguely assumed to be a biological distinction

Connell (2000, p180)

Indeed Connell and Huggins (1998) also note that the widespread and tacit acceptance of such statistics as 'natural' (and therefore intractable) biological sex differences supports a fatalistic – "boys will be boys" – attitude to gender issues, and is a confounding cause of ill-health, injury and death.

There are differences between men, not just between men and women

Whilst on one level, the presentation of sex differences between men's and women's health offers clear insights into the unique health concerns of each sex, this aggregation of data critically overlooks the much more complex issue of gender and the substantial differences between different categories of men. The focus on margins of difference between the sexes based on aggregated data is in Watson's (2000) view a very limited approach, and may miss the bigger picture. Differences among a certain subgroup of men may yield statistically significant differences in overall male/female differences, which potentially could be construed as categorical differences between women and men. For example, more careful examination of the statistics on suicide (Figure 2.2.2) reveals a disproportionate incidence of suicide among younger men. Careful and cautious examination of aggregated data is warranted therefore, particularly where policy or service delivery issues may be under consideration. There is a need to explicitly identify and map knowledge of the wider determinants of men's health, and the type of interventions that are likely to influence them.

Men's health versus women's health

The sex-differences literature evokes a sense of what Schofield et al (2000, p250) describe as "mutual suffering and health disadvantage between the sexes".

Whilst there is a certain convenience at a policy, research or conceptual level in labelling 'men's health' and 'women's health', this segregation tends to give rise to a focus on margins of difference between men and women, and may indeed invite conflict and rivalry. The pursuit of a 'men's health agenda' can very easily be construed as an attempt to play 'catch up' with women, and as a way of competing for scarce health resources. This approach, as Sabo (1999) describes, reveals a tendency to see issues of gender equity in categorical and binary terms (men versus women), and puts the focus on biological health outcomes more than the social processes that influence health and well-being. It can also be divisive, by inviting competition between lobbyists for men's and women's groups, as to which sex is the bigger victim, or which gets the best resources. For example, Wadham (2001) states that the earlier men's health movement tended to rely on two key strategies of 'equivalence' and 'comparison' in its attempts to highlight

men's health issues. its reliance on women's health is manifested in the issues that it raises, such as female violence towards men and fathers' rights in relation to child custody. The underlying argument in these strategies is that of 'equality', and that men and women should receive equal funding and equal attention. The difficulty with such an approach, Wadham argues is that

...men and women's health issues become decontextualised – gender analysis becomes inarticulate and power relations become obsolete (Wadham, 2001, p74)

The author cites the very different aetiologies and diagnostic and treatment procedures for prostate and breast cancer, as an example of trying to make the 'dissimilar' similar, and of ignoring the critical contexts in which men and women's health issues arise. This can be exacerbated by the media's willingness to endorse this approach of equivalence.

The equality debate sometimes makes the claim that men's health has been neglected by the domination of the health care system by women's health. For example, Rees, Jones and Scott (1995) reported on the low priority given to men's health by health authorities in the UK. Zinn (1998) cites evidence from Australia showing that health care costs for women are a third higher than for men. The Institute of Public Health in Ireland similarly construes Irish men's health as an equality issue

On the island (of Ireland), excess mortality amongst males represents a fundamental inequality in health.

Balanda & Wilde,(2001, p11)

Indeed, the broader issue of equality in Ireland has been pushed to the centre of political discourse in recent years, with the creation of a government department (Department of Justice, Equality and Law Reform) and an independent body (The Equality Authority). The terms of reference of the latter, in particular, are to investigate claims of inequality that are made by an organisation or individual, on specific grounds, one of which includes gender. It would be important that the adoption of any future men's health policy in Ireland would show cognisance of the complexity of issues that underpin men's health, and not be unduly influenced by or based in a narrow way on the 'rights' or 'entitlements' of an 'equality' agenda. As Wadham (2001) notes, the suggestion that women's health is privileged over men's belies a legacy of masculine privilege, and may in fact cloud issues relating to genuine male neglect or disadvantage. Barnett and Marshall (1991) in Wadham (2001, p78) propose that women experience a 'triple

lifestyle burden'. They are primarily responsible for reproductive work; they engage like men in productive work, but mainly as secondary-income workers; and they are the principal players within the informal/unpaid sector, working as volunteers within a wide range of community development initiatives. Men on the other hand are primarily seen as 'the breadwinner' and are more likely to be absent from domestic responsibilities.

Sex versus Gender

The lack of a clear distinction between 'sex' and 'gender' (See Section 1.3.5) in much of the literature is also a limitation, with 'gender' being used to denote the biological distinction of male from female. Indeed many so-called 'gender-specific' studies in effect focus solely on quantitative differences in research variables without examining the social construction of behaviours and practices that impact on health and illness (Moller-Leimkuhler, 2002). Sabo and Gordon (1995) note that not only do patterns within descriptive epidemiology need to be identified, but also interpreted within the total context of the gender order.

Failure to unravel gender differences

Finally, what appears to be an obvious gap in the research is a general failure to probe the underlying causes of sex (or 'gender' as used to describe sex differences) that are associated with health and longevity. In other words, the findings and conclusions tend to stop short at highlighting sex differences, without examining the role of gender as a complex and dynamic concept, in actively constructing behaviours that directly or indirectly impact on health. The failure to recognise gender as an interactive system is fundamentally a failure to come to grips fully with the underlying causes for men's and women's health issues. The general absence of research in Ireland to date on gender relations and masculinities means that our understanding of the causation of men's health problems is largely vague and speculative. As Courtenay notes in an American context:

The consistent, underlying presumption in medical literature is that what it means to be a man in America has no bearing on how men work, drive, fight or take risks

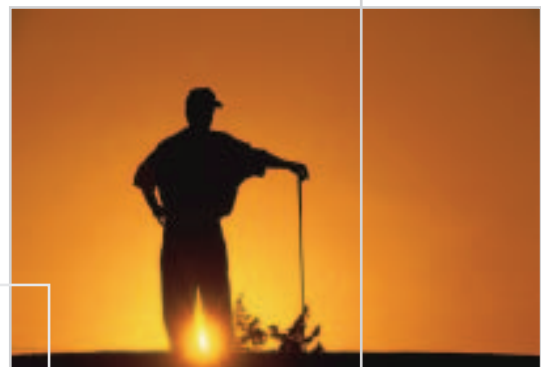
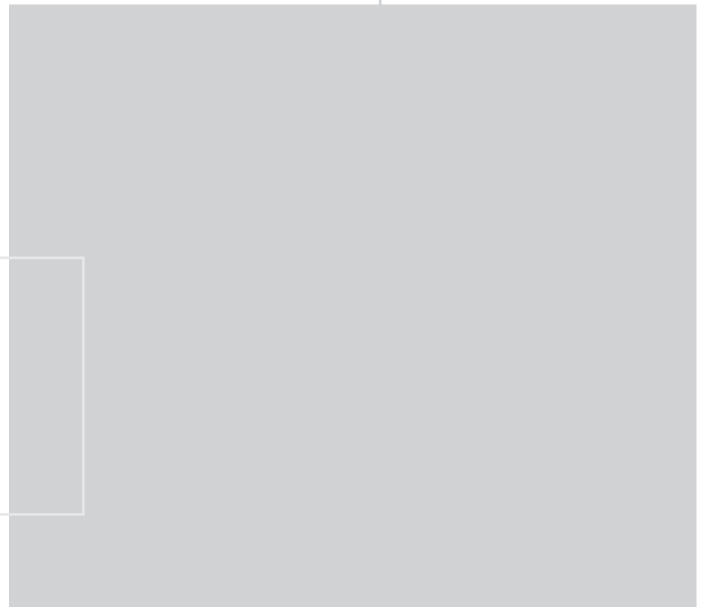
Courtenay (1998 p280)

2.9 Conclusion

What it is 'to be a man' in Ireland is indeed an important and necessary question if we are to understand how Irish men actively construct behaviours and attitudes that ultimately determine their health status. This will enable a much better understanding of the complexity of issues underpinning the statistics on men's health as outlined in this section. The absence of any significant literature to date on men and masculinities in Ireland can only serve to hinder our understanding of why men continue to die younger than women, why men are less likely to engage in preventative health behaviours and more likely to take risks with their health. This will also facilitate opportunities at the levels of care and prevention that are more focused on and sensitive to the specific needs of different male subgroups, and that are ultimately more likely to have a greater effect than the traditional generic, 'one cap fits all' approach.



GENDER,
MASCULINITIES & HEALTH



Section 3

Gender, Masculinities & Health

3.1 Introduction

Throughout Western history and culture, men have occupied a central and powerful presence at the centre of discourse, and have traditionally been the major holders of political and religious office, of economic resources and of cultural authority (Connell et al, 1998, p97). Women on the other hand have been confined to the margins 'objectified' in relation to what was assumed to be a neutral centre of 'men' (Hearne and Collinson, 1996). Despite their prominent and commanding presence in discourse, the categories of 'men' and 'masculinity' usually remained implicit and untheorised. Men were not recognised as explicitly gendered beings, and masculinity was assumed to be 'a monolithic unproblematic entity' (Mac an Ghail, 1996, p1). However, the influence in particular of the second wave feminist movement in the 1970s started to challenge men's privileged position, and identified a number of key patriarchal structures within the state, the family and the workplace, that served to maintain this privilege. As a result, men were challenged to reflect on the nature of their relationships both with women and with other men.

The following section maps out the historical and political context to masculinity, and examines different approaches to understanding 'masculinity'. Particular attention is focused on the power relations between the construction of hegemonic and dominant masculinities on the one hand, and marginalised, subordinated and stigmatised masculinities on the other. Consideration is also given to the implications of this framework for men's health, and specifically for Irish men's health. As a starting point, the position of masculinities within the broader context of gender will be examined.

Men's Health – A Gendered Approach

Sabo and Gordon (1995) trace the origins of the gender of men's health and illness from the traditional and narrower 'biomedical model' to a more holistic and interdisciplinary 'sociocultural model'. The latter emphasized the influences of cultural practices, social conditions, emotions, environment and personal beliefs, but, until relatively recently, tended to equate the study of gender and health to studies of women's health and illness (Sabo, 2000). As Connell and Huggins state

Few health care policy documents recognise gender as an interactive system and address issues about men Connell and Huggins (1998, p 295)

In the past, the predominant focus on sex differences between men's and women's health has been limited largely to considerations of biological mechanisms that underpinned such differences. A focus on gender on the other hand requires a much broader analysis of social, cultural and psychological issues that impact on the characteristics, norms and roles of both men and women. Whilst, on one level, the presentation of sex differences between men's and women's health offers valuable insights into the unique health concerns of each sex, this aggregation of data critically overlooks the much more complex issue of gender and the substantial differences between different categories of men. Indeed, Schofield et al (2000) cite a number of studies that seek out sex differences but find none, and conclude that the issue of similarity between men's and women's health is problematic, since the whole focus is on margins of difference. Rarely is an attempt made to explain or discuss such findings by examining the links between men's and women's health, and how they are connected through particular social mechanisms that may have an impact on health. For example, in the context of industrial health (ibid), there is little questioning or conceptualisation, as a health issue, of the disproportionate incidence of work-related injuries and fatalities among men, and the gendered organisation of paid work in society. Neither is the impact of gender on the emotions and sexuality considered as a conceptual backdrop against which sex differences might be explored across a range of sexual and emotional health issues.

A 'gender relations' approach

A gender relations approach (Schofield et al, 2000) proposes that

... men's and women's interactions with each other and the circumstances under which they interact contribute significantly to health opportunities and constraints

Schofield et al, (2000 p251)

With this approach, we can understand the margins of difference in men's and women's health outcomes as the product of gender-structured conduct or practices...

ibid p 253

Connell et al similarly stress the importance of examining the specific patterns of difference and similarity within as well as between genders,

...there are significant health issues that have to do with the positions of men (and women) in gender relations

Connell et al (1998, p34)

There is therefore an urgent need for the development of a gendered approach to men's health, at both a research and policy level, which identifies the links as well as the margins of difference between men's health and women's health issues, and which acknowledges the diversity of men's health issues between male subgroups. Sabo emphasizes the reciprocal nature of men's and women's health and states that:

"The social construction of different types of masculinities and feminities, both individually and collectively, produce different types of health outcomes within each sex and between the sexes"

Sabo (2000, p134)

The male gender role is inextricably linked with the active construction of masculinities, which are influenced by ongoing social and cultural change, and which result in different groups of men being positioned differently in gender relations. It also provokes an exploration of the relationship between 'being a man' or proving one's manhood, and men's attitudes to health, health care, health behaviours and risk behaviours. In the context of gender as an interactive system, Schofield et al, 2000, P254) argues that the continued segregation of men's and women's health, whether at a research or policy level, is "intellectually indefensible". It must be acknowledged however, that Men's Health must first find its own feet, and needs to map out clear policy measures to address men's health issues. The development of a national policy for men's health can be the basis for future collaboration with Womens Health.

Mainstreaming gender in health

A recent WHO seminar on gender mainstreaming health policies in Europe, recognised the importance of working collectively on both men's and women's health issues

Mainstreaming gender in health is recognised as the most effective strategy to achieve gender equity. This is a strategy that promotes the integration of gender concerns into the formulation, monitoring and analysis of policies, programmes and projects, with the objective of ensuring that women and men achieve the highest health status. A mainstreaming strategy does not preclude initiatives specifically directed towards either women or men or towards equality between them. Such positive initiatives are necessary and complementary to a mainstreaming strategy. (European Institute of Women's Health, 2001, p5)

Building on this relational theory between men's and women's health, Sabo (1999) emphasizes the notion of 'reciprocity', and argues that the health of each sex is influenced by sociocultural synergies between the sexes. In certain contexts, the pattern of gender relations may promote a 'positive gendered health synergy', resulting in favourable health processes or outcomes for both sexes. Taking the example of fathers' involvement in childcare, the author cites evidence to support the development of closer bonds with their partners and healthier relationships with their children, after men had participated in programmes to support them in their role as fathers. The development therefore of policies focusing on 'shared parenthood' and men as active fathers, can positively influence both men and women's health, and indeed the health of their children. Conversely, a 'negative gendered health synergy' can arise where gender relations are associated with unfavourable health outcomes or processes for both sexes. The author cites a number of studies, from a number of different cultures, in which the reciprocal construction of gender identity and behaviour inform sexual practices between males and females in ways that elevate the risk of sexually transmitted infection for both sexes.

The role of women in men's health

Baker (2002) notes that men in relationships with women generally experience better health than single men, whereas women in relationships with men tend to experience poorer health than single women. This is also borne out by the data presented in relation to mental health in Section 2.3 of this report. This highlights the reciprocal nature of health, and that by seeking to improve men's health, women's health is also likely to benefit. However, whilst women have traditionally played a vital role in positively influencing men's health, Baker (2002) also suggests that it is time to look beyond initiatives directed at improving men's health via women. Such an approach does not encourage men to take greater responsibility for their own health, and places an additional burden on women. It is also based on traditional and outdated views of women's and men's roles, and fails to cater for a high proportion of men who are not in relationships with women. Kindler (1993) in Connell et al (1998) distinguishes between 'gender specific' and 'gender-relevant' health care and health promotion programmes. Whilst the former are designed to actively target either men or women, the latter are based on a gender relations framework, and address gender issues by involving men and women together. In the context of health issues which involve gender dynamics (e.g. parenting, sexual health), such programmes may be essential.

Conclusion

A gendered approach to men's health therefore poses a number of challenges to health care providers and policy makers. Fundamentally, it requires an approach to health that probes much deeper than the simplistic and narrow definition of men's health as a set of sex-specific biomedical conditions. There is a need to distinguish between sex (being male) and gender (living as masculine in a particular culture), in examining those health issues that are solely or predominantly 'men's health' issues. In the case of many health issues, both are inextricably linked. For example, whilst prostate and testicular cancer are unequivocally sex-specific conditions, they become gender-specific in the way that many men present late to their doctor with symptoms, or in the way that they subsequently cope with their illness. A gendered approach to health also requires the building of bridges between the fields of *women's health studies* and *men's health studies*. Whilst there is a need to focus on sex-specific and gender-specific health issues affecting men and women separately, the concept of 'gendering' health looks at health care in a relational and 'gender relevant' way, rather than as just sex and service-specific.

The pursuit of a 'men's health agenda' should not therefore be construed as an attempt to play 'catch up' with women, or to compete for scarce health resources. This approach, as Sabo (1999) describes, reveals a tendency to see issues of gender equity in categorical and binary terms (men versus women), and puts the focus on biological health outcomes more than the social processes that influence health and well-being. It can also be divisive, by inviting competition between lobbyists for men's and women's groups, as to which sex is the bigger victim, or which gets the best resources. It is perhaps more constructive to examine ways in which the study of men's health can be integrated with women's health or, with a more integrated policy on gender and health. A gendered approach to health would allow for the development of gender specific policies and initiatives that would enable in particular, more marginalised and vulnerable men and women to be offered more appropriate and effective health care. It would also encourage and facilitate men to move away from narrow and stereotypical codes of acceptable behaviour, and to develop skills that would make them more adaptive to a changing culture and to become better fathers, husbands/partners, carers and nurturers.

3.3. Origins of 'Masculinity' – Moving From 'Sex-Role' Theory to a Social Constructionist View of 'Masculinities'

Sex-role theory

'Sex role' theory emerged in the 1930s to describe a general

set of expectations around one's sex, expectations that were generally polarised on the basis of being male or female. These roles were widely interpreted as a cultural extension of biological sex differences, were generally interpreted as internalised sex roles and became aligned with the notions of 'masculinity' and 'femininity'. As a result, societal expectations and norms were different for men and women, and these norms were influenced by various role models - parents, teachers, friends, the media - and were subject to change over time. These so-called 'attributes' were, and perhaps for many men still are, perpetuated through the way men behaved in the workplace, as fathers, and how they related to women. They also have particular implications in relation to how men relate to other men. For example, teenage boys may embrace to celebrate success on a hurling field, but will generally feel pressurised into actively rejecting any form of inter-male intimacy outside of this setting. This can mean that internal conflict and tension often exist, and freedom of emotional expression can be curtailed. The imposition of boundaries on the way men express their emotions is aptly summed up by a contributor to *'fathers matter'*

It isn't that men don't cry. They do when they have permission to cry. They have that permission when Bolton or Bradford are relegated. The cameras are on the terraces and a lot of them are pumping, but that's ok. Permission is given there.

North Western Health Board (2002, p17)

Sex role theory distinguished for the first time between the notion of inherited or biological 'male' attributes, and 'masculine' traits that were the product of social learning and subject to change. Connell (1995, p22-23) highlights some important contrasting interpretations from the sex role theory literature. These included the proposition that in addition to being defined at an individual level, gender was also a function of behaviour differentiation in social groups such as the family. Sex roles were therefore subject to change as the agencies of socialisation such as the family or school changed or evolved to convey different expectations. Thus, the earlier accounts of conflict, within masculinity, derived from conflicting or unmanageable social expectations of male roles.

Critique of sex role theory

The emergence of feminism in the 1970s posed a significant challenge to the existing body of sex role theory literature. New feminist research highlighted the oppressive and subordinated female role, and proposed strategies for reform and for the liberation of women through the various agencies of socialisation. The appearance in the

United States of the 'Men's Liberation' movement (Pleck and Sawyer, 1974, in Connell, 1995), supported the notion of the male sex role as being oppressive, in the sense of the 'constricting pressure placed by the role upon the self'. This set a platform for 'men's studies' to be formed in parallel with the emerging feminist development of women's studies. Connell (1995) presents a comprehensive critique of sex role theory, which he concludes has been reactive and has failed to generate a strategic politics of masculinity, and which can be summarised as follows:

- It has been stretched to encompass a myriad of different meanings in different contexts, from occupation to gender, from social or political status to stage in the life cycle. Because roles are subject to change, as the agencies of socialisation change, a number of inconsistencies are endemic in using role theory as the basis from which to analyse social life.
- The theory exaggerates the extent to which people's social behaviour is prescribed, and greatly underestimates the diversity and complexity of gender patterns, which are constantly being influenced by many other socio-cultural, economic and political factors. The author also challenges the passive role of children that is implicit in the concept of socialisation, emphasizing the exploratory and dynamic aspects of child growth, and that individuals actively construct their gender identity and behaviour.
- Perhaps the major limitation is the assumption that these prescriptions of social behaviour are reciprocal, and indeed that men's and women's positions are complementary to one another. Such a position fails to grapple in particular with the hierarchy of power and social inequality between men and women, and indeed between men.
- Finally, the polarisation of 'male' and 'female' roles, which is a necessary part of the reciprocal definition of sex roles, leads to categoricalism and the reduction of gender to two homogeneous categories. Such a position is in many ways divorced from social reality, resulting in exaggerated or unfounded differences between men and women, and is conveniently obscured from the structures of race, class and ethnicity.

The notion of 'traditional' masculinity

The notion of 'traditional' or 'natural' masculinity is inherently linked with or seen as an expression of the male body or the male anatomy. So-called male 'attributes' such as independence, aggression, ambition, competitiveness, forcefulness and dominance, can be identified as actions that are driven from within male bodies. Inexpressiveness and stoicism on the other hand are associated with limits imposed upon the male body. The construction of gender identity and behaviour that is aligned to traditional

masculinity has been found to be particularly damning in terms of greater risk for morbidity and mortality. Courtenay aptly summarises what Sabo (1999, p2) describes as 'traditional gender scripts for men':

A man who does gender correctly would be relatively unconcerned about his health and well-being in general. He would see himself as stronger, both physically and emotionally, than most women. He would think of himself as independent, not needing to be nurtured by others. He would be unlikely to ask others for help. He would spend much time out in the world and away from home. The intense and active stimulation of his senses would be something he would come to depend on. He would face danger fearlessly, take risks frequently, and have little concern for his own safety

Courtenay (1998, p21)

There is a strong argument to be made, based on the statistics on men's health, (Section 2) that in constructing, displaying and maintaining their male identity, men engage in health-damaging behaviours and reject preventative health and health seeking behaviours that can be seriously hazardous to their health. Courtenay (2000a) argues that whilst women are encouraged to be knowledgeable about their bodies, to recognise and acknowledge susceptibility to illness, and to freely express their emotions, the gender pattern for men is very different. Men are more likely to conceal vulnerability, to be stoic and independent, and to turn to unhealthy behaviours and indeed risk behaviours that are culturally defined as masculine, to 'prove' their masculinity to themselves and others. (Courtenay, 2000a).

Social constructionist view of 'masculinities'

The 1990s witnessed a great expansion and diversification of research on 'masculinity', which challenged further the concept of a 'male role', and that of traditional or 'natural' masculinity. This brought about a new language of 'masculinities', which was influenced by critical feminist analyses, and which emphasized that power differences underpin relationships between men and women, men and men, and women and women. It also acknowledged in particular the impact of historical, cultural and political contexts on the way men 'do' masculinity. One of the key themes underpinning the modern sociology of gender is that rather than being fixed in advance of social interaction, gender is constructed in interaction and masculinities are actively produced in wide-ranging social interactions. This 'social constructionist' approach is concerned with the way in which conventions in social practice are constantly shifting.

...cultural definitions of “masculinity” and “femininity” are seen as historically emergent, structurally dynamic constructs through which individuals and groups actively interpret, engage and construct their daily behaviours and relationships
Sabo (1999, p2)

The growing recognition of the interplay between gender and other social structures has given wider acceptance to the concept of ‘multiple masculinities’. Connell (1995) cautions against over simplistic pigeonholing of masculinities such as ‘black’ or ‘working class’ masculinity. It is critically important to examine the relations between masculinities, and indeed to unravel the gender relations operating within masculinities. This relational approach ensures that the focus remains on the dynamic forces that are at play in the way gender configurations are formed.

Hegemonic versus subordinate masculinities

In addition to recognizing diversity within masculinities, it is also necessary to explore the ‘relations’ between the different kinds of masculinity. These include relations of ‘alliance, dominance and subordination’, and are constructed through a broad range of behaviours, within a very dynamic gender politics. Hegemony refers to the culturally exalted position afforded at any given time to one form of masculinity over others, and reflects both men’s domination of women and a complex system of intermale dominance. Subordinated masculinities have become symbolically assimilated to femininity (Connell, 2000). The language of ‘domination/ subordination’ around masculinities has also given rise to the term ‘marginalisation’, which Connell notes is always relative to the ‘authorisation’ of the hegemonic masculinity of the dominant group. For example, Traveller masculinities in a ‘settled’ social setting, or homosexual masculinities in a traditionally male, sporting setting, in each case may create different conflicts. Hegemonic masculinity is therefore defined against a range of subordinated, marginalised and often stigmatised masculinities, and accentuates many of the ‘masculine traits’ associated with traditional masculinity. Hegemony is not ‘fixed’, as the circumstances or conditions that uphold a particular masculinity may become eroded.

Whether boys and men in any given culture choose or feel pressurised into pursuing hegemonic masculinity, or reject and distance themselves from it, they must learn to deal with the presence of, what from a historical context is the most idealised and valorised form of masculinity. Schofield et al note that:

...the effects of hegemonic masculinity, as a cultural ideal, spread far beyond the (possibly small) group of men who consistently enact the full pattern.

Schofield et al (2000, p251)

This raises what Connell (1995) describes as ‘relationships of complicity’, that is, reaping the ‘patriarchal dividend’ while remaining a safe distance from the frontline of hegemonic enforcement. As a result, men for example continue to earn considerably more than women, and are still the major stakeholders of elite positions of corporate and state power. There is therefore quite a broad continuum of alliance to hegemonic masculinity, the strength of which is influenced by the compromises that men make through for example marriage or fatherhood.

3.4 Masculinities and Work

An examination of the economic circumstances and organisational structures within the workplace can provide many useful insights into men’s health. Connell notes how the incidence of occupational injuries and accidents in the workplace is in large part a function of the gendered organisation of work. This defines as ‘men’s work’

...most labouring, most work involving heavy machinery, most transport work, most work involving weapons and dangerous tools, and most work in heavily polluted environments.

(Connell, 2000, p187)

As Donaldson (1991 in Connell, 2000, p187) notes, the principal asset that working class men have is ‘their bodily capacity to labour – and their bodies are, over time, consumed by the labour they do’. Indeed, Irish history is rife with tales of Irish working class men in London or Boston, who actively constructed a masculinity which frequently meant foregoing safety and taking risks, with ultimately significant wear and tear on their bodies.

3.5 Masculinities and Health

One of the more recent and emerging themes from the social scientific discourse on masculinities has been the relationship between masculinities and health. Against a backdrop of worsening statistics around specific men’s health issues, and an increasing disparity between men’s and women’s life expectancy, the shortcomings of focusing solely on the literature of ‘sex-differences’ have begun to be exposed (see Section 2.8). The discourse around

masculinities and health considers men's health in relation to the active construction of beliefs, attitudes and behaviours that impact on health. Connell emphasizes that the active construction of masculinities, both individually and collectively, and in a wide range of settings, is central to understanding men's health.

The health effects are not mechanical consequences of either the physiological or the social condition of being a man. They are the products of human practice, of things done in relation to the gender order

Connell (2000, p178)

Sabo (1995) identifies health as one of the most clear-cut areas in which the damaging effects of this type of masculinity are evident. The development and maintenance of a heterosexual male identity is associated with pressurizing many males into risk behaviours and lifestyles that in turn, heighten their susceptibility to illness or accidental death. Kimmel refers to the

...outdated ideology of masculinity to which boys are struggling desperately to adhere, and which is applied ruthlessly and coercively by other boys.

Kimmel (2000, P5)

In the context of hegemonic masculinity, femininity may be ascribed to those heterosexual men who fail to conform to the rules of the dominant hegemony. This has major implications at a time when health-care and self-care practices have become culturally defined as 'feminine'. The practice of unhealthy behaviours and risk behaviours as a means of constructing gender identity may also occur in relation to what Connell (1987) describes as 'emphasized femininity'. Emphasized femininity refers to the cultural ideal that is emphasized for women, and operates in a reciprocal and subordinated way to hegemonic masculinity. Potentially compromising health behaviours may be used by some men not just to 'prove' their own masculinity, but also to avoid the ridicule or stigma of being labelled feminine or effeminate.

Connell refers to 'heterosexual sensibility' as the sense of obligatory heterosexuality that begins to develop among young boys during adolescence. The development and maintenance of a heterosexual male identity is associated with pressurizing many males into risk behaviours and lifestyles that in turn, heighten their susceptibility to illness or accidental death (Sabo, 1995). Connell et al note that the practice of risk behaviours are part of the construction of masculinity, each with a specific social context, and have health consequences because the masculinity is embodied.

Certain kinds of daring, certain kinds of bodily display, a certain indifference to risk, are not just gender-specific – they are gender, the enactment of a certain kind of masculinity

Connell et al (1998, p33)

Connell (2000) cites drink driving as an example of a resource for the active construction of masculinity, particularly in the context of young men, and also as a means of defining collective gender practice. It is the peer group, more than the individuals within it that sustains the definition of masculinity. The peer group in turn, acts within a broader context of mass media and corporate business, which maintain a masculinized 'car culture' (Walker, 1998 in Connell, 2000). The globalisation in this case of the motor industry is interwoven with the globalisation of gender.

Aspiring or conforming to hegemonic 'codes' of masculinity can have particularly adverse consequences for health. It is worth noting how advertising is used to evoke images from Irish mythology and Irish history that have a particular resonance with hegemonic masculinity. For example, a recent series of sponsored sports advertisements ran with the captions 'not men but giants', and 'you don't choose your club, you inherit it'. The use of such language in association with traditionally male and 'national games', can only serve to reinforce the masculine codes that tend to glorify personal sacrifice, pain and injury within these sports, and to promote the 'values' of risk-taking and facing danger without fear. This also highlights the collective dimension of masculinity. While individual behaviour is important, the overriding group ethos and group dynamic is central to the way masculinity is defined and constructed. The lack of any meaningful debate about the possible influences and impacts of such advertising in Ireland is all the more noteworthy in that alcohol consumption, and binge drinking in particular, are much higher in young men compared to young women (Ramstedt and Hope, 2003).

Conformity to hegemonic masculinity can also pose health risks for men, through for example particular patterns of health behaviours or risk behaviours. As highlighted earlier, men in Ireland are far more likely to be hospitalised for non-fatal head and spinal cord injuries; to be victims of firearm-related injuries and firearm-related deaths; to die from falls; to be victims of fatal car crashes; and to end up in prison. Conforming to hegemonic masculinity can also mean presenting 'a brave front' in the face of illness, which is particularly significant in the context of men's propensity to present late during the course of different illnesses. Hong (2002) cites a wide range of studies linking traditional male gender roles and hegemonic masculinity

with violence, and with a much greater propensity for men to be perpetrators and victims of violence. Weinberg (1998) contends that:

The motivation for all male violence is related to males attempting to reinforce and render incontestable their heterosexual masculinity

Weinberg 1998, in Hong 2002, p116

A good example is provided by Tomsen (1997) in Connell et al (1998) who describes the circumstances that lead to violence when young working-class men are involved in social drinking. Male 'honour' is at stake as the heavy group-drinking habits of the men, empowered with a dominant masculinity, become frustrated with what they perceive to be repressive measures of authority figures such as door staff. Being seen to make a claim to power in this instance is critically important for these young men. This can take the form of a constant concern with 'front or credibility', such as presenting an intimidating 'hyper-masculine' façade, and adopting a collective practice of masculinity which builds on a working-class masculine ethic of solidarity. Understanding this dynamic is fundamental to understanding the violence that very often ensues, and more importantly to the identification of preventative measures.

3.6 Masculinities Research in Ireland

Whilst there has been a substantial increase in masculinities and health research internationally in recent years, this has largely not been the case in Ireland. Ferguson (2001) provides an overview of the academic literature on men and masculinities in Ireland. The author highlights the lack of any real critical discourse or inquiry into Irish men as gendered beings, despite their relative dominance of Irish history and society. **Men Talking** (North-Eastern Health Board, 2001) provided the first meaningful insights into the relationship between masculinities and health in an Irish context. **Exploring Masculinities** (Department of Education and Science, 2000) evolved from gender equality research, and attempted to address some health issues within a broader framework of masculinities, for senior cycle boys in single-sex secondary schools. One of the most interesting developments following the launch of the programme was the rather hostile response of certain sectors of Irish society to the programme, despite successive Department of Education-appointed external evaluations of the programme. For example, **The Irish Catholic** newspaper reported that

This programme, clearly, is based on ideological myth rather than empirical fact...the fact is that our biological nature predisposes each sex to certain roles and characteristics. Kelly (2002, p20)

Quoting the Catholic Secondary Parents' Association (CSPA), the same article stated that

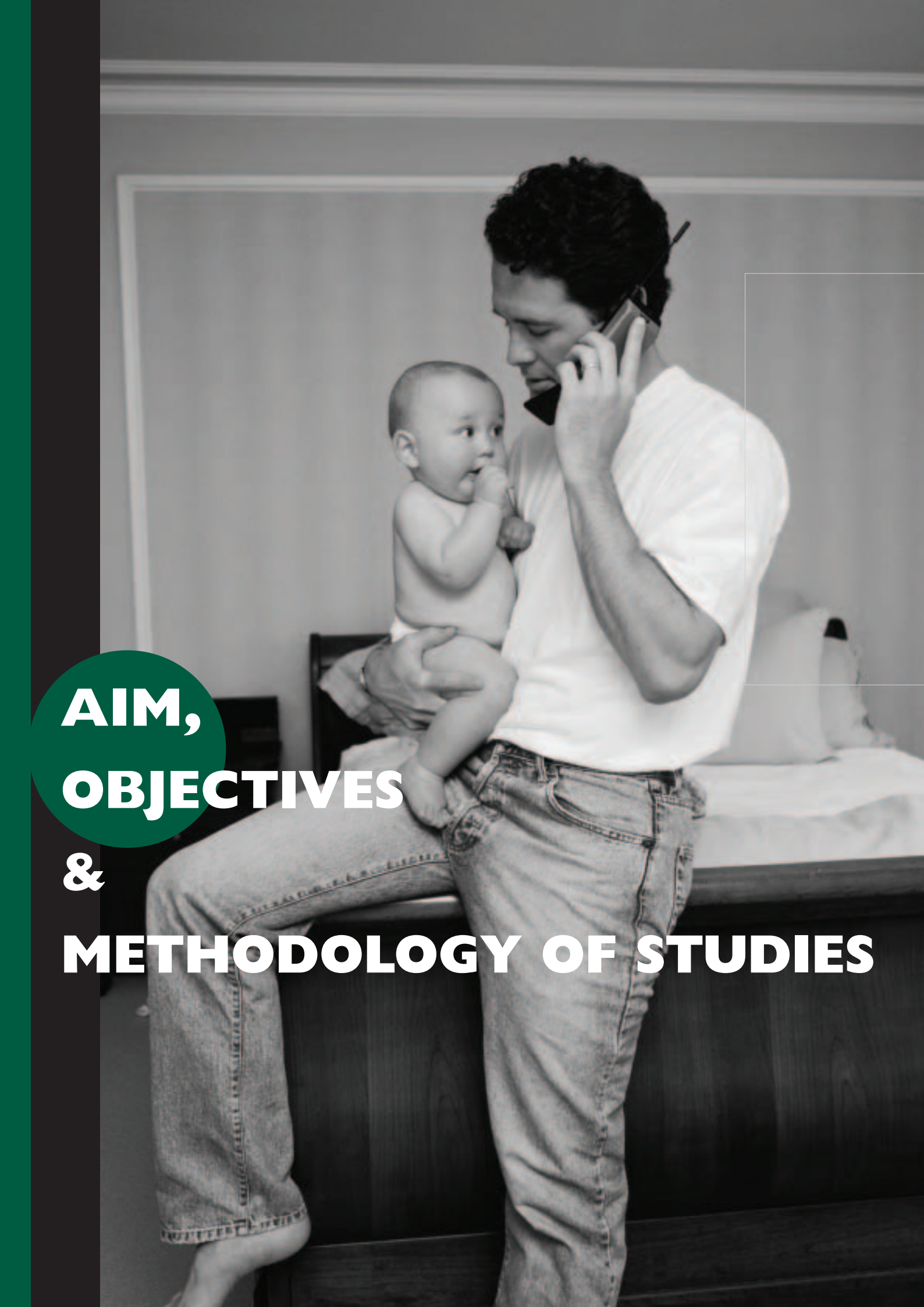
Expecting pupils to disclose their feelings about private and personal matters in public is unnecessary and objectionable

Kelly (2002, p20)

Following its launch, the CSPA also consistently expressed concern that the **Exploring Masculinities** programme reinforced negative stereotypes of males. This is ironic since a central philosophy running through the programme, was that of challenging boys to be more aware and reflective of masculinities, and in particular of the potentially damaging effects of traditional constructions of masculinity. It appears therefore that both the language and content of Exploring Masculinities, and the proposed methods of delivering the programme were deemed to be objectionable to some sectors of Irish society. One could postulate that this response is reflective of a general unease among wider conservative sectors of Irish society, about changing male roles in general, and in particular about the continued erosion of patriarchy in a post-feminist society. It is to be expected therefore that any initiative which attempts to challenge mainstream heterosexual masculinity may be met with strong opposition by certain sectors of society.

3.7 Conclusion

Whilst the statistics as summarised in Section 2 serve as an important backdrop to understanding men's health, the literature on gender and masculinities presented in this section offers more in-depth insights into the factors that underpin these statistics. A gendered approach to men's health begins to address the disparity in male/female life expectancy, and why mortality rates are higher for males at all ages and for all leading causes of death. As Connell (2000) highlights, the active construction of masculinities, both individually and collectively, and in the context of different settings, is central to understanding men's health. Given the importance of historical, political, economic and socio-cultural influences on masculinities, there is an urgent need to explore masculinities specifically within the context of health in Ireland. One of the key targets of men's health research in this and future work must be to identify how the construction of masculinities varies between male subgroups, and how different masculinities are connected to different types of ill-health, health behaviours, risk behaviours and mortality. Based on the evidence from Section 2, it is apparent that priority needs to be given to the health status of marginalised male subgroups, such as men affected by poverty, social exclusion and unemployment.



AIM,

OBJECTIVES

&

METHODOLOGY OF STUDIES

Section 4 Aim, Objectives & Methodology of Studies

Recommendation 15 of the current Health Strategy states that ‘a policy for men’s health and health promotion will be developed’ (Department of Health and Children, 2001). The purpose of this report is to inform the development of this policy.

>> 4.1 Aim

To investigate the role of gender and masculinities on Irish men’s lay concept of health, their knowledge, beliefs and attitudes in relation to health and illness and health practices, and on the barriers that Irish men perceive in accessing health services.

>> 4.2 Objectives

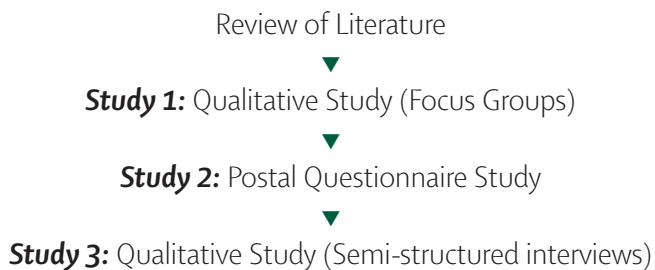
- 4.2.1 To provide a critique of the existing literature on men’s health, both internationally and within Ireland, including: (i) life expectancy and the principal causes of mortality and morbidity among Irish men, (ii) health and lifestyle behaviours of Irish men, (iii) gender/masculinities and men’s health
- 4.2.2 To examine men’s lay concept of health, and the sources of influence underpinning men’s understanding of health
- 4.2.3 To clarify the responses and coping strategies of men in dealing with illness, and how illness and ill-health influence the way in which men perceive and construct themselves
- 4.2.4 To highlight the barriers that men perceive in accessing health services, in particular primary care
- in collaboration with Irish College of General Practitioners (ICGP)
- 4.2.5 To develop an understanding of men’s health seeking behaviours, self-care practices and preventative health behaviours
- 4.2.6 To survey men’s knowledge and awareness of health issues, including the causes and symptoms of different aspects of illness, and the implications in terms of morbidity/mortality
- 4.2.7 To examine: (i) the aetiology behind men’s risk behaviours (in particular the potential links with masculinities), (ii) the factors likely to reduce risk-behaviours (iii) the social and cultural context of excess alcohol consumption among Irish men



4.3 Study Design

Ethical approval for the study was sought and obtained from Waterford Regional Hospital Ethical Committee. Following a comprehensive review of the literature, the study design comprised four discrete phases (Figure 4.3.1).

Figure 4.3.1 Study design



4.4 Study 1: Qualitative Study (Focus Groups)

4.4.1 Introduction

Study 1 was an exploratory study designed to address the principal research question and explored men's concept of health, how men cope with illness, men's health behaviours and risk behaviours, and men's 'self-care' practices. The study was also instrumental in shaping the design of Study 2 (Postal Questionnaire Study).

4.4.2 Methodology

- Eight focus groups were conducted for the purpose of this study, using a purposive sampling method (Charmaz, 2000). While the purpose of the study was not to seek statistical representativeness (Barbour, 2001), the sample did represent diversity in terms of age, social class, educational attainment, occupation, employment status, sexual orientation, marital status, parental status and able/disabled men. This ensured that a range of personal characteristics and experiences were highlighted in the study, and offered greater potential in terms of reflecting the heterogeneity of Irish men. Although the sample was diverse in its composition, it did not purport to be inclusive all subgroups of Irish men. The individual differences and characteristics of the men that were chosen were not intended to influence or control the study questions, but rather to draw attention to the range and pattern of influences on men's health practices.
- In each case, participants provided written informed consent to partake in the study, and permission for the discussions to be audio taped was sought from participants in advance.

- Pseudonyms were used for direct quotations of qualitative data to safeguard participant confidentiality
- Each audiotape was transcribed verbatim. A sum of €25 was paid to each focus group participant. This nominal sum was paid as a mark of respect to the men who contributed to the research process

4.4.3 Analysis of data

The principles of 'grounded theory' (Strauss and Corbin, 1990) were used for data analysis. Each transcript was coded, with codes subsequently being synthesized into categories or themes.

4.4.4 Results

The main themes to emerge from Study 1 are presented in Section 7. Since both qualitative and quantitative methodologies were designed to address the same research questions, the presentation of the qualitative data in conjunction with rather than as separate to the quantitative data was deemed to be most appropriate. This also afforded 'triangulation' of data (Mays and Pope, 1995). Some observations on the methodologies used are presented in Section 4.7

4.5 Study 2: Quantitative Postal-Questionnaire Study

4.5.1 Introduction

A 'Men's Health Questionnaire' was designed in order to elicit quantitative data on men's health that were identified as important (a) from the literature on men's health, and (b) as important themes that emerged from Study 1. The questionnaire comprised the following sections: (i) perceived barriers for men in terms of accessing primary care; (ii) men's knowledge and awareness of health; (iii) men's 'health practices' – including indices relating to risk behaviours, preventative health behaviours, self-care practices and lifestyle behaviours; (iv) men's emotional and relational health.

4.5.2 Questionnaire design and data collection

- The support of the ICGP was sought and obtained in relation to the study, specifically in terms of the selection of subjects and the dissemination of questionnaires through general practices. The sample was selected from general practices, as a key objective of the study was to investigate male patients' views on GP care. However, all questionnaires were sent back directly to the researcher to ensure as much honesty as possible in terms of how respondents completed the questionnaires.
- A draft postal questionnaire was circulated for critical comment to a wide range of academics, general

practitioners, allied health professionals, men's health advocacy groups and lay men. A number of modifications and adaptations were made to the questionnaire based on this consultative process.

- The questionnaire was then piloted to a stratified random sample of men (n=64), selected from two general practices within the health board region. A forwarding letter was sent to each subject outlining the purpose and context of the study, and requesting that contact be made with their general practitioner (GP) by a specified date if they chose not to take part in the study. Both the forwarding letter and the covering letter accompanying each questionnaire were printed on practice headed notepaper and signed by a GP from the practice. This was done for ethical and confidentiality reasons, thereby alleviating any possible concerns that the men might have had in relation to outside access to their GP records. (It should be stressed that the only access requested by the researcher to male patients' records was to their name/address and General Medical Service (GMS) status). A stamped addressed envelope (addressed to the researcher) also accompanied each questionnaire, and it was made clear in the covering letter that completed questionnaires were being returned directly to the researcher. Incentives were offered for return of completed questionnaires, and up to two reminders were sent to non-responders.
- The response rate to the pilot questionnaire was 65%, which represented all male subgroups randomly. Some additional amendments were made to the content of the questionnaire and to the wording of questions.
- Based on a relatively consistent response rate to the pilot study across age and social class, it was deemed appropriate to use a completely random sample for the main study, based also on the selection of subjects from a broad base (n=30) of general practices
- A much larger random sample was sought for the main study. A letter requesting co-operation with the study was sent by the chair of the ICGP to a random sample (n=40) of general practices selected from within the health board region, with twenty-five general practices consenting to take part in the study. A random sample (random order numbers) of 30 to 40 male patients was selected from each practice, yielding a final sample of n=920. The same methodology was employed as for the pilot study. An extensive local and national media campaign was organised to promote publicity and to garnish support for the study. The response rate (after two reminders) was 62% (n=572), with an additional 4% of uncompleted questionnaires returned. Inevitably, there were some missing values, and this explains why the 'n' value may vary between questions (see Appendix 1). As expected, the level of completion in relation to

the latter sections of the questionnaire was somewhat lower than the earlier sections.

- An attempt was made to profile non-responders, by requesting each participating general practice to provide information relating to non-responders (in an anonymous way), on age, social class (private/GMS patient), education, marital status and employment status. Of the sixteen practices who responded with this information, no discernible pattern in terms of the socio-demographic profile of non-responders was evident.

4.5.3 Analysis of data

- All completed questionnaires were inputted to an SPSS data sheet for analysis.
- Data was cleaned and both descriptive and inferential statistics produced. In the case of the later, $p < 0.05$ was taken as significant.

4.5.4 Results

The results of Study 2 are presented in Section 5. 'Composite scores' based on the variables described in Section 5 are presented in Section 6. A discussion of all quantitative data is presented in Section 7, in conjunction with the principal themes to emerge from Studies 1 and 3.

4.6 Study 3: Qualitative Semi-Structured Interview Study

4.6.1 Introduction

The purpose of Study 3 was to probe more deeply the issues that emerged from Studies 1 and 2, using a different qualitative methodology (semi-structured interviews). Semi-structured interviews were used for two reasons: (i) because a ready sample of men existed from Study 2, about which extensive quantitative data already existed; (ii) because of possible methodological limitations raised in relation to focus groups (see Section 4.7)

4.6.2 Methodology

- A sub-sample (n=20) of men was selected from the quantitative study. Only those subjects who had consented in the questionnaire to take part in an interview with the researcher (n=316) were considered for selection. An initial sample (n=8) was selected based on those subjects who reported different negative profiles in terms of health behaviours and health status (i.e. self reported 'poor' health; high risk takers; low levels of preventative health etc – see Section 6). Subsequent data collection was guided by 'theoretical sampling' (Charmaz, 2000), whereby the emerging theory was used to guide further data gathering.
- Semi-structured, open-ended interviews were used. As

in the case of Study 1, participants provided written informed consent to partake in the study, and permission for the discussions to be audio taped was sought from participants in advance. Each audiotape was transcribed verbatim.

- Pseudonyms were used for direct quotations of qualitative data to safeguard participant confidentiality.
- A sum of €25 was once again paid to each man who participated in an interview, as a mark of respect to the men's contribution to the research process.

4.6.3 Analysis of Data

A 'constructivist' grounded theory approach (Charmaz, 1998) for data analyses was used. Each transcript was coded, with codes subsequently being synthesised into categories or themes. 'Multiple coding' (Barbour, 2001) was used for a subsample (n=9) of the transcripts, which involved the cross checking of coding strategies and interpretation of results

4.6.4 Results

The main themes to emerge from Study 3 are presented in Section 7. As outlined in Section 4.4.4, it was deemed most appropriate to present the qualitative data in conjunction with rather than as separate to the quantitative data, thereby enabling 'triangulation' of data (Mays and Pope, 1995).

4.7 Overall methodological considerations from this study that may have implications for future men's health research initiatives

Men do care about their health and are willing participants in the research process

Despite a very extensive questionnaire covering 14 pages, a comparatively high response rate (62%) was achieved, and the level of completion of questionnaires (including open questions) was also high. Of those who completed and returned questionnaires, 55% consented to take part in an interview with the researcher at a future date. Overall, the level of disclosure and openness on the part of the men who participated in the qualitative studies was high.

The research process itself can be a mechanism for the active construction of masculinity

There were a number of examples of displays of machismo/bravado from the focus groups, with the methodology itself thereby becoming a mechanism for the active construction of masculinity and for collective practice. For example, laughter and humour was used in some of the focus groups as an apparent diversionary tactic

to enable respondents to maintain a distance from openly engaging in particular issues. This was particularly apparent in relation to issues around sexuality or the male body. In the following example, Eoghan's openness with the group on how he supported his friend who reported symptoms to him of swollen testicles is in marked contrast to the reaction of other group members.

...one day he (friend) says to me, I've got something very embarrassing, I said, you know, 'what's wrong like', I presumed he picked a sexually transmitted disease, you know, I was going to slag him off over it, of course but it wasn't, he said it was a slight swelling of the testicles, I said, I said 'do you mind just showing me, ('you did what?' Conor, 41 followed by murmurings, nervous laughter and shuffling from other group members) and God the things were, you know they were fairly swollen, I said 'are they sore', he says 'yeah they are', ('were they bigger than normal?' Andrew, 39, GROUP LAUGHTER) no, but seriously though, I said 'how long have they been at ye?', he said, 'I don't know, two months or so'. Two months and he still hadn't gone to a doctor! I literally had to grab him by the hand and make him go to the doctor... (Eoghan, 29)

The potential to explore further with other group members how Eoghan responded in this situation, was undermined and restricted to a superficial level by Conor and Andrew's 'humorous'/sarcastic contributions. This raises the question therefore as to whether focus groups are an effective methodology to enable participants reflect at a level beyond what Connell (1995) describes as the 'heterosexual sensibility' of men's bodies. To do so might run the risk of undermining one's own (hetero)sexuality, and therefore being consigned to a lower or subordinate masculinity. On the other hand, this particular example did provide an opportunity to reflect back to participants their own reactions, and in particular facilitated discussion and increased awareness around the notion of homophobia as a barrier to friendship between men. This may be noteworthy in the context of using focus groups as a way of developing awareness among men of sensitive issues, as distinct from focus groups as a research tool. This is also interesting in the context of White and Johnson (1997) and Moynihan's (1998) assertion that there is a scarcity of research devoted to the effects of masculinity or "maleness" on the research process or the research outcome. Gender tends to be considered in the context of sex and sexuality

rather than as a dynamic social structure.

Focus Groups versus semi-structured interviews when researching men

Some of the data from the focus group study was based on subjects' retrospective accounts of their own experiences or their accounts of other men's practices. In other words, there was a tendency on the part of some participants to distance themselves from disclosing current or more personal experiences. It is proposed that this 'distancing' was due at least in part to the desire of some participants to maintain a sense of control over their level of disclosure, rather than sharing (with other men) their own current practices or experiences. This raises the possibility of a very real barrier in terms of asking men to engage in a research methodology that demands that they openly and honestly share their experiences and current practices with other men. It also raises the question of trust and confidence that is implicit in gaining the necessary and appropriate disclosure around sensitive or intimate issues. Schofield et al's (2000) account of men's reticence in reporting concerns relating to mental or emotional problems (in the context of accessing health services) may have implications also in terms of the level of disclosure that will be forthcoming around these issues during the research process. The 'distancing' reported in the current study was much less evident in the interview data, although this may have been due to the researcher's increased focus on participants' current practices and their own experiences following the focus group study. Future focus group research work with men should take note of these observations, and from retrospective data attempt to track how men coped or managed themselves through to the present. While acknowledging their probable limitations as a research tool, the use of focus groups in developmental work or personal development work with men should not be undermined.

Men affected by marginalisation and focus groups

There was evidence from participants in two focus groups involving unemployed and lower social class men of an overriding sense of frustration, and in some cases of overt cynicism and hostility towards the research process. Some of these men had been engaged by prior research initiatives or 'consultation' processes, and very evidently felt a sense of frustration and even despair in terms of the disparity between what the research process was deemed to have 'promised' and what it subsequently 'delivered'. Others felt 'let down' and disrespected by a research process that 'consulted' with them, but then failed to follow-up by not communicating the research findings or outcomes back to them. This raises a very important concern around the research process itself being a potential source for further undermining an already so-called 'marginalised' group. It also explains why marginalised groups may view the

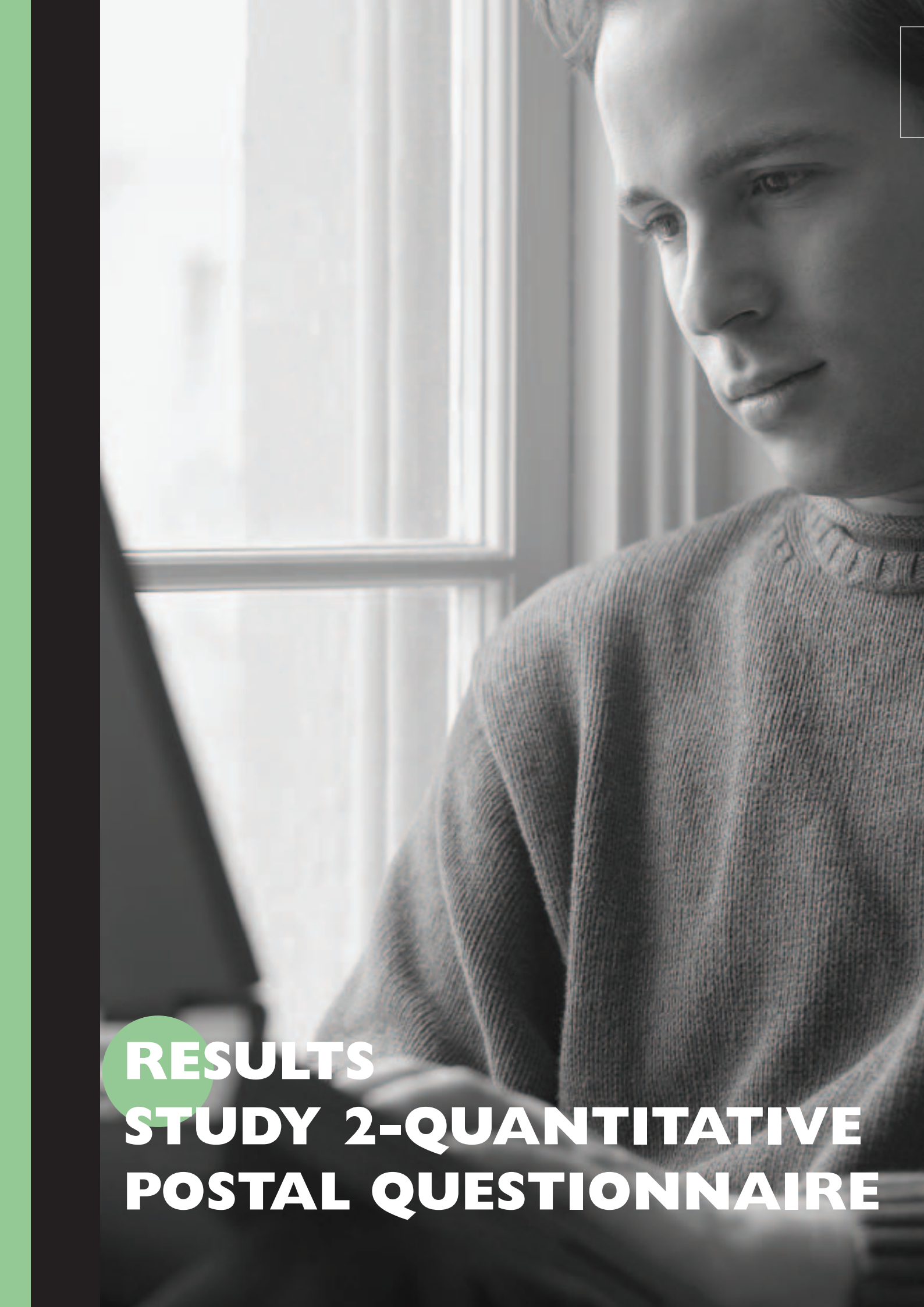
researcher (and the research process) with some degree of hostility.

In hindsight, therefore, it was hardly surprising that a general sense of mistrust and disdain for authority permeated both focus groups cited in this instance. It was even less surprising that a strong sense of loyalty/collusion was apparent from within these groups about 'sticking together' and not disclosing issues that might betray or damage further the integrity or identity of an already marginalised group/community. To do so might in a sense be disempowering, as the alternative would be to trust in a system that may have been seen as implicit in sustaining the group's marginalisation. This has important implications in terms of engaging marginalised men in the research process, most notably in terms of how these men are respected by the research process. The question might be asked as to whether it is ethical to raise expectations through research around for example health policy or service delivery, when in practice there may be a huge void between research outcomes and actual delivery.

Discrepancies between quantitative and qualitative data

Some discrepancies emerged between responses from the quantitative study and what participants communicated through the focus groups and interviews, most notably in relation to satisfaction with GP services. There are two possible reasons for this, which may be worth noting in the context of future men's health research work. Because the questionnaire for the quantitative study was sent to subjects by their GP, some may have been disinclined to criticise aspects of GP care (despite assurances of confidentiality and anonymity and that completed questionnaires were to be returned directly to the researcher and not the GP). To do so might from some men's perspective have risked compromising their relationship with their GP. Nevertheless, it can be argued that the ethical and confidentiality issues that underpinned the methodology chosen for disseminating the questionnaire outweighed any potential bias in the responses to the questionnaire. It is also possible that affording men the opportunity to 'speak' may allow them to express themselves more effectively and perhaps in a less inhibited way than is possible through the more constrained method of a research questionnaire.

It should also be stressed that the 'triangulation' of data used in this study was designed to compliment rather than to corroborate or refute the findings of one methodology against another, particularly since quantitative and qualitative methods defy direct comparison. Indeed, Mays and Pope (1995) stress that in the context of qualitative methodologies, 'comprehensiveness' can be achieved by allowing contradictions or exceptions in the data to broaden the scope for refining theories.

A young man with short hair, wearing a grey crew-neck sweater, is looking out of a window with white blinds. The scene is dimly lit, with light coming from the window. The overall mood is contemplative and quiet.

RESULTS
STUDY 2-QUANTITATIVE
POSTAL QUESTIONNAIRE

SECTION 5

Results – Study 2 Quantitative Postal Questionnaire

In addition to providing an overview of the demographic profile of the sample population (Section 5.1), this Section comprised eight additional sub-sections. Section 5.2. investigated male patients' views on accessing GP care; Sections 5.3 – 5.7 explored a range of attitudinal, knowledge and behaviour factors relating to men's health practices; Section 5.8 examined emotional/relational health issues; and Section 5.9 considered the impact of marriage/Cohabiting and fatherhood on men's health.

5.1 Demographic Profile of Sample Population

The age, education and social class profiles of the sample population are illustrated in Figures 5.1.1, 5.1.2 and 5.1.3 respectively. For the purpose of cross-tabulating 'education', 'no schooling' and 'primary school only', and also 'some' and 'complete third level' were combined as single variables in each case. Social class categories were compiled in accordance with CSO guidelines, using occupation, or occupation of principal wage-earner (whichever was highest) to assign respondents to one of six categories. This explains the high proportion of men in SC2.

Figure 5.1.1 Age distribution of sample population

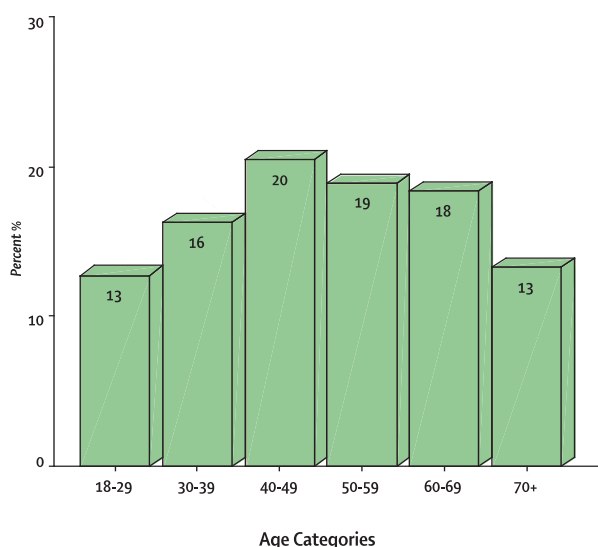


Figure 5.1.2 Education distribution of sample population

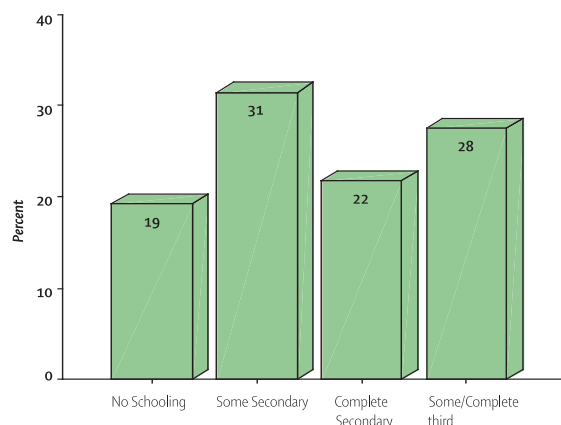
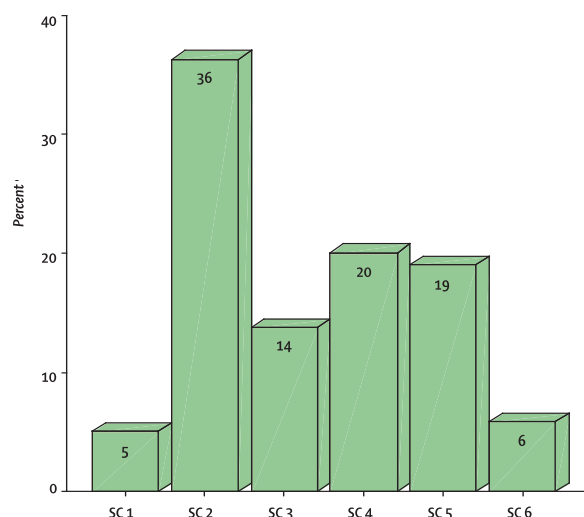


Figure 5.1.3 Social Class (SC) distribution of sample population



SC1: Professional workers SC2: Managerial and technical
 SC3: Non-manual SC4: Skilled manual
 SC5: Semi-skilled SC6: Unskilled

Tables 5.1.1 and 5.1.2 present the marital status and parental status of the sample population. For the purpose of conducting cross-tabulations, marital status was recoded into two categories; 'married/cohabiting' and 'not married/not cohabiting'. Of the 411 men who identified as fathers, 89% (n=366) identified the age(s) of their child(ren). This subgroup was subdivided into fathers of 'younger children' (at least one child under the age of 16; n=190); and fathers of 'older children' (child/all children 16 years or over; n=176).

Table 5.1.1 Marital status

	Frequency	Valid Percent
Married	374	66.1
Cohabiting	15	2.7
Widowed	13	2.3
Separated	25	4.4
Divorced	5	.9
Single	127	22.4
Remarried	7	1.2
Total	566	100.0

Table 5.1.2 Parental status

a. Parental status			b. A father of 'younger' or 'older' children?		
	Frequency	Valid Percent		Frequency	Valid Percent
Yes	411	74.2	Father of 'younger' children	190	51.9
No	143	25.8	Father of 'older' children	176	48.1
Total	554	100	Total	336	100

NOTE: *fathers of 'younger' children (at least one child under the age of 16; and fathers of 'older' children (child/all children 16 years or over).*

Unemployment was not considered for cross-tabulation purposes, in light of the small number of men (4.6%) who reported as unemployed. For the same reason, neither sexual orientation (just 2.8% who reported as 'homosexual' or 'other' (than heterosexual)), or nationality (just 3% non-Irish) were considered as variables for cross-tabulations.

5.2 Male Patients' Views on Accessing GP Care

This section comprises three sub-sections: (5.2.1) length of time since attendance at doctor; (5.2.2) male patients' views on a range of aspects of GP care, including: (i) access to care; (ii) continuity of care; (iii) communication; (iv) inter-personal care; (v) doctors' knowledge of patient (vi) enablement and (vii) overall satisfaction with GP; (5.2.3) barriers around male patients attending their doctor, including: (i) men's disposition towards going to the doctor; (ii) factors associated with reluctance to go to the doctor; (iii) factors that cause fear or anxiety about going to the doctor; (iv) issues concerning preference for a male/female doctor.

5.2.1 Length of time since attendance at doctor

Contrary to the widely held perception that men do not attend GPs, more than three out of four men (77.4%) reported having consulted a doctor within the previous 6 months (Table 5.2.1).

Table 5.2.1 Length since attended doctor

	Frequency	Cumulative Percent
Less than 3 months	314	55.8
3-6 months	122	77.4
7-12 months	70	89.9
1-2 years	35	96.1
3-4 years	14	98.6
5 years or more	8	100.0
Total	563	

It should be stressed that the sample was selected from GP patient records and that this figure may have been lower had the sample been taken from the general male population. A significant association was found between 'duration since attending a doctor' and age (Chi-Square = 43.221; df = 15; p=.000), with men in the youngest age category being over six times more likely than men in the oldest age category (34.2% v 5.3%), not to have consulted a doctor within the past six months.

5.2.2 Male patients' perceptions of GP care

5.2.2.1 Access to care

Practice Opening Hours

Whilst the majority of men (82.9%) reported being satisfied (i.e. a rating of at least 'good') with the hours that their practice was open for appointments (Table 5.2.2), additional opening hours at evenings and week-ends were cited as being desirable (Table 5.2.3)

Table 5.2.2 Satisfaction with practice opening hours

	Frequency	Valid Percent
Very poor	5	.9
Poor	15	2.7
Fair	75	13.4
Good	207	37.0
Very good	159	28.4
Excellent	98	17.5
Total	559	100.0

Table 5.2.3 Additional hours for practice to be open

Option	Yes	No
Evenings	28%	72%
Week-ends	25%	75%
Lunch Time	8%	92%
Early Morning	6%	94%

Waiting Times

27.9% reported that consultations began 'on time' or within 10 minutes, with 14.4 % reporting waiting times in excess of 30 minutes (Table 5.2.4). In terms of how men rated waiting times, 38.7% were dissatisfied with waiting times (i.e. a rating of 'fair' or less), with 14.9% being very dissatisfied (i.e. a rating of 'poor' or less).

Table 5.2.4 Waiting times

Usual waiting time for consultations to begin

	Frequency	Cumulative Percent
Not at all, begin on time	35	6.4
Less than 10 minutes	118	27.9
11-20 minutes	187	62.0
21-30 minutes	129	85.6
31-45 minutes	39	92.7
More than 45 minutes	40	100.0
Total	548	

Rate Waiting time

	Frequency	Cumulative Percent
Very poor	19	3.7
Poor	39	11.2
Fair	143	38.7
Good	154	68.3
Very good	109	89.2
Excellent	56	100.0
Total	520	

Duration of a typical consultation

Eleven to fifteen minutes was the most frequently reported (41.3%) duration of a typical consultation (Table 5.2.5). 36.5% reported typical consultation times of 10 minutes or less, with 22.4% of consultations lasting more than 15 minutes. A significant association was found between 'duration of a typical consultation' and age (Chi-Square = 50.668; df =25; p=.002), with older men more likely to report longer consultations than younger men. A minority of male patients (7.4%) rated as 'somewhat rushed' or 'very rushed' the duration of a typical consultation (Table 5.2.5).

Table 5.2.5 Duration of consultations

Duration of a typical consultation			Rate duration of a typical consultation		
	Frequency	Valid Percent		Valid Percent	Frequency
5 minutes or less	35	6.3	Very rushed	1.3	7
6-10 minutes	169	30.2	Somewhat rushed	6.1	34
11-15 minutes	231	41.3	Adequate	24.9	138
16-20 minutes	95	17.0	Sufficient time	51.5	286
21-25 minutes	23	4.1	More than sufficient time	16.2	90
Greater than 25 mins	7	1.3			
Total	560	100.0	Total	100.0	555

5.2.2.2 Continuity of care

Frequency of seeing own doctor

Two thirds of men reported ‘always’ or ‘almost always’ seeing their usual doctor, with the vast majority (83.4%) expressing satisfaction (i.e. a rating of at least ‘good’) with the frequency of seeing their usual doctor (Table 5.2.6).

Table 5.2.6 Frequency of seeing own doctor

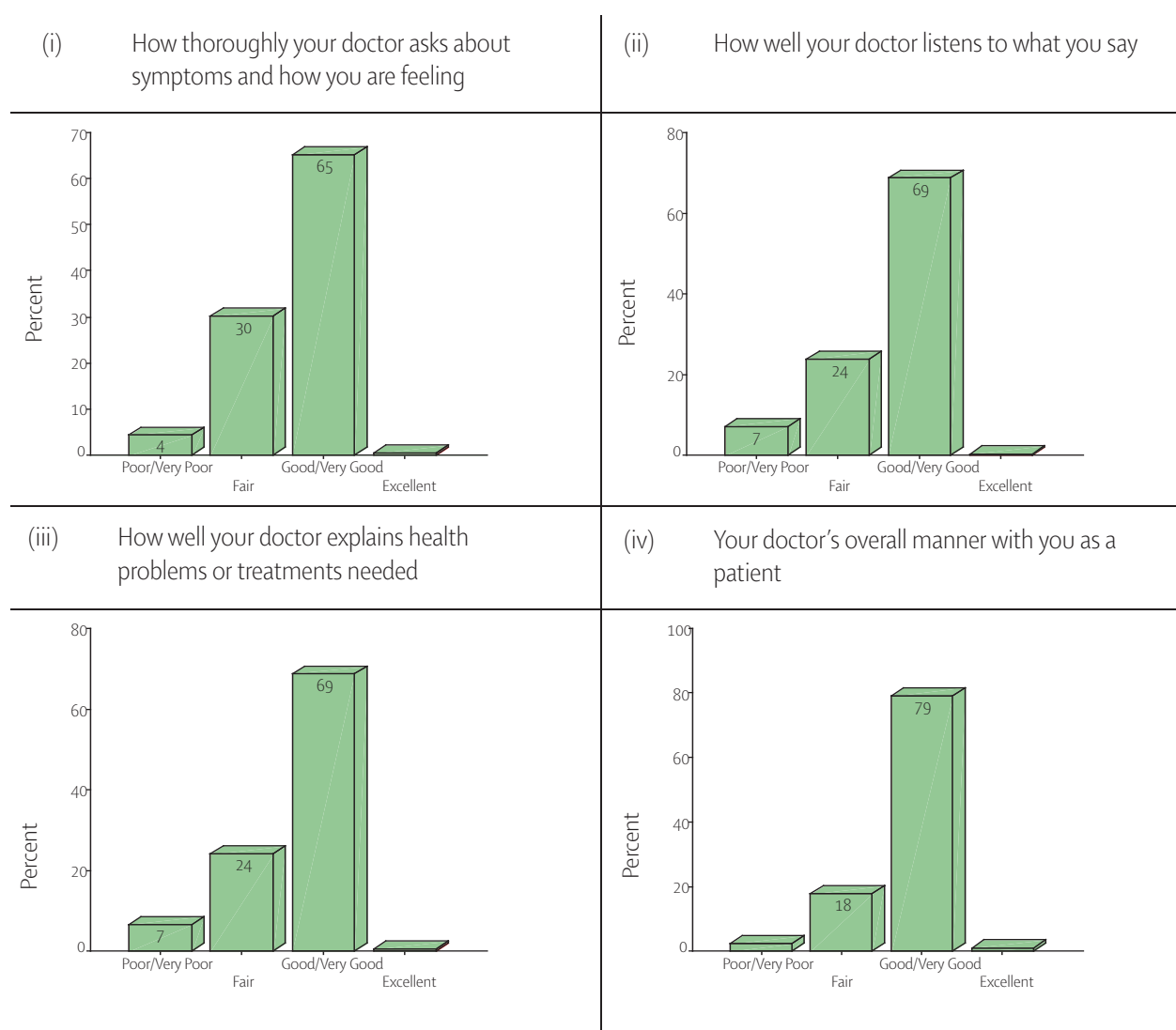
Frequency of seeing own doctor			Rate frequency of seeing own doctor		
	Frequency	Cumulative Percent		Frequency	Valid Percent
Always	196	35.0	Very poor	7	1.3
Almost always	176	66.4	Poor	14	2.6
A lot of the time	60	77.1	Fair	70	12.8
Some of the time	86	92.5	Good	145	26.6
Almost never	38	99.3	Very good	175	32.0
Never	4	100.0	Excellent	135	24.7
Total	560		Total	546	100.0

5.2.2.3 Communication

Doctor-patient communication

Figure 5.2.1 illustrates how respondents rated different aspects of how doctors communicated with them as patients.

Figure 5.2.1 Doctor-patient communication



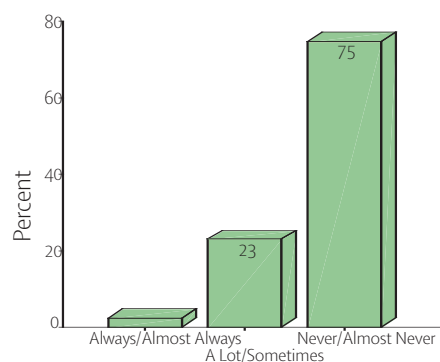
Over a third of men expressed some reservations in relation to how thorough they perceived their doctor to be in asking about symptoms and how they were feeling. This factor was associated with both social class (Chi-Square = 16.855; df =6; p=.010), and education (Chi-Square = 17.461; df =9; p=.042), with less well-off and less well educated men being more likely to have some concerns in this respect. Almost a third had reservations about how well their doctor listened to what they said. This factor was also associated with social class (Chi-Square = 13.834; df =6; p=.032), with less well-off men more likely to express doubts about this aspect of care. Almost a third also had some reservations about how well their doctor explained health problems or treatments needed. While eight out of ten men rated highly their doctor's overall manner with them as patients, men from lower social classes were also significantly more likely to have concerns about this aspect of care (Chi-Square = 15.959; df =6; p=.014).

Leaving doctor's surgery with 'unasked' and 'unanswered' questions

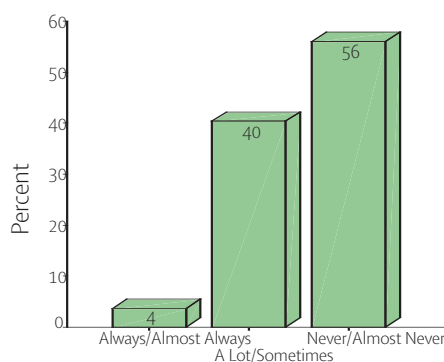
Figure 5.2.2 illustrates the extent to which patients reported leaving their doctors' surgeries with either 'unasked' or 'unanswered' questions. One in four men reported leaving their doctors' surgeries with 'unanswered questions' at least some of the time. Almost twice this number (44%) acknowledged that they left their doctors' surgeries with 'unasked questions' at least some of the time. In both instances (leaving doctor's surgery with unanswered questions/unasked questions respectively), significant associations were found with age (Chi-Square = 30.749; df =10; p=.001; Chi-Square = 22.303; df =10; p=.014). Younger men were significantly more likely than older men to leave their doctors' surgeries with questions 'unanswered' (44.4% v 18.8%) and/or questions 'unasked' (56.9% v 33.8%).

Figure 5.2.2 Frequency of leaving doctor’s surgery with unanswered/unasked questions

a. Unanswered questions



b. Unasked questions



Issues perceived as difficult to communicate to GP

Table 5.2.7 outlines the issues about which men have difficulty in talking to their GP. Approximately one in three men identified a serious relationship problem with partner/spouse, suspected symptoms of an STI, and impotence as issues that give rise to such a difficulty. It was also noteworthy that over a fifth of men may opt to remain silent in relation to both symptoms of testicular cancer and a stress/mental health issue.

Table 5.2.7 Issues perceived as ‘difficult to talk to your doctor about’

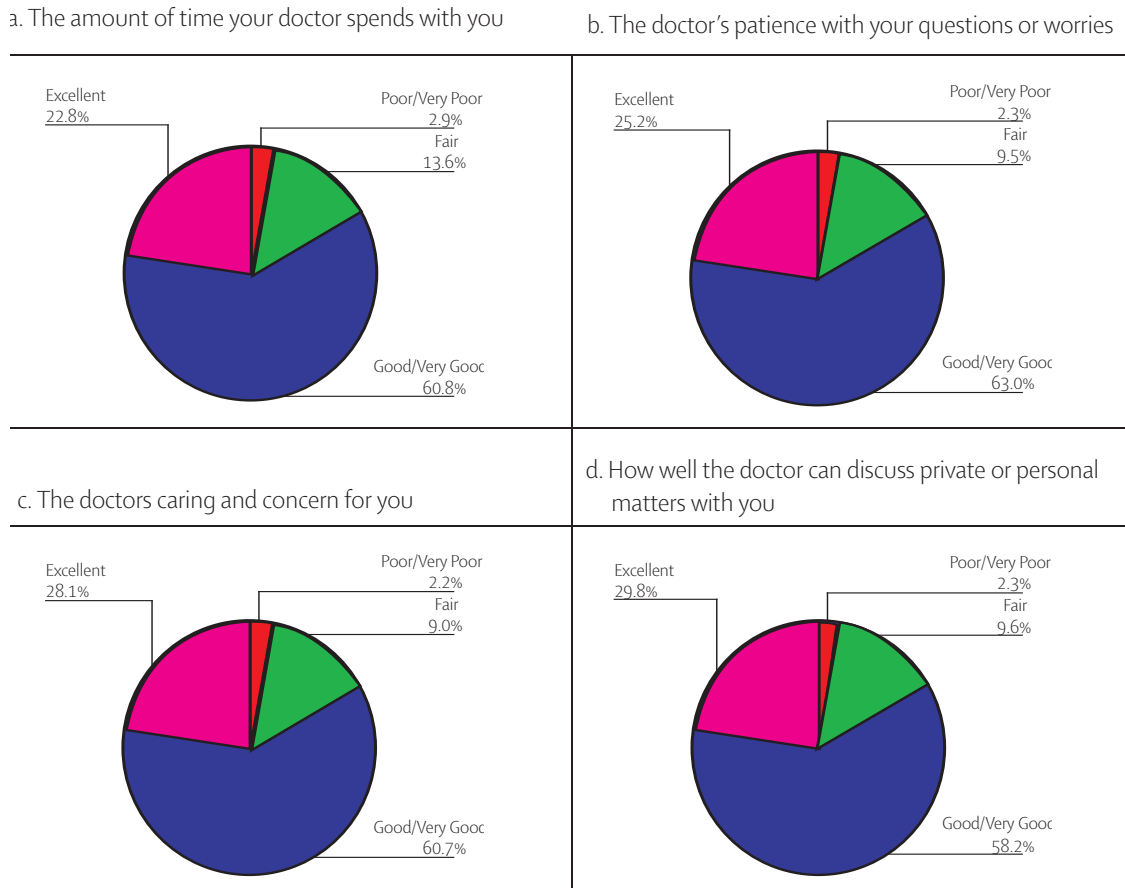
ISSUE	Disagree/ Strongly Disagree	No Strong Feelings	Agree/ /Strongly Agree
Serious relationship problems with partner or spouse	34.9%	28.1%	37%
Suspected symptoms of an STI	41.8%	26.7%	31.5%
Impotence	42.4%	26.5%	31.2%
Problem with back passage	47.5%	25.7%	26.7%
Swollen or painful testicles	51.2%	26%	22.8%
Stress or a mental health problem	47.6%	31.8%	20.6%
A suspected drink or drugs problem	47.5%	33%	19.5%
Feeling generally unwell or in poor form	59.5%	26.7%	13.8%

5.2.2.4 Inter-personal care

The vast majority of men felt positively disposed to the personal aspects of care that they received from their doctors (Figure 5.2.3): 83.6% were satisfied with the amount of time that their doctors spent with them, while 88.2% were satisfied with their doctors’ patience with their questions or queries. The same percentage rated positively their doctors’ caring and concern for them, and their doctor’s ability to discuss private or personal matters with them. Significant associations were found between age and three of these four factors; ‘time spent by doctor’ (Chi-Square = 36.272; df =15; p=.002); ‘caring and concern’ (Chi-Square = 40.930; df =15; p=.000) and ‘ability to discuss private/personal matters’ (Chi-Square = 28.741; df =15; p=.017). In each of these three cases, older men were more likely to view more highly the personal aspects of care that they receive from their doctors, which is noteworthy in the context of older men reporting longer consultation times (Section 5.2.2.1).

Figure 5.2.3

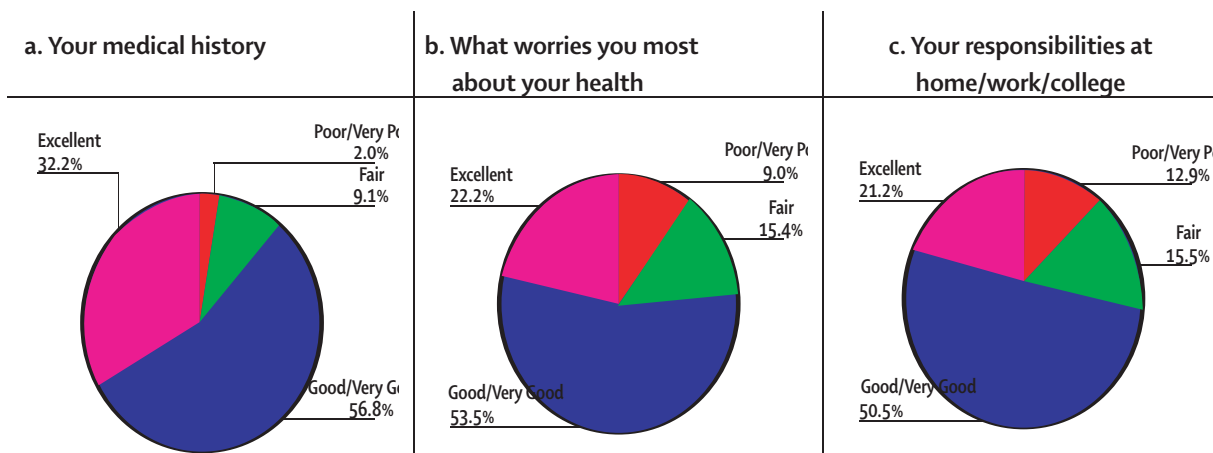
Interpersonal aspects of GP care



5.2.2.5 Knowledge of patient

Figure 5.2.4 illustrates respondents' perceptions of GPs' knowledge of them as male patients. The vast majority of men (89%) rated as good or better their doctors' knowledge of their medical history. This figure was somewhat lower (75.7%) in relation to their doctors' knowledge of what worried them most about their health; and (71.7%) with regard to their doctors' knowledge of their responsibilities at home, work or college. In each respective case, a significant association was found with age (Chi-Square = 41.578; df =15; p=.000; Chi-Square = 56.556; df =15; p=.000; Chi-Square = 45.229; df =15; p=.000), with older men being significantly more likely to rate highly their doctors' knowledge of them as patients

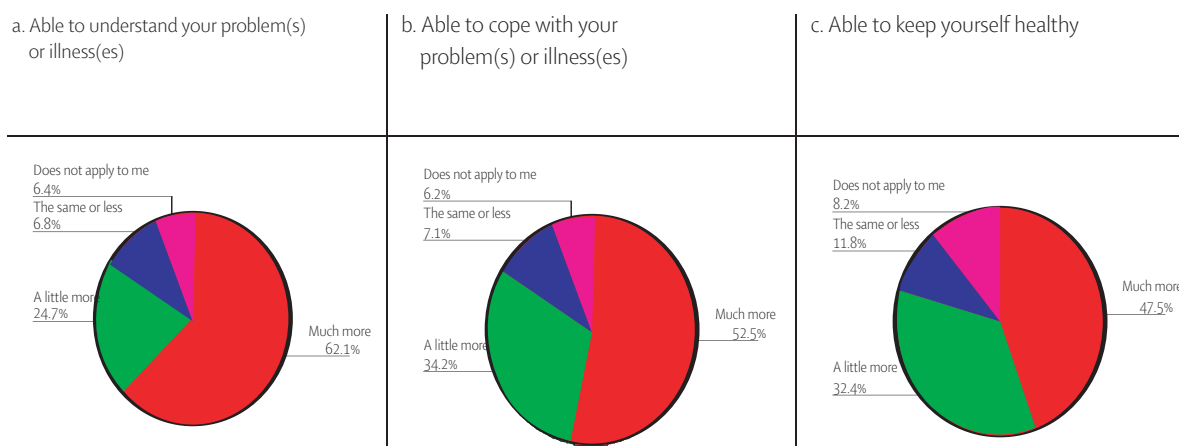
Figure 5.2.4 Perception of GPs' knowledge of patients



5.2.2.6 Enablement

Figure 5.2.5 outlines the extent to which respondents felt enabled to manage their problem(s) or illness(es) after a visit to their doctor. 62.1% felt they were able to understand their problem(s) or illness 'much more', while 52.5% felt they were able to cope with their problem(s) or illness 'much more' than before the visit. 47.5% reported feeling enabled to keep themselves healthy 'much more' than before the visit.

Figure 5.2.5 'Enablement' – how patients generally feel after a visit to the doctor



Age was associated with all three variables and was significant in the case of 'understanding problem(s) or illness(es)' (Chi-Square = 18.701; df =10; p=.044) and 'able to keep yourself healthy' (Chi-Square = 46.542; df =10; p=.000), with older men being much more likely than younger men to feel 'enabled' after a visit to their doctor. A significant association was also found between social class and able to keep yourself healthy (Chi-Square = 10.444; df =10; p=.034), with men from SC 5/6 feeling less enabled than men from SC 1/2 (18.4% v 12.2%) to keep themselves healthy after a visit to their doctor.

5.2.2.7 Overall satisfaction with general practice

The vast majority of men (91.7%) expressed overall satisfaction (i.e. 'fairly satisfied' or better) with their practice, with over two out of three men being either 'very' or 'completely' satisfied (Table 5.2.8).

Table 5.2.8 Overall satisfaction with practice

	Frequency	Cumulative Percent
Completely dissatisfied	3	.5
Very dissatisfied	5	.9
Fairly dissatisfied	13	2.3
Neither satisfied/dissatisfied	26	4.6
Fairly satisfied	129	32.9
Very satisfied	238	42.2
Completely satisfied	150	26.6
Total	564	100.0

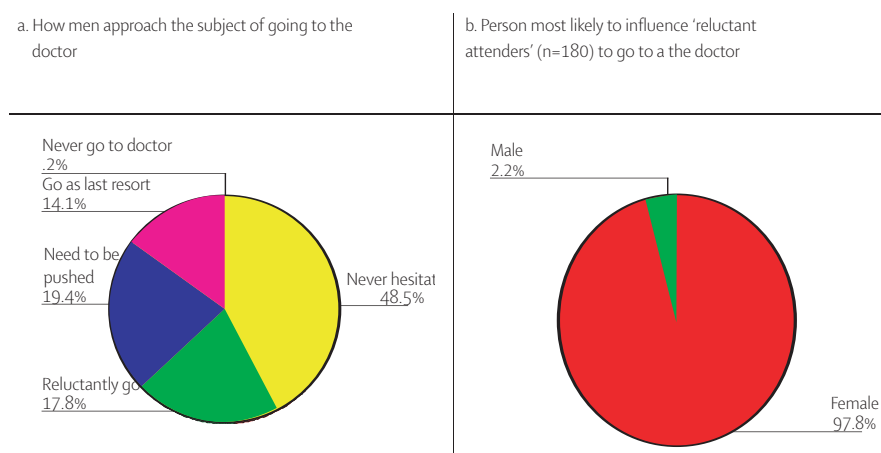
A significant association was found between overall satisfaction with practice and age (Chi-Square = 52.132; df =20; p=.000) and with social class (Chi-Square = 30.111; df =8; p=.000). Older and more well-off men were more likely to be very/completely satisfied with their practice, compared to younger, less well-off men.

5.2.3 Barriers around male patients attending their doctor

5.2.3.1 Disposition towards going to the doctor

Despite an overall pattern of satisfaction generally with GP services (Section 5.2.2), over half of the men surveyed (51.5%) can be described as 'reluctant attenders', expressing varying degrees of reluctance to attend their GP (Figure 5.2.6a)

Figure 5.2.6 Disposition towards going to the doctor



'Disposition towards going to the doctor' was significantly associated with age (Chi-Square = 49.852; df = 20; p=.000); social class (SC) (Chi-Square = 22.080; df =6; p=.000); and education (Chi-Square = 41.696; df =12; p=.000). Older, better-off and better-educated men were more likely to have a positive disposition towards going to the doctor. 72.2% of men from the oldest age category stated that they 'never hesitate' about going to the doctor, compared to just 37% of men from the youngest age category. 25.6% of men from SC 5/6 stated that they would only go to the doctor 'as a last resort', compared to 9.2% from SC 1/2. A similar difference was found in relation to education, with 22.1% of men with 'no schooling/primary school only' stating that they would only go their doctor 'as a last resort', compared to 10.5% of men with third level education.

The overwhelming consensus (97.8%) amongst 'reluctant attenders' was that a female close relative/acquaintance was most likely to influence their decision to go to a doctor (Figure 5.2.6b).

5.2.3.2 Factors associated with reluctance to go to doctor

Table 5.2.9 outlines the factors likely to contribute to men's reluctance to go to their doctors, with two out of three men reporting that the problem was rarely serious enough to go. 'Cost' and 'missing out on work' also featured prominently as reasons for not going to the doctor. A significant association was found between age and 'problem is rarely serious enough' (Chi-Square = 25.226; df =10; p=.005), with younger men being much more likely to play down symptoms. The identification of work as a barrier that was likely to influence men's decision to go to a doctor was significantly associated with age (Chi-Square = 24.232; df =10; p=.007), social class (Chi-Square = 11.420; df =4; p=.022), and education (Chi-Square = 24.624; df =6; p=.000). Younger, less well-off and more highly educated men were more likely to cite 'missing out on work' as a factor that contributed to their reluctance to go to the doctor. 58.2 % of non-medical card holders (n=316) were dissatisfied (i.e. a rating of 'fair' or less) with the cost of visiting a GP in terms of value for money, of whom 20.6% rated the cost as 'poor/extremely poor'.

Table 5.2.9 Factors associated with reluctance to go to doctor

Factor	Disagree/Strongly	No Strong Feelings	Agree/Strongly Agree
Problem is rarely serious enough	14.5%	21.4%	64.1%
Cost is too high	33%	25%	42%
Missing out on Work	39.7%	22.3%	37.9%
Don't like going to doctor	32.6%	30.5%	36.9%
Not enough time	41.6%	22.6%	35.8%
No after hours service	41.5%	27.4%	31.1%
Excessive waiting times	50.5%	23.4%	26.1%
Doctors surgeries are more geared towards women and children	60.5%	25%	14.5%
Embarrassment	67.2%	22.3%	10.5%
Not wanting to be seen in doctor's surgery	74.1%	20.4%	5.6%
Transport difficulties getting there	78.8%	18%	3.2%

5.2.3.3 Factors that cause fear or anxiety about going to the doctor

Fear and anxiety about confronting and dealing with illness featured prominently throughout the focus groups in Study 1. Table 5.2.10 outlines the factors perceived by men as causing fear or anxiety about going to the doctor. Almost a third of respondents were fearful of having a serious condition diagnosed, while a quarter were concerned about being admitted to a hospital as a result of the visit. One in five men were fearful of having their private parts examined, which is consistent with 22.8% of respondents expressing reluctance to talk to their GP about swollen or painful testicles (Table 5.2.7). A significant association was found between education and 'concern about having a serious condition diagnosed' (Chi-Square = 13.241; df =6; p=.039), with less well-educated men being more likely to express fear or concern. 'Losing out on work/not getting promoted' correlated significantly with age (Chi-Square = 20.420; df =10; p=.026), with younger men being more likely to express concern than older men. 'Having private parts examined' was significantly associated with both social class (Chi-Square = 15.403; df =4; p=.004) and education (Chi-Square = 18.026; df =6; p=.006). 'Concern about being admitted to a hospital' also correlated with both social class (Chi-Square = 9.954; df =4; p=.041) and education (Chi-Square = 15.636; df =6; p=.016). In both instances, less well-off and less well-educated men were more likely to be concerned about these issues.

Table 5.2.10 Factors that cause fear or anxiety about going to the doctor

Factor	Disagree/Strongly Disagree	No Strong Feelings	Agree/Strongly Agree
Concern about having some serious condition diagnosed	43.1%	24.3%	32.6%
Concern about being admitted to hospital as a result of the visit	52.1%	22.6%	25.3%
The prospect of having my private parts examined	57%	23%	20%
Being given advice that I don't want to hear	56.7%	25.8%	17.5%
Concern about having to endure pain	58.5%	25.2%	16.3%
Running the risk of losing out on work or of not getting promoted	61.3%	23.4%	15.3%
Being seen as weak or vulnerable	71.9%	20.1%	8%

5.2.3.4 Issues concerning preference for male/female doctor

93.5% reported that their usual doctor was male (Table 5.2.11).

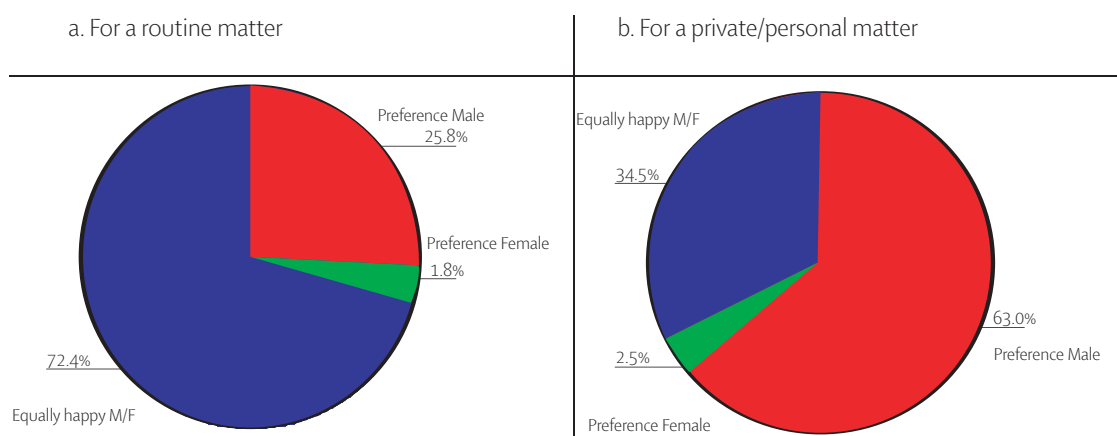
Table 5.2.11 Sex of doctor

	Frequency	Valid Percent
Male	463	93.5
Female	32	6.5
Total	495	100.0

Figure 5.2.7 highlights clear differences in men's preferences for a male/female doctor based on the nature of the complaint. 72.4% reported that they would be equally happy with a male/female doctor for a routine matter, such as a flu or simple check-up. Less than half of this number, however, maintained this view in relation to a private/personal matter (e.g. stress or pain/discomfort with private parts), with 63% expressing a preference for a male doctor. A significant association was found between preference for male/female doctor 'for a private/personal matter' and age (Chi-Square = 28.656; df = 10; p=.001), with older men being significantly more likely to have a preference for a male doctor.

Figure 5.2.7

Preference for Male/Female Doctor



5.3 Self-Reported Health Status and 'Self-Care Practices'

This section deals with respondents' 'self-reported health status' and 'self-care practices', and includes measures for: (5.3.1) self-reported health status; (5.3.2) neglect of health as a contributory factor to self-reported 'poor' health; (5.3.3) self-reported long-term illness/disability; (5.3.4) late presentation as a contributory factor to self-reported long-term illness/disability; and (5.3.5) male patients' sense of personal responsibility in relation to health.

5.3.1 Self-reported health status

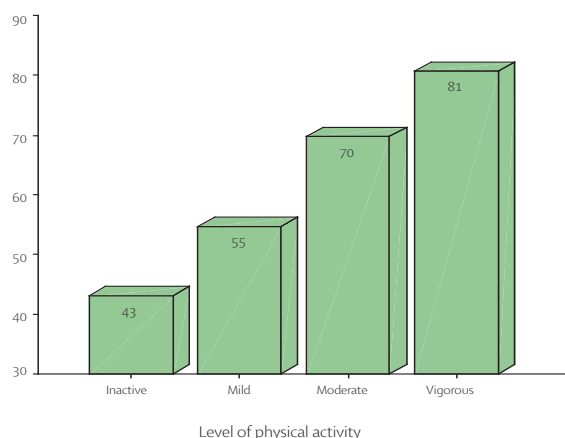
60.3% of men rated their health as good/very good, with 39.7 of men rating their health as fair/bad/very bad (Table 5.3.1). For the purpose of further analysis, these categories were collapsed into self-reported 'good' health and 'poor' health respectively.

Table 5.3.1 How health has been over past 12 months

	Frequency	Cumulative Percent
Very good	133	23.8
Good	205	60.3
Fair	178	92.1
Bad	34	98.2
Very bad	10	100.0
Total	560	

Using linear regression, a significant relationship was found between self-reported health status and self-reported physical activity ($r=0.99$), with self-reported good health increasing with increasing levels of physical activity (Figure 5.3.1). Those engaged in vigorous physical activity were twice as likely to report good health compared to those who were inactive, while those who were inactive were three times more likely to report poor health compared to those who were engaged in vigorous physical activity. The relationships between self-reported health and other lifestyle behaviours (smoking, alcohol consumption) were found not to be significant.

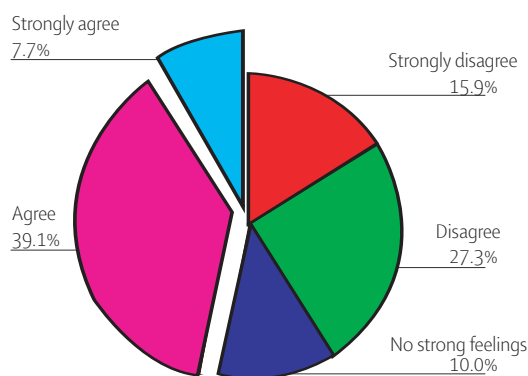
Figure 5.3.1 Relationship between self-reported 'good' health and self-reported physical activity



5.3.2 Neglect of health as a contributory factor to self-reported 'poor' health

Of those who self-reported 'poor' health (n=222), 46.8% 'agreed/strongly agreed' that 'neglect of health' was a reason for their impaired health status (Figure 5.3.2). Neglect of health was significantly associated with age (Chi Sq =23.327; df=10; p=.010), with younger men (<30) being twice as likely as older men (50+) to report neglect of health (69.6% v 34.4%) as a reason for poor health.

Figure 5.3.2 Neglect of health as a reason for poor health (n=222)



5.3.3 Self-reported long-term illness/disability

33.2% of respondents reported a long-term illness, health problem or disability (Figure 5.3.3). Using linear regression, a significant relationship was found between this variable and both age (r=0.99) and level of education (r=0.96), with older and less educated men being significantly more likely to report a long-term illness/disability (Figure 5.3.4). For example, men who had completed no more than primary education were twice as likely (49% v 24.2%) as those who had completed at least some third level education to report

a long-term illness/disability.

Figure 5.3.3 Percentage with long-term illness, health problem or disability

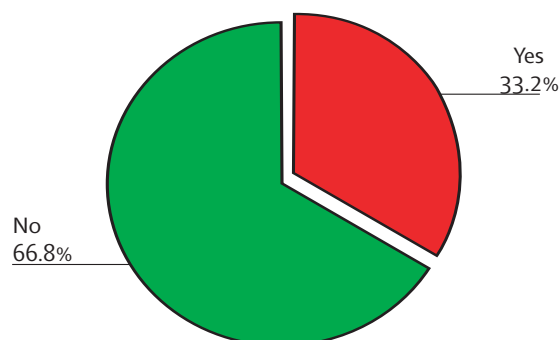
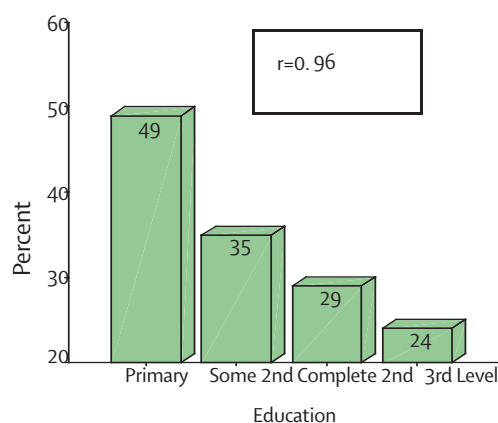
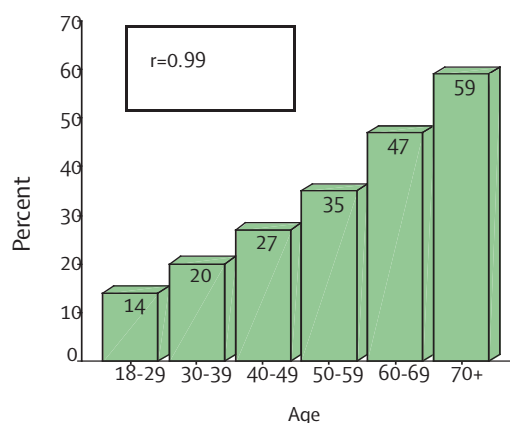


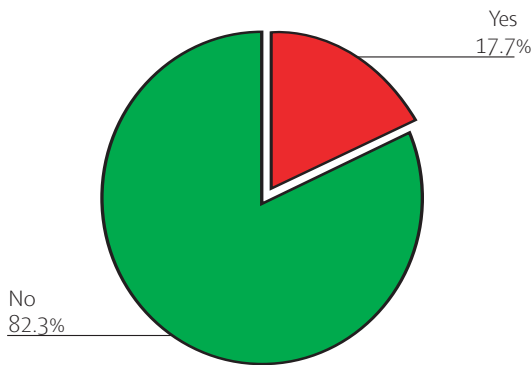
Figure 5.3.4 Relationship between having a long-term illness/health problem and (i) age and (ii) education



5.3.4 Late presentation as a contributory factor to self-reported long-term illness/disability

Of those who reported having a long-term illness/disability (n=181), 17.7% (n=32) reported that their problem could have been cured or managed better if they had gone to their doctor or sought help sooner than they did (Figure 5.3.5)

Figure 5.3.5 Percentage indicating that problem could have been cured/managed better if help was sought sooner (n=181)

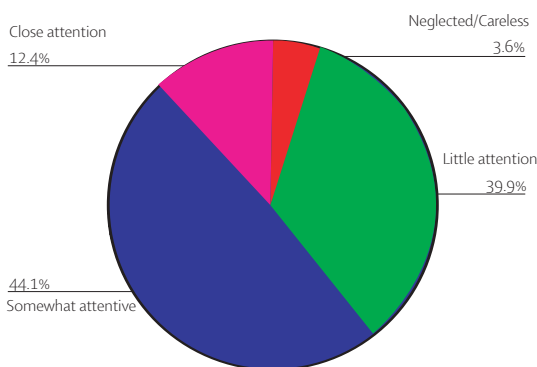


5.3.5 Male patients sense of personal responsibility in relation to health

Respondents' perceptions of how over the course of their lives they have looked after their own health

43.5% of respondents reported that they had neglected or paid little attention to their health over the course of their lives (Figure 5.3.6).

Figure 5.3.6 How respondents have looked after their own health over the course of their lives

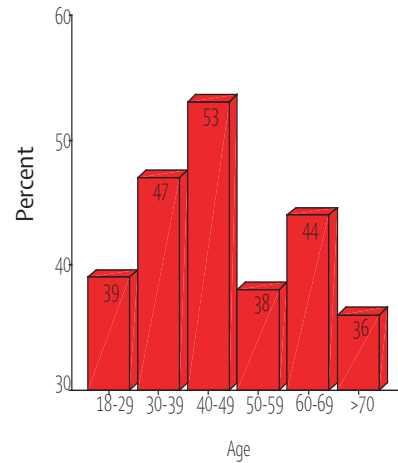


Using linear regression, a significant relationship was found between how respondents felt that they had looked after their own health over the course of their lives and age (age groups 18-29 to 40-49; $r=0.99$); social class ($r=0.98$); and education ($r=0.97$). Figure 5.3.7 presents the pattern of these relationships. In the context of age, there was an increase in neglect of health from the age range 18-29 to 40-49, which was followed by a sharp improvement in the next age category (50-59). Men from lower social classes and men with less formal education were significantly more

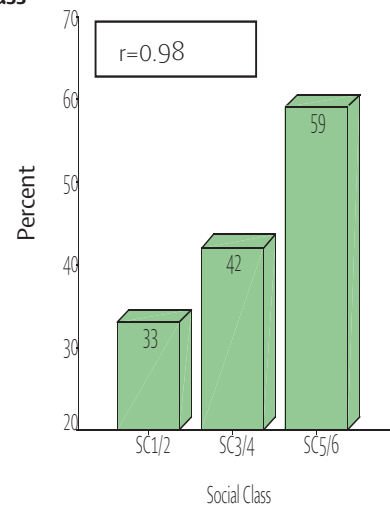
likely to have neglected/paid little attention to their health. For example, men in SC 5/6 were almost twice as likely as men in SC 1/2 to have neglected/paid little attention to their health (59% v 33%). Men with incomplete secondary education were almost twice as likely as those with third level education to have neglected/paid little attention to their health (51% v 32%).

Figure 5.3.7 Percentage of men within different categories who reported neglect of their health in relation to (i) age; (ii) social class and (iii) education

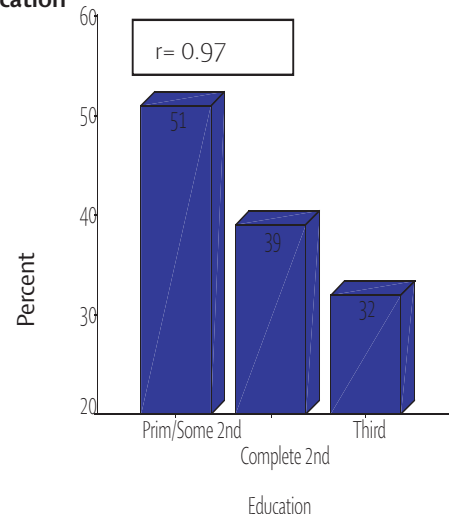
(i) Age



(ii) Social Class



(iii) Education



Neglect of health leading to health problems

Table 5.3.2 presents a summary of respondents' (n=191) responses to an open question seeking examples of how they felt their health had been neglected over the course of their lives, and how these led to health problems. Smoking, dietary issues and excess alcohol consumption were the most prevalent issues.

Table 5.3.2 Examples of how health has been neglected that have resulted in health problems (n=191)

Number	Neglect of health leading to health problems	Frequency	Percentage
1	Smoking	74	38.7%
2	Poor diet/overeating	55	28.8%
3	Excess alcohol consumption	40	20.9%
4	Sedentary lifestyle/lack of exercise	32	16.8%
5	Late presentation	12	6.3%
6	Health and safety/ environmental factors	12	6.3%
7	Over-worked/ working conditions	11	5.8%
8	Lack of free time/rest	9	4.7%
9	Lack of screening/ check-ups	9	4.7%
10	Stress/stress management	6	3.1%
11	Dental Hygiene	4	2.1%
12	Ignoring mental health issues	4	2.1%
13	Risk-taking	4	2.1%
14	Sporting Injuries	4	2.1%
15	Poor knowledge/ information on health	3	1.6%
16	Poor posture	3	1.6%
17	Drug abuse	2	1%
18	Ignoring medical advice	1	.5%
19	Lack of confidence	1	.5%

Table 5.3.3 presents the relationship (Chi-Square; $p < .005$) between respondents' approach to looking after their health and selected variables. All of the more prevalent issues that were highlighted by respondents in Table 5.3.2 (smoking, alcohol and inactivity) were found to be significantly related to respondents' perceived neglect of health. For example, those who were inactive were three times more likely to report having neglected or paid little attention to their health, that those who engaged in vigorous physical activity.

Table 5.3.3 Cross-tabulation (Chi-Square) between approach to looking after health and other variables

Variable	Categories	Percentage who felt they had neglected/ paid little attention	Approach to looking after health (*=sig) to health
Smoking	Smokers	54.8%	*P=.000
	Non-smokers	36.5%	
Alcohol - units of alcohol per week Alcohol - binge drinking	>20 Units	63.2%	*P=.045
	<20 Units	36.8%	
	Weekly	49.7%	
	Never	38.4%	
Physical activity level	Inactive	65.6%	*P=.011
	Vigorous	21.1%	
Late presentation (context of long-term health problem)	Yes	74.2%	*P=.000
	No	39.7%	
Effectiveness at managing stress	Ineffective	52.5%	*P=.004
	Effective	37.5%	

Examples of what would have been needed to manage health problems

Table 5.3.4 presents a summary of respondents' responses (n=133) to an open question seeking examples of what they felt that they would have needed in order to manage health problems more effectively. This was a filter question that applied to those respondents who felt that they had 'neglected' or 'paid little attention' to their health (n=242).

Table 5.3.4 Examples of what would have been needed to manage health problems (n=133)

Number	Need	Frequency	Percentage
1	Improved information/ education/awareness	31	23.3%
2	Abstinence from/ curtailed access to smoking	19	14.3%
3	Improved dietary habits	16	12%
4	Increased physical activity/ exercise	13	9.8%
5	Better work/rest balance; regular working hours	12	9%
6	More common sense	6	4.5%
7	Better self-discipline/ willpower	5	3.8%
8	Earlier presentation	4	3%
9	More stringent adherence to health and safety	4	3%
10	More support/ encouragement	4	3%
11	Curtailed drinking habits	3	2.3%
12	Techniques to manage stress	3	2.3%
13	Improved self-esteem	3	2.3%
14	Easier access to medications	2	1.5%
15	Free/cheaper health services	2	1.5%
16	On-line GP Services	1	.8%
17	Better relationship with GP	1	.8%
18	Dental care when young	1	.8%
19	More care with sports related injuries	1	.8%
20	Access for disabled	1	.8%
21	Improved domestic skills	1	.8%

5.4 Lifestyle/Health Behaviours

This section outlines the lifestyle/health behaviour patterns of the sample population, and includes (5.4.1) alcohol consumption; (5.4.2) smoking (5.4.3) physical activity levels; and (5.4.4) stress

5.4.1 Alcohol consumption

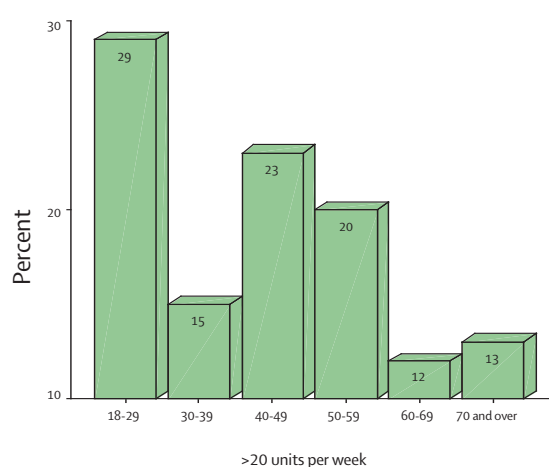
Overall alcohol consumption

75% (n=408) of respondents reported consumption of at least some alcohol weekly (Table 5.4.1). 24.7% of 'drinkers' reported consuming 21 units or more per week, and can be described as 'excessive drinkers'. Units of alcohol consumed per week was significantly and negatively associated with age (Chi Sq =23.259; df=10; p=.010), but was not found to be significant in relation to social class or education. Excessive drinking was highest amongst men aged 18-29 (28.6%) and declined sharply (15.4%) in the age group 30-39 (Figure 5.4.1). 'Excessive' drinking was lowest amongst those men over the age of 60 (12.2%). The percentage of non-drinkers also increased steadily with age, and was three times higher amongst men 70 years and over (37.5%) compared to 18-29 year old men (12.9%).

Table 5.4.1 Units of alcohol consumed per week

	Frequency (Overall Sample)	Valid Percent (Overall Sample)	Frequency (‘Drinkers’)	Valid Percent (‘Drinkers’)
0 Units	136	25.0	N/A	N/A
1-5 units	101	18.6	101	24.8
6-10 units	107	19.7	107	26.2
11-20 units	99	18.2	99	24.3
21-30 units	57	10.5	57	14.0
31-40 units	23	4.2	23	5.6
41-50 units	9	1.7	9	2.2
Over 50 units	12	2.2	12	2.9
Total	544	100.0	408	100.0

Figure 5.4.1 ‘Excessive’ drinkers by age



Units of alcohol consumed per week was significantly associated with ‘use of seat belts in the back of a car’ (Chi Sq =17.931; df=4; p=.001), ‘speeding’ (Chi Sq =9.528; df=4; p=.049), ‘driving having had two or more alcoholic drinks’ (Chi Sq =38.357; df=2; p=.000), ‘been a passenger with a driver who was drunk’ (Chi Sq =17.081; df=2; p=.000), ‘unsafe sex’ (Chi Sq =15.330; df=4; p=.004), and ‘drinking’ as a means of managing stress (Chi Sq =145.950; df=4; p=.000). Consumers of more than 20 units per week were twice as likely as non drinkers (28% v 14%) not to wear seat belts in the back of a car; over twice as likely as non-drinkers (25.6% v 10.3%) not to observe speed limits; twice as likely as non-drinkers (28% v 14.4%) to have driven having had two or more alcoholic drinks; twice as likely (18.8% v 9.2%) as non-excessive drinkers (<21 units per week) to have been a passenger with a driver who was drunk; and over five times more likely as non-excessive drinkers (6.9% v 1.3%) to have engaged in unsafe sex (Note – small number of respondents in last category; n=7 and n=2 respectively). 86.4% of consumers who drank more than 20 units per week reported ‘drinking’ as a means of managing stress.

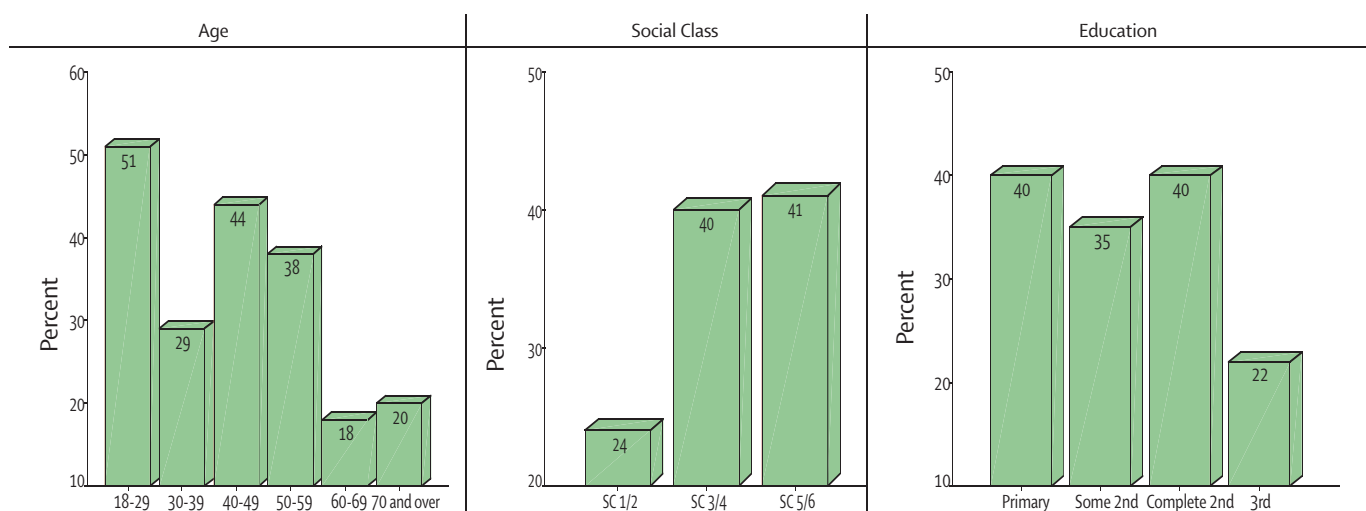
Binge Drinking

Almost two-thirds of men (63.2%) reported some level of binge drinking, with one out of every three men reporting binge drinking at least once per week (Table 5.4.2). Binge drinking was significantly and negatively associated with age (Chi Sq =71.740; df=10; p=.000) and education (Chi Sq =31.706; df=6; p=.000), and significantly and positively associated with social class (Chi Sq =14.892; df=4; p=.005). The relationship between ‘at least weekly binge drinking’ and socio-demographic factors is illustrated in Figure 5.4.2. Similar to overall alcohol consumption, binge drinking (at least weekly) was highest amongst young men (50.7%), and declined sharply (29.3%) in the age category 30-39 years. The lowest rate of weekly binge drinking was amongst men 60 years and over (19%). Binge drinking (at least weekly) increased from 24% in SC1/2 to 40% and 41% in SC 3/4 and SC 5/6 respectively. Weekly binge drinking was almost twice as high amongst those with not more than primary education compared to those with third level education (40.4% v 22.2%).

Table 5.4.2 Frequency of 'binge drinking' (6 drinks or more)

	Frequency	Cumulative Percent
5-7 times per week	10	1.8
2-4 times a week	67	13.9
Once a week	109	33.5
1-3 times a month	65	45.2
Less than once a month	100	63.2
Never	204	100.0
Total	555	

Figure 5.4.2 Relationship between 'at least weekly binge drinking' and socio-demographic factors



Binge drinking was also associated with use of seat belts in the back of a car (Chi Sq =24.282; df=4; p=.000); speeding (Chi Sq =23.445; df=4; p=.000); driving having had two or more alcoholic drinks (Chi Sq =34.444; df=2; p=.000); been a passenger with a driver who was drunk (Chi Sq =17.081; df=2; p=.000); unsafe sex (Chi Sq =18.483; df=4; p=.001) and drinking as a means of managing stress. Those who binge drank at least weekly were twice as likely (26% v 12.8%) as non binge drinkers not to have worn seat belts in the back of a car; twice as likely (21.7% v 9%) to have been speeding; three times more likely (37.8% v 11.8%) to have driven having had two or more alcoholic drinks; over six times more likely (16.9% v 2.5%) to have been a passenger with a driver who was drunk; and ten times more likely (4.9% v .5%) to have engaged in unsafe sex (Note – small number of respondents in last category; n=9 and n=1 respectively). 79.5% of weekly binge drinkers reported 'drinking' as at least an occasional means of managing stress.

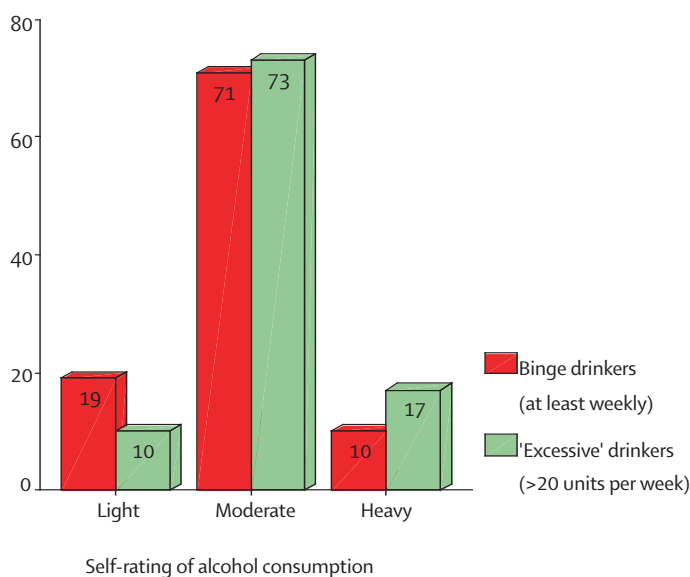
Perception of own alcohol consumption

Table 5.4.3 outlines how respondents rated their own alcohol consumption, while Figure 5.4.3 illustrates how binge drinkers and excessive drinkers rated their alcohol consumption.

Table 5.4.3 'Drinkers' perception of their own alcohol consumption

	Frequency	Valid Percent	Cumulative Percent
Light Drinker	175	43.6	43.6
Moderate Drinker	205	51.1	94.7
Heavy Drinker	21	5.3	94.7
Total	401	100.0	

Figure 5.4.3 Binge drinkers' and excessive drinkers' perceptions of their own alcohol consumption



The following points highlight what can only be described as a large anomaly between what is considered 'excessive' or 'binge' drinking at the level of public health, and how men rate such patterns of alcohol consumption.

- Despite the fact that 24.8% of drinkers drank to excess, and that 33.5% engaged in at least weekly binge drinking, just 5.3% considered themselves to be 'heavy' drinkers
- Eight out of ten (83%) excessive drinkers (> 20 units per week) regarded themselves as no more than 'moderate' drinkers
- One out of ten 'excessive' drinkers considered themselves to be 'light' drinkers
- Half of those reporting consumption of over 50 units per week (n=12) perceived themselves to be 'moderate' drinkers
- Nine out of ten weekly 'binge' drinkers (90%) regarded themselves as no more than 'moderate' drinkers
- Two out of ten weekly 'binge' drinkers considered themselves to be light drinkers
- Six out of ten men who reported binge drinking 5-7 times per week (n=10) considered themselves to be no more than 'moderate' drinkers.

5.4.2 Smoking

Incidence of smoking

Of the sample group, 26.4% were smokers, with a further 17.8% indicating that they 'used to' smoke (Table 5.4.4). A significant and positive association was found between smoking and age, up to age 49, after which the association was negative. (Chi Sq =18.747; df=10; p=.044).

Table 5.4.4 Incidence of Smoking

	Frequency	Valid Percent
Yes	147	26.4
No	310	55.8
Used to	99	17.8
Total	556	100.0

Smokers were twice as likely as non-smokers (27.3% v14%) to report consumption of more than 20 units of alcohol per week (Chi Sq =15.211; df=2; p=.000), and almost twice as likely (48.6% v 28.8%) to report weekly binge drinking ((Chi Sq =22.115; df=2; p=.000). Smokers were twice as likely as non-smokers (19.6% v 10.1%) to report sedentary lifestyles, and half as likely (6.5% v 12.8%) to report engaging in vigorous physical activity (Chi Sq =10.682; df=3; p=.014). Smokers were significantly more likely (Chi Sq =19.665; df=3; p=.000) than non-smokers (54.8% v 36.5%) to report having neglected or paid little attention to their health over the course of their lives. 60% of smokers were not aware that smoking can cause impotence. Almost half of smokers (48%) reported 'regularly' using smoking as a means of managing stress.

Level of cigarette consumption

In terms of cigarette consumption, 29.9% of smoker reported smoking 16-20 cigarettes per day, with a further 19.7% smoking more than 20 cigarettes per day (Table 5.4.5). 15% were pipe/cigar smokers. A significant and positive association (Chi Sq =23.472; df=4; p=.000) was found between level of cigarette consumption and the use of smoking as a means of managing stress. 'Heavy smokers' (>20 per day) were four times more likely (81.5% v 19.4%) than 'light smokers' (1-10 per day) to report smoking as a means of managing stress.

Table 5.4.5 Cigarette Consumption

	Frequency	Valid Percent
1-5 cigarettes	12	8.2
6-10 cigarettes	22	15.0
11-15 cigarettes	18	12.2
16-20 cigarettes	44	29.9
More than 20 cigarettes	29	19.7
Pipe or cigars	22	15.0
Total	147	100.0

Desire to stop smoking

In the context of behaviour change, only 9.2% of smokers indicated that they would 'not' like to stop smoking, with almost half of all smokers (47.9%) indicating that they had tried but had not succeeded in stopping smoking (Table 5.4.6).

Table 5.4.6 Desire to stop smoking

	Frequency	Valid Percent
No	13	9.2
Yes	44	31.0
Yes, have made plans to	17	12.0
Have tried, but have not succeeded	68	47.9
Total	142	100.0

5.4.3 Physical activity levels

In the context of self-reported physical activity levels (Table 5.4.7), three out of four men (74.3%) did not meet the current recommended type and amount of physical activity for health gain. 11.2% reported being sedentary, with a further 51.4% reporting 'mild' physical activity only. Physical activity level was significantly associated with age (Chi Sq =101.913; df=15; p=.000), social class (Chi Sq =16.168; df=6; p=.013), education (Chi Sq =29.914; df=9; p=.000) and marital status (Chi Sq =19.975; df=3; p=.000). Older, less well-off, less educated and unmarried/not cohabiting men were less likely to meet the recommended type and amount of physical activity for health gain. In the context of age, there was a marked decline in moderate/vigorous physical activity from 18-29 to 30-39 (59.1% to 40.9%), while those reporting as sedentary also doubled between these age groups (9.9% to 18.3%) and was highest overall in the 30-39 year age category.

Table 5.4.7 Level of physical activity/exercise over past few months

	Frequency	Cumulative Percent
Little or none	61	11.2
Mild activity 2 or fewer times a week	118	32.8
Mild activity 3 or more times a week	162	62.6
Moderate activity 2 or fewer times a week	64	74.3
Moderate activity 3 or more times a week	82	89.4
Vigorous activity 2 or fewer times a week	35	95.8
Vigorous activity 3 or more times a week	23	100.0
Total	545	

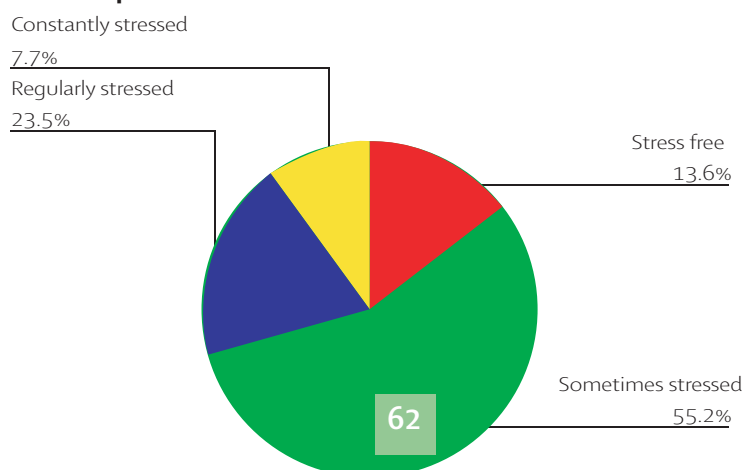
5.4.4 Stress

Levels of reported stress

Almost one in three men (31.2%) reported feeling regularly or constantly stressed over the past few months (Figure 5.4.4). A significant association was found between level of stress and age (Chi Sq =62.947; df=15; p=.000) and education level (Chi Sq =49.064; df=9; p=.000). The rate of those reporting as regularly/constantly stressed was highest in the 30-39 age group (46.8%) and declined with age. Those with third level education were more than twice as likely (44.3% v 19.4%) to report being regularly/constantly stressed than those with primary school education or less.

Figure 5.4.4

Levels of reported stress



Factors contributing to stress

Table 5.4.8 indicates the degree to which a range of factors impacted on respondents' level of stress. Work is clearly highlighted as the most prevalent source of stress, with the 'demands/pressures of work' (38%), 'the people I work with' (22.6%), and 'juggling work with home/family life' (18.7%) being some of the more significant factors contributing to stress. Financial pressures (28.6%), poor health (18.8%) and being a parent (18.8%) also featured prominently.

Table 5.4.8 Factors contributing to stress

Factor	Not Applicable	Not At All/Slightly Stressful	Somewhat/Highly Stressful
Work - demands/ pressures of work	23.2%	38.8%	38% (n=182)
Financial Pressures	16.4%	54.9%	28.6% (n=136)
Work - the people I work with	29.8%	47.6%	22.6% (n=84)
Poor health	32.7%	48.5%	18.8% (n=87)
Being a parent	30.6%	50.7%	18.8% (n=86)
Juggling work with home/family life	33.3%	48%	18.7% (n=84)
Not having enough time to myself	19.8%	62.9%	17.4% (n=79)
Feeling lonely/isolated	32.2%	51.6%	16.2% (n=77)
Relationships – others	30.9%	53.4%	15.7% (n=53)
Relationships - with wife/partner	20.6%	63.9%	15.5% (n=72)
Housework	35.2%	59.6%	5.2% (n=22)

5.5 Preventative Health Behaviours

Section 5.5 outlines patterns of 'preventative health behaviours' amongst the sample population, and includes (5.5.1) monitoring of weekly alcohol consumption; (5.5.2) experience of digital rectal examination (DRE; men aged 50 or over); (5.5.3) practicing of testicular self examination (TSE); and (5.5.4) stress management.

5.5.1 Monitoring of weekly alcohol consumption

Within the population of 'drinkers' (n=401), just 21.9% (Table 5.5.1) reported monitoring their own only weekly alcohol consumption.

Table 5.5.1 Monitoring of weekly alcohol consumption

	Frequency	Valid Percent
Yes	88	21.9
No	313	78.1
Total	401	100.0

A significant association was found between monitoring weekly alcohol consumption and age (Chi Sq =18.785; df=5; p=.002), with younger men (<40) being almost three times (12.9% v 36%) less likely than older men (60 and over) to report monitoring weekly alcohol consumption. 'Excessive' drinkers (> 20 units per week) were significantly less likely than 'non-excessive' drinkers (< 20 units per week) to report monitoring weekly alcohol consumption (10.2% v 25.7%; Chi Sq =11.818; df=2; p=.003), while weekly binge drinkers were also significantly less likely than non binge drinkers to report monitoring weekly alcohol consumption (17.1% v 43.5%; Chi Sq =11.818; df=2; p=.003)

5.5.2 Experience of Digital Rectal Examination (DRE; men aged 50 or over)

Almost three out of four men aged 50 or over (n=256) reported never having had a DRE (Table 5.5.2)

Table 5.5.2 Experience of Digital Rectal Examination (Men aged 50+)

	Frequency	Valid Percent
Yes	195	64.6
No	107	35.4
Total	302	100.0

A significant association was found between experience of DRE and both education (Chi Sq =13.501; df=3; p=.004) and marital status (Chi Sq =3.851; df=1; p=.050) with men with third level education and married/cohabiting men being more likely to have had a DRE. For example, men with third level education were almost three times more likely (29.3% v 11.6%) to have had a DRE than men with no more than primary education

5.5.3 Practicing of Testicular Self Examination (TSE)

Whilst just over half of respondents (n=302) had heard of the term TSE (Section 5.7.2.2), only 64.6% (n=195) of this group reported knowing how to practice TSE (Table 5.5.3). Just 20.7% of those who had heard of TSE reported practicing TSE once a month or more (Table 5.5.4). This corresponds to just 11.2% of the total sample population, who regularly practice TSE. Indeed, in the context of the age group at highest risk of developing testicular cancer, just 13.7% of men aged 18-29 reported practicing TSE at least monthly.

Table 5.5.3 Knowledge of how to practice Testicular Self Examination

	Frequency	Valid Percent
Yes	195	64.6
No	107	35.4
Total	302	100.0

Table 5.5.4 Frequency of practicing Testicular Self Examination

	Frequency	Cumulative Percent
Once a month	62	20.7
Once or twice every three months	68	43.4
Fewer than twice every six months	45	58.4
Do not practice TSE	125	100.0
Total	300	

5.5.4 Stress management

Effectiveness at managing stress

60.2% asserted that they were either somewhat or very effective at managing stress (Table 5.5.5), while 22.9% of men indicated that they were either somewhat or completely ineffective at managing stress.

Table 5.5.5 Perceived effectiveness at managing stress

	Frequency	Cumulative Percent
Completely ineffective	31	5.8
Somewhat ineffective	92	22.9
Neither effective nor ineffective	91	39.9
Somewhat effective	233	83.2
Very effective	90	100.0
Total	537	

A significant association was found between effectiveness at managing stress and age (Chi Sq =26.807; df=10; p=.003) with younger men being significantly more likely to report being ineffective at managing stress. 27.3% of those under the age of 50 reported being ineffective at managing stress compared to 17.7% of those 50 and over.

Behaviours used to manage stress

Table 5.5.6 outlines the degree to which a range of behaviours were used by respondents to manage their stress.

Table 5.5.6 Behaviours used to manage stress

Behaviour	Never	Occasionally	Regularly
Sedentary leisure activities	10.7%	40.1%	49.2%
Exercise/sport	25.8%	41.9%	32.2%
Gardening/DIY	32.6%	38.8%	28.6%
Talking about problems with others	35.7%	51.6%	12.6%
Being aggressive or argumentative	43.8%	47.5%	8.7%
Drinking	54.1%	38.5%	7.5%
Eating	56.6%	34.9%	8.5%
Working more/ longer hours	66%	27.9%	6.1%
Smoking	72.6%	13.8%	13.6%
Taking prescribed/ over the counter medications	82.3%	10%	7.6%
Drug Taking	96.3%	2.6%	1.1%

Sedentary leisure activities and activities involving physical

exertion (exercise/sport and gardening/DIY), were the most prevalent stress-management techniques amongst men. It was also noteworthy however that many men used a number of potentially health-compromising behaviours to manage their stress. Being aggressive or argumentative (56.2%); drinking (46%); eating (43.4%); and working more/longer hours (34%) were behaviours used at least occasionally by men to manage their stress. Younger men were significantly more likely to be aggressive/argumentative (Chi Sq =31.373; df=10; p=.016), to drink (Chi Sq =30.314; df=10; p=.001) and to work more/longer hours (Chi Sq =21.913; df=10; p=.001), as a means of coping with stress. A significant association was found between effectiveness at managing stress and a number of other key variables (Table 5.5.7). Those who reported as being ineffective at managing stress were significantly more likely to self-report 'poor' health in the past year; to have neglected/been careless about health over the course of their lives; to engage in risk behaviours; and to resort to health compromising behaviours as a means of coping, albeit ineffectively, with stress. For example, those who reported as ineffective at managing stress were twice as likely to use smoking as a means of managing stress.

Table 5.5.7 Relationship between self-reported effectiveness at managing stress and other variables (Chi Square; p<.05)

	Completely/ somewhat in effective	Somewhat/ very effective	Significant
Self reported 'poor' health in past 12 months	55.3%	35.8%	P=.001
Neglected/been careless about health over course of one's life	52.5%	37.5%	P=.004
Usually/generally exceed speed limits	9.4%	5.9%	P=.033
Been a passenger with a driver who was drunk	17.2%	6.8%	P=.004
Managing stress- working longer hours at least occasionally	45.8%	29%	P=.046
Managing stress- being aggressive/argumentative at least occasionally	75.7%	46.7%	P=.000
Managing stress- smoking regularly	18.9%	10.9%	P=.020
Managing stress- eating at least occasionally	58.9%	35.8%	P=.001

5.6 Risk Behaviours

This section describes the frequency with which respondents engaged in a range of 'risk-behaviours', including (5.6.1) use of seat belts; (5.6.2) drink driving (5.6.3) speeding; (5.6.4) use of sunscreen and (5.6.5) 'safe sex'

5.6.1 Use of Seat Belts

Whilst the vast majority of respondents (95.8%) reported 'always/nearly always' using seat belts while driving or as a passenger in the front of a car, this figure was much lower (62.1%) in relation to travelling as a passenger in the back of a car (Table 5.6.1).

Table 5.6.1 Frequency of seat belt use

	When driving or front seat passenger		As a passenger in the back of a car		
	Frequency	Cumulative Percent	Frequency	Cumulative Percent	
Always	482	85.2	Always	270	48.3
Nearly always	60	95.8	Nearly always	77	62.1
Sometimes	11	97.7	Sometimes	91	78.4
Seldom	2	98.1	Seldom	54	88.0
Never	3	98.6	Never	59	98.6
I don't use a car	8	100.0	I don't use a car	8	100.0
Total	566		Total	559	

Seat belt usage (back of a car) was significantly associated with age (Chi Sq =25.269; df=10; p=.005), marital status (Chi Sq =6.780; df=2; p=.034; and fatherhood status (Chi Sq =10.926; df=2; p=.004), with older, married/cohabiting men and fathers being significantly more likely to report seat-belt usage as a passenger in the back of a car.

5.6.2 Drink driving

A quarter of respondents answered 'yes' to having driven after consuming two or more alcoholic drinks, with 9.2% having been a passenger with a driver who was drunk (Table 5.6.2). A significant association was found between driving having had two or more alcohol drinks and age (Chi Sq =16.291; df=5; p=.006); social class (Chi Sq =15.579; df=2; p=.000); and education level (Chi Sq =7.910; df=3; p=.048). Men in the 40-59 year age category, more well-off men and men with more formal education were significantly more likely in the past year to have driven having had two or more alcoholic drinks (Figure 5.6.1). Being a passenger with a driver who was drunk was significantly associated with age (Chi Sq =18.504; df=5; p=.002); social class (Chi Sq =6.296; df=2; p=.043) education (Chi Sq =8.884; df=3; p=.031) marital status (Chi Sq =9.222; df=1; p=.002) and parental status (Chi Sq =6.223; df=1; p=.013). Younger, less well-off and men with less formal education were significantly more likely to have in the past year been a passenger with a driver who was drunk (Figure 5.6.2). Unmarried/not cohabiting men were twice as likely as married/cohabiting men (14.9% v 6.8%) and non-fathers twice as likely as fathers (14.7% v 7.6%) to have in the past year been a passenger with a driver who was drunk.

Table 5.6.2 Drink driving

Driven in the past year after consuming 2 or more alcoholic drinks

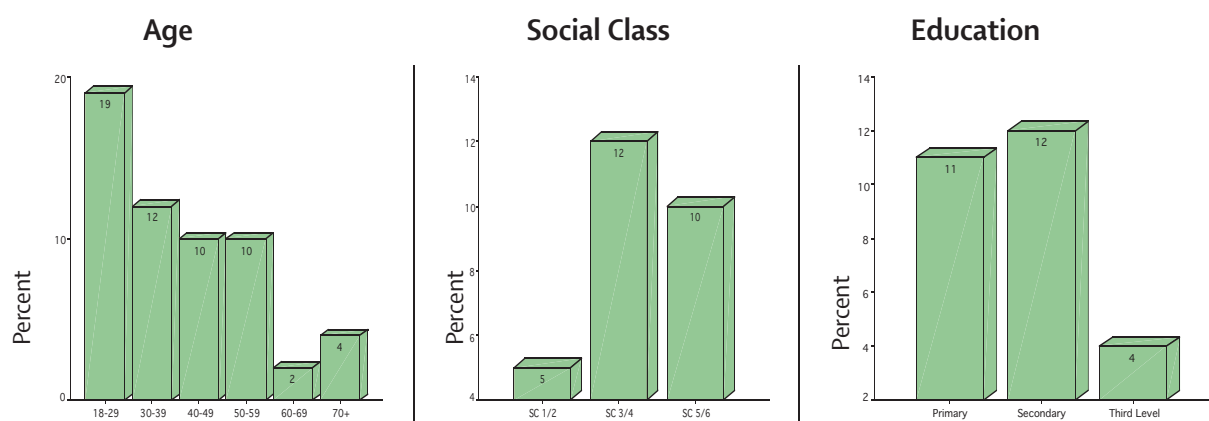
Been a passenger in the past year with a driver who was drunk

	Frequency	Valid Percent		Frequency	Valid Percent
Yes	137	24.6	Yes	52	9.2
No	369	66.2	No	513	90.8
Do not drive	51	9.2	Total	565	100.0
Total	557	100.0			

Figure 5.6.1 Relationship between 'driving having had two or more alcoholic drinks' and socio-demographic factors



Figure 5.6.2 Relationship between having been ‘a passenger in the past year with a driver who was drunk’ and socio-demographic factors



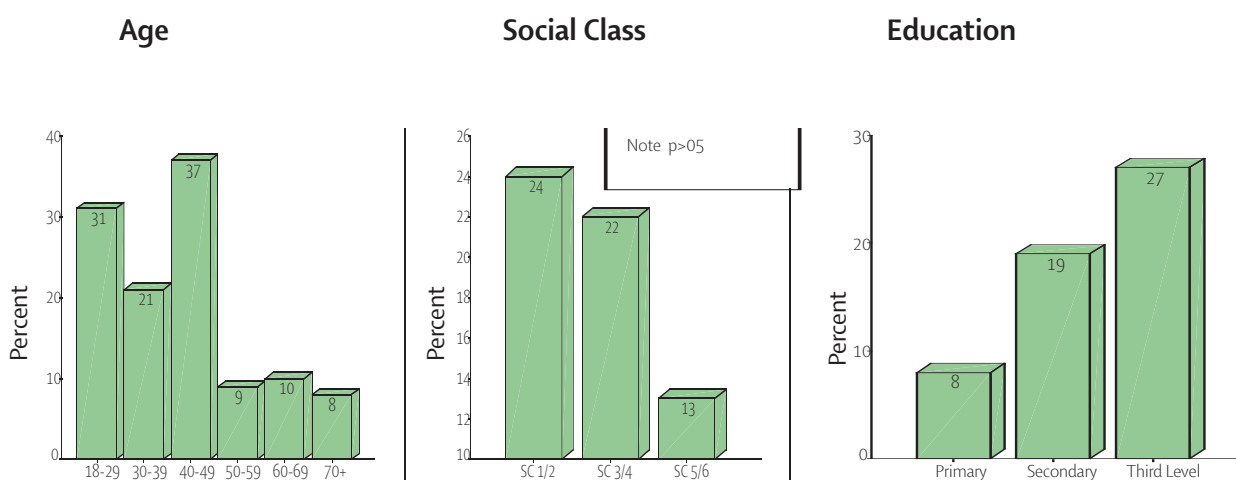
5.6.3 Speeding

71.7% of respondents (80.7% of drivers) reported overall adherence (‘always’ or ‘nearly always’) to speed limits (Table 5.6.3). It could be argued that ‘nearly always’ is hardly good enough in the context of adhering to speed limits, and that a much lower 38.4% (43.1% of drivers) reported absolute compliance with speed limits. A significant association was found between speeding and age (Chi Sq =47.665; df=10; p=.000) and level of education (Chi Sq =17.993; df=6; p=.006). Drivers aged 40-49 (36.9%) and 18-29 (30.8%) had the highest level of non-compliance, while those with third level education (27.1%) were significantly less likely than those with primary education or less (7.9%) to report non-compliance with speed limits (Figure 5.6.3). Although short of significance ($p>.05$), non-compliance with speed limits was also associated with men from higher social classes.

Table 5.6.3 Adherence to speed limits when driving

	Frequency	Cumulative Percent
Always, no matter how rushed	214	38.4
Nearly always, except when rushed	186	71.7
Usually, unless in a hurry	65	83.3
Sometimes, but usually exceed limit	23	87.5
Generally exceed speed limits	8	88.9
Don't drive	62	100.0
Total	558	

Figure 5.6.3 Relationship between non-compliance with speed limits and socio-demographic factors



5.6.4 Use of sun screen

Over half of respondents (56.4%) reported at best infrequent use of sunscreen when exposed to the sun for extended periods (Table 5.6.4). 30.8% reported 'rarely' or 'never' using sunscreen. A significant association was found between use of sunscreen and age (Chi Sq =24.956; df=10; p=.005); level of education (Chi Sq =20.255; df=6; p=.002); marital status (Chi Sq =15.476; df=2; p=.000); and fatherhood status (Chi Sq =18.791; df=2; p=.000). Younger, less educated, unmarried/not cohabiting men and non-fathers were significantly less likely to use sunscreen when their skin was exposed to the sun for extended periods.

Table 5.6.4 Use of sun screen if skin is exposed to the sun for extended periods

	Frequency	Cumulative Percent
Always	82	14.6
Nearly always	113	34.7
Sometimes	144	60.3
Rarely	70	72.8
Never	103	91.1
Stay out of sun	50	100.0
Total	562	

5.6.5 'Safe' sex

One in five men reported at least some incidence of having in the past had 'casual sex' without using a condom (Table 5.6.5). However only 2.6 % reported regularly engaging in such 'unsafe sex' practices. Frequency of casual sex without using a condom was significantly associated with age (Chi Sq =53.681; df=10; p=.000); social class (Chi Sq =11.289; df=4; p=.024); marital status (Chi Sq =37.094; df=2; p=.000) and fatherhood status (Chi Sq =829.613; df=2; p=.000). Younger, less well-off, unmarried men and non-fathers were significantly more likely to have engaged in unsafe sex. For example, single men were approximately three times more likely than married/cohabiting men to have had occasional unsafe sex (31.3% v 12%) or regular unsafe sex (4.9% v 1.5%), while similarly, non-fathers were almost three times as likely as fathers to have had occasional unsafe sex (31.4% v 12.8%) or regular unsafe sex (5% v 1.7%).

Table 5.6.5 Frequency of sex with non long-term partner without using a condom

	Frequency	Cumulative Percent
Never	444	79.9
Once or twice	66	91.7
Occasionally	32	97.5
Frequently	7	98.7
At all time	7	100.0
Total	556	

5.7 Knowledge/Awareness of Health

Section 5.7 deals with respondents' knowledge/awareness of a range of health issues, including (5.7.1) life expectancy; (5.7.2) male-specific health; (5.7.3) lifestyle factors and (5.7.4) mental health.

5.7.1 Life expectancy

Four out of five men (78.8%) were either unaware of or incorrectly identified the current life expectancy at birth for males in Ireland (Table 5.7.1). Excluding the 'Don't Knows', almost twice as many respondents (44.5%) overestimated life expectancy than underestimated it (25.2%). A slightly higher percentage (23.9%) correctly identified the life expectancy at birth for females compared to males (21.2%).

Table 5.7.1 Estimation of life expectancy for Irish males and Irish females

Life expectancy at birth for males			Life expectancy at birth for females		
	Frequency	Valid Percent		Frequency	Valid Percent
71 years	99	17.8	71 years	7	1.3
74	118	21.2	74	37	7.1
76	118	21.2	76	92	17.6
79	40	7.2	79	125	23.9
81	18	3.2	81	110	21.1
Don't Know	163	29.3	Don't Know	151	28.9
Total	99	100.0	Total	522	100.0

5.7.2 Male-specific health

5.7.2.1 Prostate health

Function/location of prostate gland

Less than half of respondents (45.2%) knew the function of the prostate gland, while almost one in four men (23.7%) were unable to correctly identify its location (Table 5.7.2).

Table 5.7.2 Knowledge of function and location of prostate gland

Function of Prostate Gland			Location of Prostate Gland		
	Frequency	Valid Percent		Frequency	Valid Percent
Growth and maintenance of body	35	6.6	Adjacent to the liver	21	4.0
Producing stress hormones	14	2.6	Beneath the bladder	402	76.3
Produces thick fluid in semen	239	45.2	In the brain	2	0.4
Don't Know	241	45.6	Don't Know	102	19.3
Total	529	100.0	Total	527	100.0

Understanding of term 'Digital Rectal Examination'

Almost two out of three men did not understand what was meant by the term 'Digital Rectal Examination' (Table 5.7.3).

Table 5.7.3 Understand term 'Digital Rectal Examination'

	Frequency	Valid Percent
Yes	215	38.9
No	338	61.1
Total	553	100.0

A significant association was found between understanding the term 'DRE' and age (Chi Sq =13.765; df=5; p=.017); social class (Chi Sq =15.576; df=2; p=.000); education (Chi Sq =20.225; df=3; p=.000); married/Cohabiting (Chi Sq =6.071; df=1; p=.014) and fatherhood status (Chi Sq =5.487; df=1; p=.019). Older, more well-off, men with more formal education, married/cohabiting men and fathers were much more likely to understand the term. For example, men in social class1/2 were almost twice as likely as men in social class 5/6 (47.9% v 25.2%) to understand the term, while men in the highest education category were almost twice as likely as the lowest education category (46.7% v 24.5%) to understand the term.

Knowledge of prostate cancer symptoms

Between a third and a half of respondents over the age of 50 were not aware of some of the most common prostate cancer symptoms (Table 5.7.4).

Table 5.7.4 Knowledge of Prostate Cancer Symptoms amongst men 50 years and over (n=279)

Symptom of Prostate Cancer	Number answering 'Yes'	Percentage answering 'Yes'
Urinating more often than usual	167	59.8%
Difficulty in urinating	148	53%
A weak stream of urine	129	42.6

5.7.2.2 Testicular cancer***Risk of developing testicular cancer***

Only 15.4% of the total sample correctly identified the 20-35 year age group as the highest risk category for developing testicular cancer (Table 5.7.5).

Table 5.7.5 Age category at highest risk of developing testicular cancer

	Frequency	Valid Percent
20-35	215	38.9
36-50	118	21.3
Over 50	163	33.8
Don't Know	187	33.8
Total	553	100.0

Whilst the figure was higher (26.4%) amongst males aged 18-29 years, three out of four men in this age category were nevertheless unaware that their own age category was that at highest risk. Similarly, only a minority of men aged 18-29 was aware of the main risk factors for testicular cancer (Table 5.7.6). Indeed a majority of respondents (60.1%) answered 'Don't Know' to this question.

Table 5.7.6 Knowledge of risk factors for developing testicular cancer

Risk Factor	Number answering 'Yes'	Percentage
Genetics	124	22.8%
One or more undescended testes	62	11.2%

Knowledge of 'Testicular Self Examination'

Almost half of the total male population had never heard of testicular self-examination (TSE; Table 5.7.7). A significant association was found between knowledge of TSE and age (Chi Sq =14.014; df=5; p=.016) and education (Chi Sq =27.859; df=3; p=.000), with older and men with less formal education being less likely to be knowledgeable about TSE. Almost half (46.6%) of men aged 18-29, the age group at highest risk of developing testicular cancer, had never heard of TSE.

Table 5.7.7 Knowledge of 'Testicular Self Examination'

	Frequency	Valid Percent
Yes	302	54.3
No	254	45.7
Total	556	100.0

5.7.2.3 Male sexual/reproductive health

The vast majority of respondents (93.1%) were knowledgeable in relation to 'safe sex' practices (Table 5.7.8)

Table 5.7.8 Knowledge of how to avoid contracting or transmitting an STI

	Frequency	Valid Percent
To have sexual intercourse less often	6	1.1
To use a condom	497	93.1
To be very careful about hygiene	15	2.8
Don't Know	16	3.0
Total	534	100.0

Table 5.7.9 refers to men's knowledge of issues relating to vasectomy. While the percentage of respondents answering correctly was very high on some factors (e.g. factors a & b), approximately a third of men incorrectly assumed that fertility could always be restored by getting the operation reversed, and were not aware that a period of three months was necessary before contraception-free sex was safe without risk of pregnancy.

Table 5.7.9 Knowledge of issues relating to vasectomy

After a vasectomy, a man...	True/False	Number answering correctly	Percentage answering correctly
a. can engage in unprotected sex with no fear of transmitting HIV	False	473	96.1%
b. is more likely to get testicular cancer	False	457	94.2%
c. is more likely to suffer from impotence	False	364	76.8%
d. is likely to have a lower sex drive	False	373	76.3%
e. can always restore his fertility by getting the operation reversed	False	331	68.8%
f. has to wait at least three months before he can have contraception-free sex with a woman with no risk of pregnancy	True	305	62%

5.7.3 Lifestyle factors

5.7.3.1 Nutrition/body composition

Nutritional intake

43.4% either underestimated or were unaware of the recommended daily number of fruit and vegetable servings, while three out of four men were not aware of what nutrient should constitute the bulk of a balanced diet (Table 5.7.10). In the context of the latter, protein was identified by more respondents than carbohydrate, despite the fact that the recommended daily allowance (RDA) of protein is less than half that of carbohydrate.

Table 5.7.10 Knowledge of recommended nutritional intake

Recommended minimum intake of fruit and vegetables per day What nutrient should make up the bulk of your diet

	Frequency	Valid Percent		Frequency	Valid Percent
2	128	23.4	Fat	6	1.2
4	213	38.9	Protein	175	34.1
6	102	18.6	Carbohydrate	133	25.9
Don't Know	104	19.0	Vitamins and Minerals	55	10.7
Total	547	100.0	Don't Know	144	28.1
			Total	513	100.0

A significant association was found between what nutrient should make up the bulk of one's diet and education (Chi Sq =20.769; df=3; p=.000), with men in the highest education category being twice as likely (35%) as the lowest category (15%) to identify the correct nutrient.

Body composition

Against a backdrop of a growing obesity problem in Ireland, over half of men answered 'Don't Know' to what constituted a healthy range of percentage body fat for men (Table 5.7.11).

Table 5.7.11 Healthy range of percentage body fat for men

	Frequency	Valid Percent
Less than 5%	52	9.5
15-20%	166	30.3
25-30%	27	4.9
35-40%	1	.2
Don't Know	302	55.1
Total	548	100.0

5.7.3.2 Physical activity

In terms of knowledge of appropriate physical activity for health gain (Table 5.7.12), just over a quarter of respondents (27.1%) correctly identified the current recommended type and amount of physical activity for health gain. A significant association was found between knowledge of physical activity for health gain and age (Chi Sq =15.561; df=5; p=.008), with men aged 20-29 (32.9%) and men over the age of 60 (34.1%) being significantly more likely than other age groups (21.2% combined) to be aware of the correct level.

Table 5.7.12 Recommended type and amount of physical activity for health gain

	Frequency	Valid Percent
30 minutes moderate activity 2-3 times per week	236	44.0
30 minutes moderate activity most days of week	145	27.1
30 minutes vigorous activity 2-3 times per week	31	5.8
30 minutes vigorous activity most days of week	19	3.5
Don't Know	105	19.6
Total		100.0

5.7.3.3 Alcohol

Just over a quarter of men correctly identified '21 units' per week as the sensible drinking limit for males (Table 5.7.13). Against a backdrop of increasing alcohol intake generally in Ireland, 43% of respondents nevertheless indicated the lower level of '12 units'.

Table 5.7.13 Sensible drinking limit for males per week

	Frequency	Valid Percent
12 units	236	43.4
21 units	153	28.1
32 units	8	1.5
40 units	2	.4
Don't Know	145	26.7
Total	544	100.0

5.7.3.4 Smoking

The majority of respondents were knowledgeable about the health consequences of smoking (Table 5.7.14) in terms of heart disease and respiratory problems (both 89.8%), and oral/dental health problems (69.1%). However, over two thirds of respondents (69.1%) were not aware that smoking was linked to impotence.

Table 5.7.14 Awareness of health consequences of smoking

Health consequence of smoking	Number answering 'Yes'	Percentage answering 'Yes'
Heart Disease	486	89.8%
Respiratory Problems	486	89.8%
Oral/Dental Health Problems	373	69.1%
Impotence	167	30.9%

5.7.4 Mental health

Knowledge of symptoms relating to depression (Table 5.7.15) ranged from 70.8% for 'disturbed sleep' to 24% for 'taking on more and more work'. The latter is noteworthy in the context of the reported prevalence of work as a source of stress (Section 5.4.4).

Table 5.7.15 Knowledge of symptoms of depression

Symptom	Number answering 'Yes'	Percentage answering 'Yes'
Disturbed Sleep	390	70.8%
Anxiety and Irritability	385	69.9%
Feelings of emptiness and dissatisfaction	359	65.2%
Feeling constantly tired	351	63.6%
Aggressive Behaviour	277	50.3%
Indecisiveness	188	34.1%
Taking on more and more work	132	24%
Don't Know	48	8.7%

5.8 Emotional/Relational Health

This section consists of (5.8.1) 'men's process', a theme that was explored in the first qualitative study; (5.8.2) the source of men's support for emotional/mental health issues; and (5.8.3) the impact of relationships on mental health and well being.

5.8.1 'Men's process'

Table 5.8.1 illustrates men's coping mechanism in terms of how they reported managing themselves through difficulties that affected their emotional or mental well being ('men's process').

Table 5.8.1 Reaction when something affects emotional/mental well-being

	Frequency	Valid Percent
Distract oneself and block out feelings	125	24.3
Acknowledge feelings but keep them to oneself	258	50.1
Acknowledge feelings but seek support of others	132	25.6
Total	515	100.0

Just a quarter of respondents reported acknowledging how they were feeling and seeking the support of others, while another quarter reported distracting themselves with other things and attempting to block out how they were feeling ('avoidance'). Half of all respondents reported acknowledging how they were feeling but remaining tight-lipped in terms of seeking help

(‘silence’). Men’s process was significantly associated with approach to going to the doctor (Chi Sq =23.104; df=6; p=.001); approach to looking after one’s own health (Chi Sq =32.069; df=6; p=.000); and effectiveness at managing stress (Chi Sq =10.924; df=4; p=.027). Those who blocked out problems/feelings were twice as likely as those who acknowledged problems and sought help(21% v 10%) to be ‘reluctant attenders’ at their GP (21% v 10%); almost twice as likely (55.2% v 31.1%) to have neglected/paid little attention to their health over the course of their lives; and significantly more likely (24.8% v 16.2%) to perceive themselves as ineffective at managing stress.

5.8.2 Source of support for emotional/mental health issue

In terms of who men were most likely to turn to for support or help for an emotional/mental health issue (Table 5.8.2), 87.6% indicated a female support (wife/partner, female close relative/acquaintance), with just 12.1% indicating a male support (male close relative/acquaintance). This is consistent with the reported role of women in supporting and influencing men to consult their GP (Section 5.2.3.1)

Table 5.8.2 Source of support for emotional/mental health problem

	Frequency	Valid Percent
Wife/Partner	263	74.1
Close female relative	7	2.0
Close male relative	16	4.5
Close female acquaintance	41	11.5
Close male acquaintance	27	7.6
A support organisation	1	.3
Total	335	100.0

5.8.3 Impact of relationships on mental health and well-being

Relationships with children and with wife/partner were more widely reported as having a positive impact on overall mental health and well being than relationships with any other category of ‘significant others’ (Table 5.8.3).

Table 5.8.3 Impact of relationships with ‘significant others’ on overall mental health and well-being

% who interpreted question as applicable to them

‘Significant Other’	Number of respondents	Number who interpreted as ‘Not Applicable’	Number of remaining respondents	Negative/Strongly Negative Effect	Little No Effect	Positive/Strongly Positive Effect
Children	459	133	326	5.5%	19.3%	75.2%
Wife/Partner	497	95	402	12.5%	16.6%	70.9%
Female close relative(s)	439	95	344	12.2%	41.3%	46.5%
Male close friends	441	91	350	6%	50.6%	43.4%
Male close relative(s)	437	89	348	13.8%	43.7%	42.5%
Female close friends	436	119	317	6.6%	57.4%	36%

What was perhaps even more noteworthy was the high percentage of respondents who answered either ‘Not Applicable’ or ‘Little/No Effect’ to each of the other four categories. For example, if these two categories are combined in the case of ‘male close friends’ (n=268); it can be concluded that 60.9% of respondents discounted any impact of relationship with male close friends on overall mental health and well-being.

Section 5.9 Impact of Marriage/Cohabiting & Fatherhood on Health

5.9.1 Marriage/cohabiting

70% of the overall sample identified as being either married/remarried or as cohabiting (Table 5.1.1). The purpose of this section is to examine the perceived impact of marriage/cohabiting on men’s health.

Impact of marriage/Cohabiting on men's health practices

Table 5.9.1 clearly highlights the very positive effect that marriage/cohabiting is perceived to have had on respondents approach to looking after their own health.

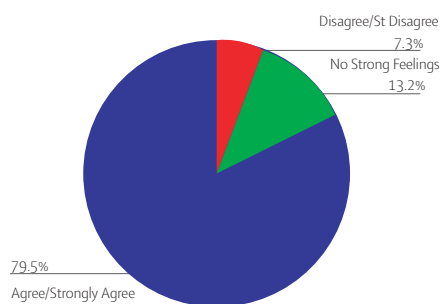
Table 5.9.1 Does marriage/Cohabiting result in men taking more care of their own health?

Factor	Number	Disagree Strongly Disagree	No Strong Feelings	Agree/Strongly Agree
Being more aware of my own health	N=344	10.5%	19.5%	70.1%
Taking less risks	N=349	12.9%	20.6%	66.5%
Eating a healthier diet	N=355	15.2%	21.7%	63.1%
Having more medical checkups	N=344	18.6%	25.6%	55.8%
Cutting down on how much I drink	N=343	22.2%	23.9%	53.9%
Exercising more	N=355	20.3%	31.1%	48.6%

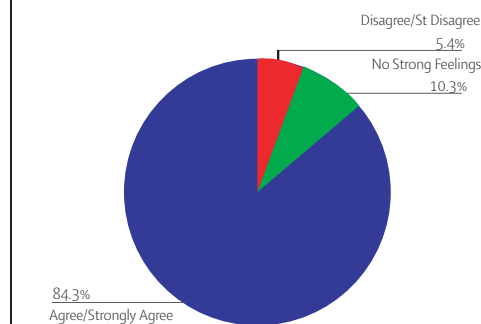
The impact of marriage/Cohabiting was also perceived to have been overwhelmingly positive in terms of becoming a more caring/sensitive person (79.5%) and more fulfilled as a person (84.3%; Figure 5.9.1).

Figure 5.9.1 Marriage/cohabiting has resulted in me becoming:

A more caring person, and more sensitive to the needs of others



More fulfilled as a person



5.9.2 Fatherhood

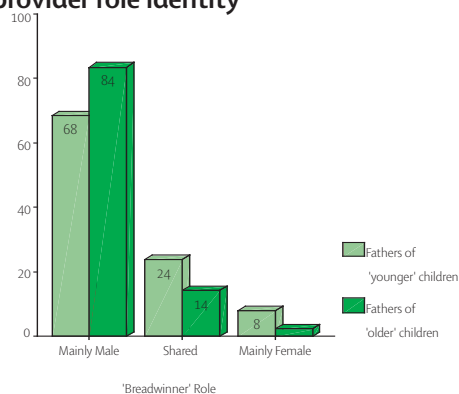
As outlined in Section 5.1, the category 'fathers' was subdivided into fathers of 'younger children' (at least one child under the age of 16; n=190); and fathers of 'older children' (child/all children 16 years or over; n=176).

5.9.2.1 Provider role

Although there was evidence of a shift in the extent to which fathers of 'older' children (83.5%) and fathers of 'younger' children (68.4%) cast themselves rather than their wives/partners in the role of main/principal provider, it is clear that Irish men continue to predominantly fill this role (Figure 5.9.2).

Figure 5.9.2

Perception of provider role identity

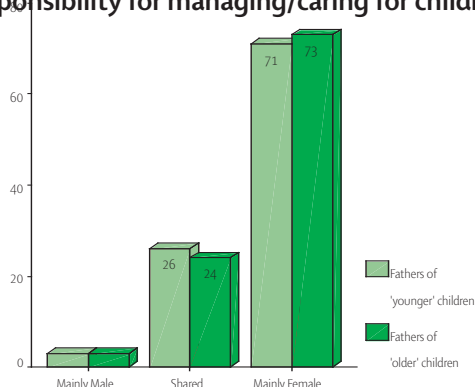


5.9.2.2 Responsibility for managing/caring for children

Figure 5.9.3 illustrates fathers' reported input into the overall managing and caring for their children. The majority of fathers of both younger (70.5%) and older (73.4%) children reported their wives/partners as occupying the main/principal role in caring for and looking after children. This can be interpreted as the corollary of fathers' identification with the main/principal breadwinner role.

Figure 5.9.3

Overall responsibility for managing/caring for children



The overall reported differences in childcare activities between fathers of 'younger' and 'older' children are quite modest (Table 5.9.2). Although there is some evidence of fathers of younger children being more proactive in childcare (e.g. preparing meals/feeding children), in the case of other tasks (e.g. 'helping children with homework'), there is evidence of greater divestment of childcare roles by fathers of younger children to their wives/partners.

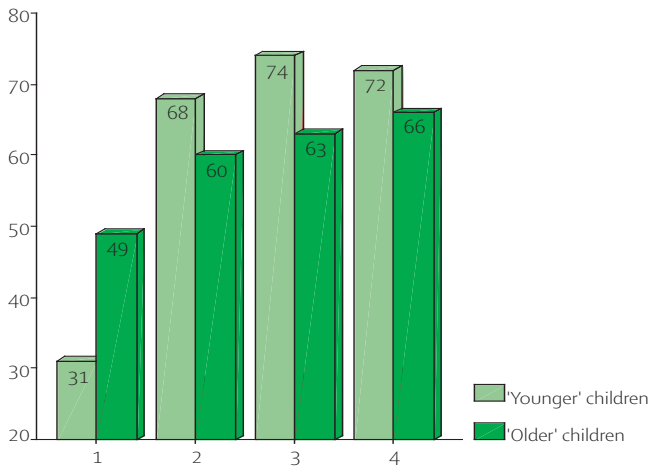
Table 5.9.2 Division of parental responsibilities in relation to managing/caring for children

Parenting Activity	'Younger' Fathers	%	'Older' Fathers	%
Washing/bathing children	Mainly wife/partner	78.3%	Mainly wife/partner	80.2%
	Shared equally	18.3%	Shared equally	18.7%
	Mainly father	2.4%	Mainly father	1.1%
Preparing meals/ feeding children	Mainly wife/partner	73.5%	Mainly wife/partner	83.9%
	Shared equally	21%	Shared equally	15.1%
	Mainly father	5.5%	Mainly father	1.1%
Dropping children to crèche/school	Mainly wife/partner	64.1%	Mainly wife/partner	60.9%
	Shared equally	18.6%	Shared equally	24.9%
	Mainly father	17.3%	Mainly father	14.2%
Helping children with homework	Mainly wife/partner	55.7%	Mainly wife/partner	40.5%
	Shared equally	32.2%	Shared equally	40%
	Mainly father	12.1%	Mainly father	19.5%
Playing with children	Mainly wife/partner	31.3%	Mainly wife/partner	26.5%
	Shared equally	58.5%	Shared equally	61.3%
	Mainly father	10.2%	Mainly father	12.2%
Taking children to doctor	Mainly wife/partner	61.3%	Mainly wife/partner	70.3%
	Shared equally	29.8%	Shared equally	24.9%
	Mainly father	8.8%	Mainly father	4.9%

5.9.2.3 Provider/fathering roles

There was evidence of a shift in the way that fathers of 'older' and 'younger' children identified with what could be described as traditional male provider and female nurturer roles, and work/fathering balance (Figure 5.9.4).

Figure 5.9.4 Percentage of fathers of 'younger' and 'older' children answering 'Agree' / 'Strongly Agree' to work/fathering balance



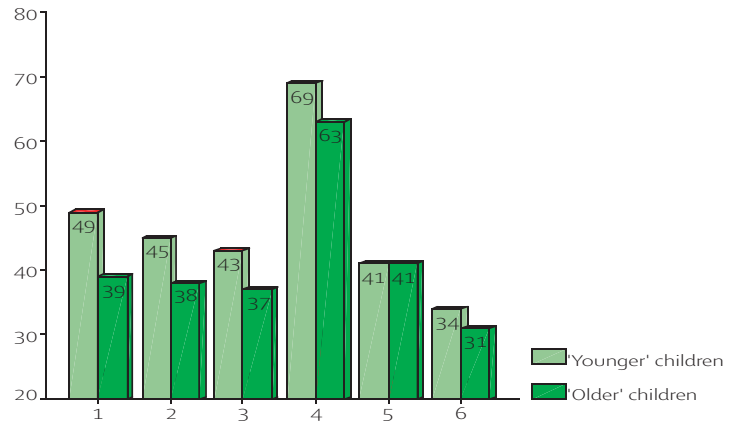
- 1 'Father's role to provide; mother's role to care'
- 2 'Provision of paternal/paternity leave highly inadequate'
- 3 'Getting on in my job – no allowances for being a father'
- 4 'Prefer to work less in order to spend more time with children'

Whilst almost half of fathers of 'older' children endorsed the male provider/female nurturer view, less than one-third of fathers of younger children held a similar view. Similarly, fathers of 'younger' children were more likely than fathers of 'older' children to support the view that the provision of state support for fathers was inadequate (68% versus 60%). In the context of work/fathering balance, fathers of younger children were more likely to perceive as incompatible one's commitments as a father on the one hand and getting on in one's job on the other (74% versus 63%), and also to express the desire to work less in order to spend more time with their children (74% versus 63%).

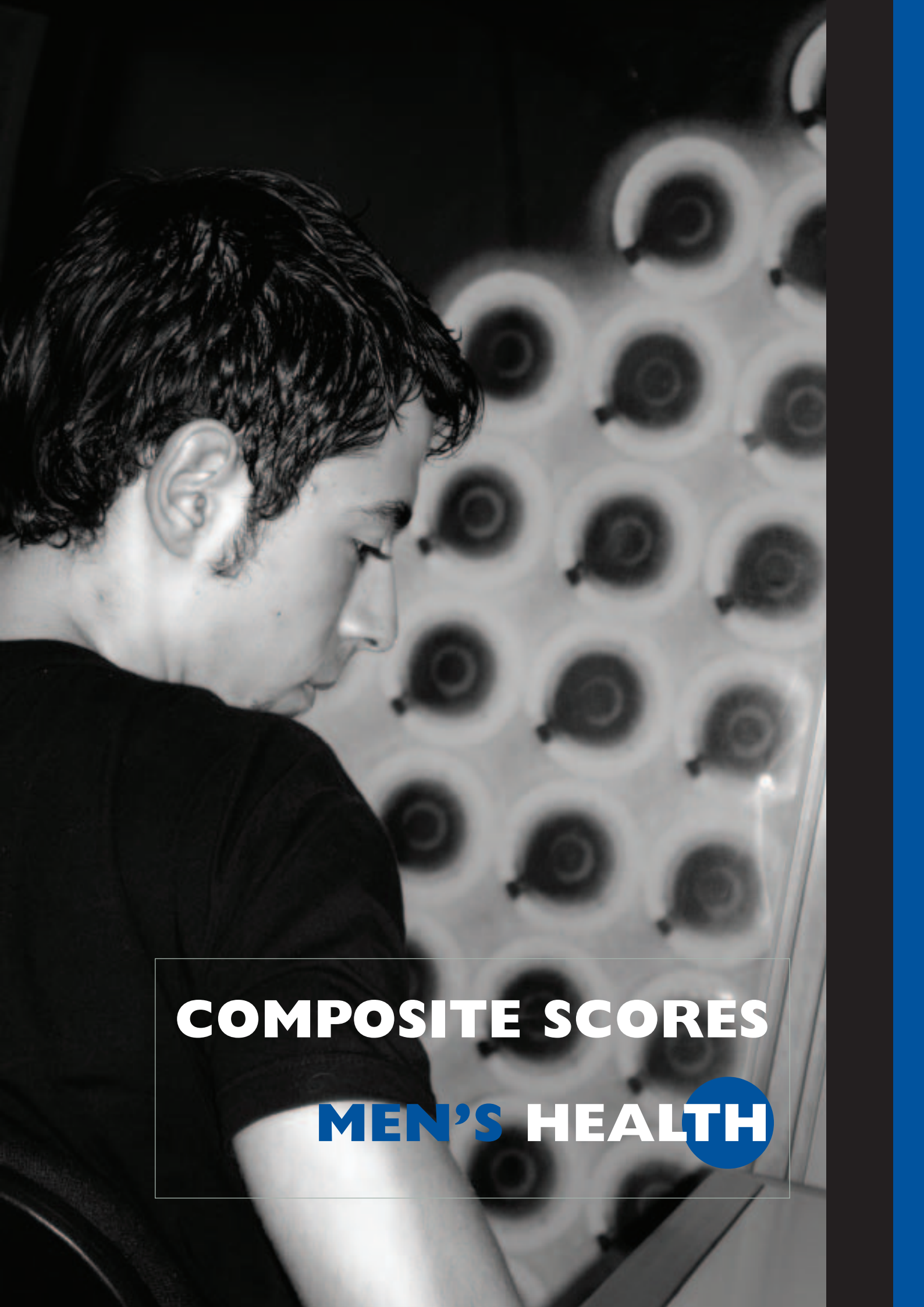
Figure 5.9.5 illustrates how fatherhood is perceived to have impacted on the way in which fathers of 'younger' and 'older' children look after their own health. The strongest relationship was found in relation to risk behaviours, with two-thirds of all fathers attributing reduced risk-taking to fatherhood. In the context of alcohol consumption, diet, exercise and stress management, between a third and half of all fathers reported that fatherhood had a positive

influence on these lifestyle behaviours. One in three fathers also reported having more regular medical check-ups on becoming a father. The extent of these associations was greatest in relation to fathers of younger children.

Figure 5.9.5 Percentage of fathers of 'younger' and 'older' children answering 'Agree'/'Strongly Agree' to impact of fatherhood on health practices

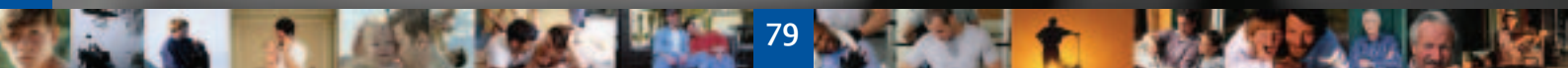
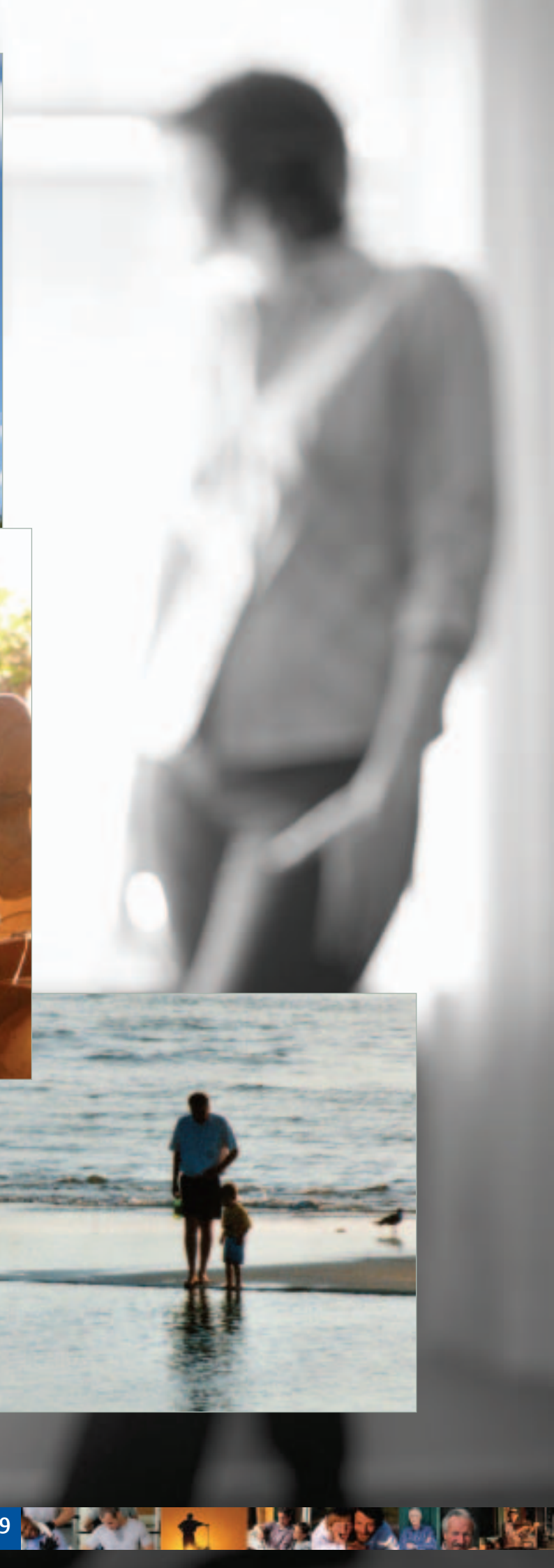


- 1 'Cutting down on alcohol consumption'
- 2 'Eating a healthier diet'
- 3 'Exercising more'
- 4 'Taking less risks'
- 5 'Managing stress better'
- 6 'Having more regular medical check-ups'



COMPOSITE SCORES

MEN'S HEALTH



Section 6 Composite: Scores Men's Health

Six 'Composite Scores' (6.1 – 6.6) were compiled based on the extraction of relevant data from Section 5, in relation to each of the following factors: (6.1) self-reported health status; (6.2) self-care practices; (6.3) health behaviours; (6.4) preventative health behaviours; (6.5) risk behaviours; and (6.6) knowledge/awareness of health. (A seventh variable 'men's process' (See Section 5.8.1) was also included in this section to investigate how composite scores related to the way in which men deal with an emotional/mental health issue. The purpose of developing composite scores was to compile collective data on each of these aspects of men's health that would enable an examination of overall trends in the data. This was carried out by a) cross-tabulating composite scores with socio-demographic variables; and b) exploring the inter-relationships between composite score variables. It should be stressed that these composite scores are at best crude measures of selected aspects of men's health, and are based on the author's subjective selection of variables within each category. It should also be noted that each variable was included in one category only, and in some cases could have been included in more than one category. While binge drinking for example was classified as a health behaviour, it could justifiably have been classified as a risk behaviour.

6.1 Composite Score: Self Reported Health Status

A composite 'self-reported health' score was compiled that separated respondents into 'good health' or 'poor health' for each self-care variable as outlined in Table 6.1.

Table 6.1 Criteria used to compile composite 'self-reported health' score

	Variable	'Good health'	'Poor health'
1	How health has been over past 12 months	Good/very good	Fair/bad/very bad
2	Long-term illness/disability	No	Yes

Table 6.2 presents composite self-reported health data for the total sample group, with half (49.5%) of respondents reporting 'good health'. Just over one in five men reported poor health and a long-term illness/disability.

Table 6.2 Composite Score: Self-Reported Health

	Frequency	Valid Percent
Good health	283	49.5
Poor health or long-term illness/disability	168	29.4
Poor health and long-term illness/disability	121	21.2
Total	572	100.0

6.2 Composite Score: Self Care Practices

A composite 'self-care practices' score was compiled that separated respondents into 'positive' or 'negative' for each self-care variable as outlined in Table 6.3.

Table 6.3 Criteria used to compile composite 'self-care practices' score

	Variable	Positive self-care	Negative self-care
1	Length of time since attended doctor	Within past 2 years	More than 2 years
2	Approach to going to doctor	Go willingly/ reluctantly without being pushed	Need to be pushed/ forced to go
3	Level of care/attention to one's own health	Somewhat attentive /close attention	Neglected/little attention
4	Neglect of health (as reason for 'poor' health)	Disagree/Strongly Disagree	Agree/Strongly Agree
5	Late presentation (as contributory factor to long-term illness/ disability)	No	Yes

Table 6.4 outlines the prevalence of negative 'self-care practices' amongst the total sample group, with 63.5% of the sample being negative on at least one variable. The table also includes the overall classification of the sample into high, moderate and low categories of self care.

Table 6.4 Composite score: self care practices

	Frequency	Valid Percent	Overall self care classification	Valid Percent
Negative on 0 variable	209	36.5	High Level of self care	36.5
Negative on 1 variable	189	33.1	Moderate Level of self care	55.1
Negative on 2 variables	126	22.0		
Negative on 3 variables	41	7.2		
Negative on 4 variables	7	1.2	Low Level of self care	8.4
Total	575	100.0		100.0

6.3 Composite Score: Health Behaviours

A composite ‘health behaviour’ score was compiled which separated respondents into ‘healthy’ or ‘unhealthy’ for each health behaviour variable as outlined in Table 6.5.

Table 6.5 Criteria used to compile composite health behaviour score

Variable	‘Healthy’	‘Unhealthy’
1 Units of alcohol per week	Less than 21 units per week	21 units or more per week
2 Binge Drinking	Binge drinking less than weekly	Binge drinking at least weekly
3 Smoking	Non-smoker	Smoker
4 Physical Activity Level	Moderate activity 3 or more times per week/vigorous activity	Sedentary – moderate activity 2 or fewer times per week
5 Level of Stress	Free of stress/ occasionally stressed	Regularly/ constantly stressed

Table 6.6 outlines the incidence of ‘unhealthy behaviours’ amongst the total sample group with 55.1% of respondents categorised as having at least two ‘unhealthy behaviours’. The table also includes the overall classification of the sample into low, moderate and high categories of unhealthy behaviours.

Table 6.6 Composite score: health behaviours

	Frequency	Valid Percent	Overall classification	Valid Percent
‘Unhealthy’ on 0 variables	56	9.9	Low level of unhealthy behaviours	44.9
‘Unhealthy’ on 1 variable	198	35.0		
‘Unhealthy’ on 2 variables	173	30.6	Moderate level of unhealthy behaviours	48.1
‘Unhealthy’ on 3 variables	99	17.5		
‘Unhealthy’ on 4 variables	29	5.1	High level of unhealthy behaviours	7.0
‘Unhealthy’ on 5 variables	11	1.9		
Total	566	100.0		100.0

6.4 Composite Score: Preventative Health Behaviours

A composite ‘preventative health behaviour’ score was compiled which separated respondents into ‘preventative’ or ‘non-preventative’ for each preventative health behaviour variable as outlined in Table 6.7.

Table 6.7 Criteria used to compile composite preventative health behaviour score

	Variable	Preventative	Non-preventative
1	Monitoring of weekly alcohol consumption	Yes	No
2	Experience of Digital Rectal Examination	Yes	No
3	Frequency of practicing Testicular Self-Examination	At least occasional practice	Do not practice
4	Effectiveness at managing stress	Somewhat/very effective	Somewhat/completely ineffective

Table 6.8 outlines the prevalence of preventative health behaviours amongst the total sample group with four out of ten men

engaging in one or fewer preventative health behaviours. The table also includes the overall classification of the sample into low, moderate and high categories of preventative behaviours.

Table 6.8 Composite score: preventative health behaviours

	Frequency	Valid Percent	Overall classification	Valid Percent
'Preventative' on 0 variables	46	8.1	Low level of preventative behaviours	40.4
'Preventative' on 1 variable	185	32.3		
'Preventative' on 2 variables	189	33.0	Moderate level of preventative behaviours	54.3
'Preventative' on 3 variables	122	21.3		
'Preventative' on 4 variables	30	5.3	High level of preventative behaviours	5.3
Total	572	100.0		100.0

6.5 Composite Score: Risk Behaviours

A composite 'risk behaviour' score was compiled which separated respondents into 'at risk' or 'not at risk' for each risk behaviour variable as outlined in Table 6.9.

Table 6.9 Criteria used to compile composite risk behaviour score

Variable	At risk	Not at risk
1 Use of seat belts in front of car	Sometimes - Never	Always/ Nearly Always
2 Use of seat belts in back of car	Sometimes - Never	Always/ Nearly Always
3 Driven in past year having consumed 2 or more alcoholic drinks	Yes	No
4 Been a passenger in past year with a driver who was drunk	Yes	No
5 Adherence to speed limits	Usually/Generally exceed speed limits	Always - Usually observe speed limits
6 Use of sunscreen if skin is exposed to sun for extended periods	Never - Occasionally	Always/Nearly Always
7 Unsafe sex	Occasionally - Frequently	Never/ Once or twice

Table 6.10 outlines the incidence of 'at risk' behaviours amongst the total sample group with four out of ten men categorised as 'at risk' for at least two 'risk behaviours'. The table also includes the overall classification of the sample into low, moderate and high categories of risk behaviour.

Table 6.10 Composite score: risk behaviours

	Frequency	Valid Percent	Overall Classification	Valid Percent
At risk for 0 variables	128	22.5	Low level of risk behaviour	59.3
At risk for 1 variable	209	36.8		
At risk for 2 variables	141	24.8	Moderate level of risk behaviour	35.7
At risk for 3 variables	62	10.9		
At risk for 4 variables	19	3.4	High level of risk behaviour	5.0
At risk for 5 variables	6	1.1		
At risk for 6 variables	3	.5		
Total	568	100.0		100.0

6.6 Composite score: Knowledge/Awareness of Health

A composite 'knowledge/awareness of health' score was compiled which separated respondents into 'knowledgeable' or 'not knowledgeable' for each variable as outlined in Table 6.11. Because of the large number of potential variables within this category (Section 5.7), it was deemed appropriate to select five factors that have been shown in the literature to have a particular relevance to men's health.

Table 6.11 Criteria used to compile composite knowledge/awareness of health score

Variable	Knowledgeable	Not Knowledgeable
1 Principal dietary nutrient	Carbohydrate	Other
2 Sensible weekly drinking limit	21 units	Other
3 Recommended weekly physical activity for health gain	30 minutes or more of moderate activity most days of the week	Other
4 Purpose of a Digital Rectal Examination	Yes	No
5 How to practice Testicular Self-Examination	Yes	No

Table 6.12 outlines the extent to which the total sample group was knowledgeable about the selected health factors, with three-quarters of all respondents categorised as being 'knowledgeable' about two factors or less. The Table also includes the overall classification of the sample into low, moderate and high categories of knowledge/awareness of health.

Table 6.12 Composite score: knowledge/awareness of health

	Frequency	Valid Percent	Overall classification	*VP
Knowledge of 0 factors	91	15.9	Low level of knowledge/ awareness	45.3
Knowledge of 1 factor	168	29.4		
Knowledge of 2 factors	164	28.7	Moderate level of knowledge/ awareness	46.5
Knowledge of 3 factors	102	17.8		
Knowledge of 4 factors	42	7.3	High level of knowledge/ awareness	8.2
Knowledge of 5 factors	5	9		
Total	572	100.0		100.0

*VP=Valid Percent

6.7 Relationship Between Men's Health Composite Scores and Socio-Demographic Factors

Table 6.13 outlines the relationship between men's health composite scores and socio-demographic factors

Table 6.13 Relationship Between Men's Health Composite Scores and Socio-Demographic Factors (Chi Squared $p < .05$)

Composite Score	Age	Social Class	Education	Marital Status	Fatherhood Status
Self-reported health	Chi Sq =26.600; df=10; p=.003	N/S	Chi Sq =15.873; df=6; p=.014	N/S	N/S
Self care practices	Chi Sq =32.983; df=10; p=.000	Chi Sq =17.663; df=4; p=.001	Chi Sq =18.263; df=6; p=.006	N/S	N/S
Health behaviours	Chi Sq =41.341; df=10; p=.000	N/S	N/S	N/S	N/S
Preventative health	Chi Sq =47.525; df=10; p=.000	N/S	N/S	N/S	N/S
Risk behaviours	Chi Sq =24.153; df=10; p=.007	N/S	N/S	Chi Sq =4.635; df=2; p=.099(*)	Chi Sq =4.270; df=2; p=.118(*)
Knowledge/ awareness of health	N/S	Chi Sq =9.531; df=4; p=.049	Chi Sq =24.573; df=6; p=.000	Chi Sq =7.207; df=2; p=.027	N/S
Men's process	N/S	N/S	N/S	N/S	N/S

(* not statistically significant, $p > 0.05$)

The following is a summary of the relationship between men's health composite scores and socio-demographic factors

- With respect to self-reported health, older and less-educated men were significantly more likely to report poor health and a long-term illness/disability. For example, older men (>70) were over four times more likely (35.5% v 8.2%) than younger men (18-29) to report poor health and a long-term illness/disability, while men with primary education or less were over twice as likely (32.7% v 14.4%) as men with third level education to so report.
- With respect to self-care practices, younger, less well-off and less educated men were significantly more likely to engage in negative self-care practices. For example, men from SC5/6 were over twice as likely (12.6% v 5.6%) as men from SC1/2 to report negative self-care practices, while men with primary education or less were over three times more likely (14% v 3.9%) than men with third level education to so report.
- With respect to health behaviours, men over the age of 60 were significantly more likely to be classified as having a low level of unhealthy behaviours. For example, men in their 60s were twice as likely as men in their 30s (61% v 31.9%) to be classified as having a low level of unhealthy behaviours.
- With respect to preventative health behaviours, younger men were significantly more likely to report a low level of preventative health. For example, men under the age of 40 were over twice as likely (54.6% v 21.9%) as men in their 60s to report a low level of preventative health.
- With respect to risk behaviours, younger men were significantly more likely to belong to the high-risk group. Although not statistically significant (Chi Sq =4.635; df=2; p=.099) and based on relatively small numbers, single men were more than twice as likely (7.7% v 3.8%) to belong to the 'high risk' group compared to married/cohabiting men. Similarly, in relation to fatherhood status (Chi Sq =4.270; df=2; p=.118), non-fathers were almost twice as likely as fathers (7% v 4%) to belong to the high-risk group. This is indicative nevertheless of a trend towards a reduction in high-risk behaviours associated with marriage/Cohabiting and fatherhood, and may warrant further investigation.
- With respect to knowledge/awareness of health, less well-off men, less-educated men and unmarried/not cohabiting men were significantly more likely to belong to the 'low level of awareness' category. For example, men with primary education or less were almost twice as likely (58.9% v 35.9%) to belong to this category than those with third level education.
- It was deemed appropriate to include the variable 'men's process' in this section, due to the importance of this issue in the broad context of men's health (See Section 5.8.1). Men's process was found not to be significantly associated with any of the socio-demographic variables. It can only be concluded that how men manage themselves through emotional/mental health issues is not dependent on socio-demographic factors.
- There were notably few significant relationships between the composite score variables and either marital status or fatherhood status variables. This may have been due to the heterogeneity within these variables. For example, married/cohabiting males and fathers each comprised men from all age, social class and education categories. As a result the diversity within each of these categories (i.e. married/cohabiting males and 'fathers') may have undermined the potential of marital status and fatherhood status as discriminatory variables.

6.8 Inter-Relationships Between Men's Health Composite Scores

Table 6.14 presents a summary of the significant (*p< .05) inter-relationships that were found between men's health composite scores.

Table 6.14 Inter-relationships between men's health composite scores

	Self-reported Health	Self-care Practices	Health Behaviours	Preventative Health Behaviours	Risk Behaviours	Knowledge/ Awareness of Health	Men's Process
Self-reported health		*Chi Sq =24.707;N/S df=4; p=.000	N/S	N/S	N/S	N/S	
Self-care Practices			*Chi Sq =19.421; df=4; p=.001	*Chi Sq =23 107; df=4; p=.000	*Chi Sq = 9.924; df=4; p=.042	*Chi Sq = 13.864; df=4; p=.008	*Chi Sq = 23.255; df=4; p=.000
Health Behaviours				*Chi Sq = 24.514; df=4; p=.000	*Chi Sq = 36.406; df=4; p=.000	N/S	N/S
Preventative Health Behaviours					*Chi Sq = 23.056; df=4; p=.000	*Chi Sq =48.272; df=4; p=.000	N/S
Risk Behaviours						N/S	*Chi Sq =16.353; df=4; p=.003
Knowledge/ Awareness of Health							*Chi Sq =12.323; df=4; p=.015
Men's Process							

The following is a summary of the inter-relationships between men's health composite scores

- Men who reported poor health and a long-term illness or disability were five times more likely (16.5% v 3.2%) to report negative self-care practices than those who reported good health
- Men who reported negative, as distinct from positive self care' practices were (i) almost twice as likely (64.6% v 37.3%) to have a low level of awareness of health; (ii) three times more likely (16.7% v 5.4%) to have unhealthy health behaviours; (iii) almost three times more likely (8.3% v 2.9%) to engage in high risk behaviours; (iv) over twice as likely (66.7% v 30.6%) to have a low level of preventative health; and (v) half as likely (17.8% v 36.4%) to acknowledge problems and seek help when faced with an emotional/mental health issue.
- Men who engaged in unhealthy, as distinct from healthy health behaviours were (i) twice as likely to have a low level of preventative health and (ii) over five times more likely to engage in high risk behaviours.
- Men who engaged in a low, as distinct from a high level of preventative health were (i) over twice as likely (6.5% v 2.7%) to engage in a high level of risk behaviours; and (ii) over twice as likely (57.1% v 23%) to report a low level of awareness of health.
- Men who reported a high, as distinct from a low level of risk behaviours were twice as likely (50% v 23.9%) to distract themselves and block out feelings when dealing with an emotional/mental health problem.
- Men with a low, as distinct from a high level of knowledge/awareness of health were four times more likely (29.1% v 6.7%) to distract themselves and block out feelings when dealing with an emotional/mental health problem.

**DISCUSSION OF
FINDINGS FROM BOTH
QUANTITATIVE AND
QUALITATIVE STUDIES**



Section 7 Discussion of findings from both quantitative and qualitative studies

The principal aim of this research was to investigate the role of gender and masculinities on Irish men's lay concept of health, their knowledge, beliefs and attitudes in relation to health and illness and health practices, and on the barriers that Irish men perceive in accessing health services. This section will draw together the principal themes that emerged from both qualitative studies (Study 1 & Study 3), in conjunction with the findings from the quantitative study (Study 2). It will comprise the following subsections: (7.1) men's health-consciousness and concept of health; (7.2) male patients' views on GP care; (7.3) how men cope with illness; (7.4) self-reported health status and self-care practices; (7.5) lifestyle/health behaviours; (7.6) preventative health behaviours; (7.7) risk behaviours; (7.8) emotional/relational health; (7.9) impact of marriage/cohabiting and fatherhood on health; (7.10) men's health composite scores.

7.1 Men's Health Consciousness and Concept of Health

7.1.1 Are men health-conscious?

There was a lack of a sense of health-consciousness amongst almost half (43.5%; Figure 5.3.6) of respondents in Study 2, who reported having neglected or paid little attention to their health over the course of their lives. This was evidenced most amongst men in the age range 30-49, amongst less well-off men and men with less formal education. This finding bears weight to the notion that men are sometimes seen by health professionals as not interested in health and as 'hard work' (Baker, 2002). However, it was abundantly clear from both qualitative studies that for many men there was a lack of identification with health and with identifying as participants in health care.

'Health' simply never on the agenda for men

In the context of the feminisation of health and health services described earlier, it appears that boys and young men have not engaged with health within the broader education system. Tony (a 38 year old bouncer) recalls a total absence of health from the school curriculum, while Kevin (a 20 year old student) emphasizes the need for education to improve men's awareness of their health.

There was never any real mention of health at all. I cannot actually remember anywhere in school that we actually discussed health, at any level...as a young man, you don't really talk about things [medical issues] like

that...they [young men] don't get sick, you know.

Tony 38

Education would be a big thing [to increase awareness of health among men]. If men were made more aware of the risks and the consequences of things...I mean like, you said about the testicular cancer there which none of us [student men] in this room knew about. Kevin 20

The general absence of any type of forum for men in Ireland to explore health-related issues is underlined by Kian's (a 20 year old student) response at the end of a focus group.

...seems like wonderful talking here today, nearly everyone has said something about their friends, how they talk to their friends or their friends have helped them out or whatever...I think a bit more education in that area would help like, like some people are just natural loners...I feel like those people need to be drawn in and taught that you know, if you have some friends around you they'll help you out like when you're in a tough situation or if you need to go to a doctor...and even to just like work in groups as well like, and get people to focus on how to help out their friends like. Kian 20

The spontaneity of Kian's reaction does much to undermine the notion that men are simply not interested in their health or are not prepared to provide support to one another. Clearly, men need more support, direction and openness around the importance and acceptability of health for men (as well as for women).

Sabo (1999) argues that while girls are taught by their mothers about their bodies, and tend to have regular contact with health services through reproductive health care (menstruation, child-bearing and menopause), boys on the other hand tend to be left on their own. As a result, boys tend not to develop self-nurturing attitudes and behaviours in the same way that girls do. Similarly, Bonhomme (2004) notes that while female-targeted medical specialties (obstetrics /gynaecology and women's health) are likely to habituate women into regular contact with health care early in life, men on the other hand are much more likely to remain outside the gaze of health care provision. The lack of male-targeted specialties and health care programmes may as a result hinder the surveillance capability for men's health problems and men's ability to identify as participants in health care. There may also be a fragmentation of men's health issues across different specialties, thereby hindering the potential for integrated interventions. For example, depression and erectile dysfunction may be inherently linked, but may be treated as separate conditions by different health care specialists.

Lack of health-consciousness compounded by sense of invincibility

Boys' and young men's lack of exposure to health is

compounded by what Stephen (a 24 year old post-graduate) describes as his sense of invincibility.

...health is something, well in my own case that wouldn't come in to the equation, I think, yeah, I'll worry about that in twenty or thirty years down the road. I think definitely the younger you are you have that feeling of invincibility. Stephen 24

It appears therefore that many men may go through their formative years without ever being exposed to health issues and without any sense of needing to be exposed to health issues. This absence of health-consciousness may indeed be the precursor to behaviours likely to compromise health, such as increased risk behaviours (See Section 7.7) or health-damaging behaviours (See Section 7.5).

Exposure to serious illness a 'wake-up call' to an increased health-consciousness

Most participants commented on taking health for granted at various points in their lives. An interesting disparity in the amount of importance placed on health emerged between participants who had experienced serious illness and those who had not. It appears that those participants who had not experienced serious illness or witnessed serious illness in others were more likely to take health for granted or regard it as a matter of low priority. This disparity is illustrated in the following extracts.

Ian (a 47 yr old butcher) who suffered from serious asthma spoke about the immense importance of his health.

Well it (health) means a lot to me, I developed asthma when in '99, because I smoked for, I smoked up until '99, so I developed asthma in '99. And now I have high blood pressure as well, so...I think the asthma I think a lot of it came on from smoking because that's when I gave up cigarettes. So I'm concerned with health now alright...Ian 47

It is interesting that Ian connects his awareness around the importance of his health with the onset of asthma. Asthma appears to have acted as a catalyst in increasing his awareness of his health. Similarly, Cathal (a 44 yr old unemployed man) speaks about the effect rheumatoid arthritis has had on the manner in which he perceives his health. Since his illness it has become a matter of greater priority.

Well at the moment because I'm on disability, I'm worried more about it (health). My disability is rheumatoid arthritis and the pains of that and the need to take medication on that. Like a couple of years ago if there was something wrong with me I'd be leaving it until the last moment to get it checked out, you know, whereas now I do worry about my health. Cathal 44.

By contrast a number of participants who had not experienced serious illness spoke of taking their health for

granted to a certain extent.

Brian (a 37 yr old solicitor) acknowledges that he might take his health for granted, as he has never experienced personal serious illness.

I suppose I've never really been sick so I don't, I take it for granted probably. Brian 37

Barry (a 54 yr old unemployed man) articulated the notion of the transition from taking health for granted to perceiving it as an issue of priority as a result of illness.

Well the thing was I always had good health until then, except, you know, the first thing was the high blood pressure and got that under control, then as I said the heart attack, but you just take it for granted you see, and you don't take steps to look after it until something happens, and then you're trying to get back to what you were, but you really don't, you know. But I know the value of good health now, but too late. Barry 54

An increased level of health-consciousness with age

Age also seems to play an important role in getting men to be more reflective about their health, as Ray (a 47 year old accountant) and Robert (a 42 year old sales manager) describe:

I'd say I have become very conscious of health probably I think because I've reached middle age...whereas I always thought I was going to live forever. Ray 47

...when I was twenty years of age I'd run eight hours a day, I could play two matches back to back but that's twenty years ago. Robert 42

The increased awareness around health of men in their 40s seems to be linked to a perceived physical decline in men's bodies (See Section 7.1.2). Ray identifies a definite shift from perceiving himself to be invincible in his youth to a position of being now 'very conscious' about his health. There is an air of resignation in Robert's description of his own physical decline, although his recollection of the way he was twenty years ago is perhaps more reminiscent of the legendary Irish hero, Cu Chulainn than based in reality. That men develop an increased level of health-consciousness with age is borne out by the quantitative data from Study 2. Older men were significantly more likely than younger men to engage in positive self-care practices; to adopt positive health behaviours, to engage in more preventative health behaviours and to take fewer risks with their health (See Section 6.7). Previous studies (e.g. Aoun, Donovan, Johnson and Egger, 2002), have also noted that as men grow older they are likely to become more health-conscious. This does have implications for targeting specific health interventions or health awareness campaigns at middle-aged/older men, at a time when they are more likely to be receptive and to act on such initiatives. It also raises questions about the efficacy of existing measures in targeting younger men.

Role of Media in raising health-consciousness

The media was also cited by participants as playing a key role in raising awareness of certain health issues and affecting attitudes and behaviours. Ned (a 65 yr old retired businessman) speaks about being influenced by the media to go to his GP to get a check-up.

I suppose at the time I was influenced by the media, but this was an issue that came up a few years ago and I said 'oh I better go and get examined' so and went to my GP and he sent me off and I met a specialist and everything turned out okay, so...I was happy after that. Ned 65

Chris (a 70 yr old estate agent) makes a similar assertion about media influence.

Well, media I suppose one would have to admit would have some influence on it, yeah. For instance it does promote fitness do you know, and I suppose subconsciously I've taken that on board. Chris 70

Barry (a 54 yr old unemployed man) mentions that he obtains health information from magazines that has led directly to his asking his GP for specific tests.

*She arranged for me to go in fasting and which was alright and then I got a blood test done, that was of my own idea, I'd seen an auld article in a free newspaper, '***** **' that do a health thing whenever, every week. I got her to do that when she said she was going to do the prostate test and I think I had another blood test then when I seen another article in a magazine. Barry 54*

These extracts emphasise the impact of the media in generating awareness of health issues among men. They are particularly noteworthy in light of the response to Men's Cancer Action Week 2003 (Irish Cancer Society, 2004). For example, during the campaign, there were over 1,000 calls to the Irish Cancer Society (ICS) helpline. This represented one-sixth of the yearly total, and approximately 90% of the calls were from men. There was also a dramatic increase during the campaign in the number of 'hits' to the ICS website (41,000 per day), with approximately 50% of the entire months hits occurring during the campaign. As well as highlighting the efficacy of such campaigns for men, and in particular the appropriateness of making available appropriate internet and helpline supports for men, the ICS's detailed evaluation of the campaign is also to be commended as an example of compiling worthwhile evidence of best practice when working with men. In conclusion, it can be said that, given the opportunity, men are conscious of their health.

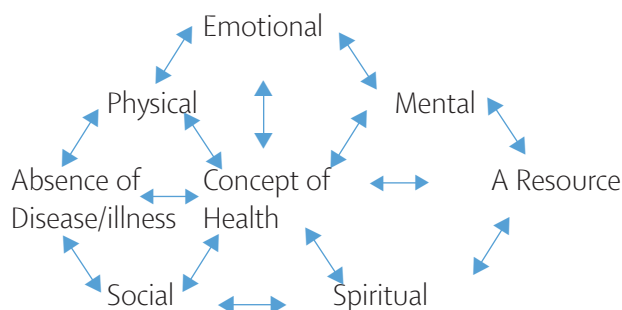
7.1.2 Men's concept of health

Watson cites one of the major limitations of men's health as the absence of knowledge grounded in the everyday experiences of men themselves:

...current medical and social debate around men's health is undermined and under-informed by a failure to explore men's perceptions of health and maleness as a personal, cultural and social phenomenon. Watson (2000, p2)

In the quantitative study, 60.3% of respondents rated their health as 'good', with 39.7% rating their health as 'poor' (Section 5.3.1). A key component of both qualitative studies was to gain insights into Irish men's conceptualisations of health that would also provide a context in which more complex health attitudes and behaviours might be grounded. Overall, health was described as having physical, mental, social and emotional features, as an absence of illness/disease and as a resource to fulfil the more traditional provider male role. While most participants favoured particular orientations to conceptualise health, in most of the men's accounts, these orientations were presented not as discrete entities, but as inter-related concepts of health (Figure 7.1.2). Overall, a broader and more holistic concept of health emerged, than that which has been reported elsewhere (e.g. Blaxter, 1990; North Eastern Health Board, 2001). Some of the men described being very much in control of their health, whilst, for others, health was more aspirational and subject to a number of limitations.

Figure 7.1.2 Orientations used to conceptualise health



Health as a utilitarian and tangible entity

For many of the men, a strong theme underpinning their accounts was of an essentially pragmatic and utilitarian concept of health that was grounded in the need to meet their 'obligations' to work and to provide for their families. Dan, a 52 year old farmer sees health as synonymous with being able to work.

The day you can't get up to milk is the day you know you have a problem with your health. Dan 52

By contrast, another farmer (Tom, 62) constructs his concept of health (or ill-health) around the physical wear and tear of farm labour on the body, and how the body is over time 'consumed' by such labours (See Section 3.4): *its pure codology. I see fellas coming in there [to farm mart] bent over with hardship...years of wettings and drownings, pulling and dragging all their lives. Tom 62*

Many participants conceptualised health as a tangible entity. 'Health' was often perceived predominantly in concrete physical terms. For example, a number of participants constructed health simply as sufficient physical fitness to undertake physical activity. When asked what is constituted by 'being healthy', Peter (a 63 yr old pharmacist), describes this concept in tangible terms.

Well, I'd say a healthy person is a person who within reason looks after themselves, I mean diet wise and takes a certain amount of exercise. Peter 63

Health as physical fitness

Physical fitness was synonymous with health throughout the mens' narratives. As Calum, a 22 year old student notes: *Its [being healthy] about not feeling curtailed in what you want to do physically. I just know when I'm starting to feel off form by the way I feel physically, and the way my energy levels start to fade. Calum 22*

The appearance of being physically fit is also important. Ned (a 65 year old retired businessman) describes feeling angry when someone points out to him that he has a limp. *Well what annoys me now and again is eh, this fellow said to me when I'm playing golf 'you're limping, is there something wrong?' I have a slight knee problem, its that physical appearance, then it niggles me because I don't like to appear to be limping. Ned 65*

In Ned's account there is a sense that his pride is affected when his limp is noticed. Having an impaired physical function is perhaps synonymous with a less able man and therefore with a subordinate masculinity. Barry (a 39 year old business manager) acknowledges a sense of compulsion in having to exercise regularly in order to maintain his sense of well-being, a theme that is developed further in a later section.

...its feeling good, its feeling healthy, its feeling fit...if I don't do a bit of training a couple of times a week, I feel, I feel dreadful... I need to burn a bit of energy and I feel better after it ...if I don't do that I feel crap. I have to do it two or three times a week. Barry 39

Health as well-being

Brian (a 37 yr old solicitor) states that health is characterised by a general sense of well being, and being able to combat stress.

In terms of being healthy, I suppose sort of what you might describe as a general sense of well being, a general zest for life, sort of an ability to counteract crisis things in your life, you know be able to deal with stress and that kind of thing, that's how I would view it anyway, you know. Brian 37

Chris (a 70 yr old estate agent) hypothesised that being healthy was important in terms of a man's self-confidence. *It (being healthy) gives you that extra bit of confidence I*

think, yeah. And I suppose when you're healthy, you're more conscious of your appearance shall I say, than if you're unhealthy, you're inclined to neglect your appearance. Chris 70

'Mens sano in corpore sano' [Healthy mind healthy body]

A number of participants described physical and mental well-being as being synonymous with one another. Chris (a 70 yr old estate agent) perceived health in these terms.

Healthy in mind and body, I'd say, that, one is as important as the other. Mmm, they can go hand in hand I suppose. The mind is very powerful too I would say, yeah, to be positive. Chris 70

James (a 48 year old teacher) describes being very much in control of and proactive about his health, and argues that good physical appearance is a precursor to emotional well-being.

...if you're told you look well, which I am regularly, its good for your well-being ... its a feel-good factor to be told that you look well, and that's where health comes in to it... I think a lot of it is pride, pride in how you look, and to be told at forty-eight you haven't changed in twenty years, I mean that was worth diamonds... and that's why I'm so conscious of diet, I'm so conscious of exercise, I'm conscious of all that, you know. James 48

Good physical appearance is complimentary to and a trigger to feeling well and appears to be the principal driving force in the way that James manages his health and engages in health behaviours. The corollary of the link between physical and emotional health is described by Kian (a 20 year old student), as he explains how 'depression' can be physically manifested in bodily appearance, while Cathal (a 44 yr old unemployed man) refers to a man's general demeanour as being indicative of health status and indeed health behaviour.

Sometimes it [being depressed] can effect the posture, you know the way some people if they're depressed are always slumped over and they look down, they look depressed, you can say a person looks depressed, you know. Kian 20

I believe, the more bubbly you are, the more clean you look, the appearance of your dress, whatever, I think makes the person, and you know that person, in fairness, I'm speaking just on the male side now at this stage, he's got up that morning, he's had his shower, he's had his breakfast, he's out there, he's wishing everyone a good morning, you know that he's healthy because he's got, he's got a buzz in him, but if you see a person not rising out of bed until twelve o'clock, probably strolling down to the shop to get his twenty fags and his paper, you know that he's just going back to sit down on the chair and basically[pause]...Cathal 44

Each of these accounts also suggests a strong

interconnectedness between physical and emotional dimensions of health. Good physical health, physical appearance and physical fitness are seen as highly complimentary to emotional well-being, while impaired emotional well-being can potentially be manifested in a 'depressed' physical body.

Constructions of health around the idealised male body

A number of young men, in particular, cite the growing influence of the popular press in feeling pressurised to conform to an idealised mesomorphic male body, and that failure to aspire to such physical appearance may have consequences in terms of emotional well-being. Paul (a 24 year old postgraduate student) emphasizes the pervasiveness of this message, and its potential impact on his own mental or emotional health.

...nowadays, we are bombarded with the image of the perfect male, I think my generation and definitely younger, is certainly going to start affecting... there is a self-consciousness there, for me personally if I don't look well, I don't feel well mentally. Paul 29

Robert (a 42 year old sales manager) concurs with Martin, but describes himself as 'gone beyond being a really fit person' and is now content to pursue what he describes as a 'casual fitness'. This is part of having an overall balance and harmony in his life and being able to put things in perspective and resist extremist behaviour.

*...its a balance... whether that's what you eat, how much exercise you do, the level of stress you have in your system, the work you do and getting a balance that you're comfortable with your lot as distinct from looking at this book and saying J**** I have to look like him... its like the craze of marathons twenty years ago, everyone had to run a marathon then. Robert 42*

Robert's rejection of the 'body beautiful' and what he judges to be the 'craze' of achieving extreme levels of fitness is noteworthy in the context of Watson's (2000) findings with Scottish men (i.e. men reacted against images of the idealised male body and were even likely to reject health behaviours that were implicit in such images). Images of the 'perfect' male body or the body as a machine that are used in health advertising or health awareness initiatives, may paradoxically constitute a form of resistance among some men to adopt health-promoting behaviours or to adopt 'healthy bodies'.

Despite some grave reservations expressed on the part of many of the men in this study about stereotypical male images, the mesomorphic model nevertheless appears to be embedded in a cultural understanding of what appears to be 'normal' or masculine, giving rise to abnormal or 'distorted' body shapes. As Connell notes:

Masculinity is not inherent in the male body, it is a

definition given socially, which refers to characteristics of male bodies Connell (2000, p76)

Garret (a 20 year old student) describes a utilitarian element to the pursuit of the idealised male body:

...for an awful lot of fellows our age to get in good shape, not just to be healthy and live long but to look good at the time... to be attractive say to the opposite sex

Garret 20

This echoes the underlying message of much of contemporary advertising, which identifies the mesomorphic male body as the principal means of attracting the opposite sex. This is consistent with the way in which the shapely female body has been used for considerable time. From the perspective of masculinity as a social construct, the likely impact of such advertising on the construction of a narrow and stereotypical definition of masculinity is a cause for much concern. Implicit in this stereotypical definition of masculinity is the expectation that the male body must conform to specific mesomorphic characteristics. This is very apparent in Kian's (a 20 year old student) sense of having lost some of his strength as a result of not having trained:

...you want to feel strong... I noticed when I was training, I felt physically strong and more able for things, like if I fell now or took a stab off someone [in context of sport], it would be sore whereas it shouldn't be, you know.

Kian20

Kian's resistance to the consequences of not being as strong as he would wish is evidence of his collusion with this narrow, mesomorphic definition of masculinity.

The significance of feeling attractive to the opposite sex as a motivating tool to being responsible for one's appearance and one's weight, is also borne out by the following accounts from students Garret and Conor:

They [unfit/overweight] turn into lad's lads... because the opposite sex don't find them attractive, they say, 'why bother like exercising or getting fit' Garret 20

...lads that don't seem to be scoring [with] girls very often, they just say 'ah sure, who cares', they have a few drinks with the lads and that's the way they kind of opt out of that aspect of their life, you know, they just leave out the trying to look good and trying to get a girl like and instead they just go drinking with the boys. Conor 21

The implication here is that failure to reach the 'heights' of the ideal male form or the 'successful male' (vis-à-vis the opposite sex) can result in young men throwing in the towel as regards trying to maintain a healthy weight or healthy lifestyle. Turning into a 'lad's lad' appears to have consequences not just for the marginalisation of the physical body, but also for the adoption of behaviours that are likely to be compromising to health. As outlined earlier (Section 1.4), one of the major challenges facing men's health at a policy or health promotion level must be to

challenge such stereotypes of male 'health'. If men's health is to be constructed around images of the idealised male body, then the vast majority of men may feel that any attempt to be proactive about health may be futile, and that such 'health' is in fact beyond them.

There was also evidence from the men's narratives of a lower value or status being consigned to men who are overweight. Tony (a 38 year old bouncer) refers to men's aversion to being told that they are putting on weight, or to be willing to acknowledge it. This, he believes is due to wide-ranging connotations of ill health, laziness, indiscipline and slothfulness that are associated with being overweight:

*...its definitely when someone says 'you're putting on a few pounds like', lads don't like it at all, they won't admit it but lads don't like putting on weight...if you're putting on weight, you're unhealthy... and you know, 'you're not doing nothing, you're lazy'... a lot of people have a tendency to think of is, 'oh he's a lazy s***, look at the weight he's carrying' and 'betya he doesn't do anything',* Tony 38

James (a 48 year old teacher) is perhaps even more forceful and vivid with the inferences that he draws in relation to a fellow guest at a recent wedding:

There was this particular chap, I mean, he was younger than me I'd say, but he had not one but three double chins on him, a big belly, he was five foot six high, and his wife was taller than he was, and she was grand looking, she was a lovely looking lady and I said to myself 'how does she put up with him like', you know, I mean why does she, I mean, she wakes up in the morning and sees him, she must love him to fecking bits like [laughter]... and when I see some of these lads with stunning wives, I mean what do they discuss like, its just beyond me, its certainly not his body, maybe he must have money or something ...and like to see that happening I mean in this day and age when we're supposed to be all educated. James 48

There is in James's view an inherent incompatibility between the short, overweight (and therefore) unattractive husband, and the tall(er), 'normal' weight (and therefore) attractive wife. Indeed, there is even the inference that this physical 'incompatibility' is somehow linked to a mental, intellectual or emotional incompatibility. Overall, the tenets that underpin James's line of argument show evidence of collusion with many of the tenets of hegemonic masculinity. Being short and overweight is incongruous in the aggressive and forceful male who can dominate other males, but especially females. This is consistent with Watson (2000) who reported that being overweight and the loss of body shape resulting from unhealthy behaviours was perceived to lead to a new shape that parodied the female body form, whilst premature ageing was also

associated with lost body shape.

Health as an 'embodied' experience

Many of the men either implicitly or explicitly grounded their accounts of health in terms of their own or other's bodies. As outlined in the previous section, health, or being healthy was described in terms of being of an appropriate or 'healthy' weight in relation to one's height, whilst there was also the implication of a link between body shape and (un)healthy behaviours. Implicit in James's (a 48 year old teacher) earlier account of being told 'you look well' is that of being an appropriate or 'healthy' weight for his height. Ian (a 47 yr old butcher) bemoans the onset of a 'beer belly', which he feels has made him 'less of a man' than he used to be.

I'm getting, well as they say the beer belly, I never had a belly as such but now I do and I find that it doesn't look well on me, I'm not the man I used to be, I'm not as trim as I used to be and I'd like to be quite honest with you. Ian 47

His assertion that it 'doesn't look well on me' suggests a desire to separate himself from something that has been imposed upon him rather than 'created' from within.

Tony (a 38 year old bouncer) attributes the consumption of too much convenience food with contaminating his body, or feeling impure in body:

I'd know after a couple of days, I'd actually notice, I'd notice it in my body now if I'd had too many takeaways.

How would that feel?(Interviewer)

Sounds a stupid word to say but...maybe a little bit unclean Tony 38

In contrast to Ian's sense of detachment from his 'beer belly', Tony describes being acutely aware of the impact of excess convenience food on his body, and describes it as an embodied experience. It may have been that Tony, a regular exerciser, may have had a heightened consciousness of his physical body, compared to Ian, who led a sedentary lifestyle. This raises the possibility of a heightened sense of unhealthy behaviours at the level of 'healthy bodies', and may be worth further investigation in light of the positive association between physical activity and other health behaviours (See Section 7.4.1)

Joe (a 38 year old social worker) describes another example of how falling outside the realm of the 'perfect male' had 'devastating' consequences for him as a young man:

...I can remember like in my early twenties when I began to lose my hair and the devastating effect that had on me, because the fact that I was losing my hair, I was losing my attractiveness, I was losing my you know, whatever worth I had... Joe 38

The impact that premature hair loss had on Joe's sense of

'worth' is particularly noteworthy in light of his earlier acknowledgement during the interview of having a low level of self-confidence and low self-esteem as a boy and a younger man. Sections 3.3 considered the relationship between hegemonic or traditional masculinity and men's detachment and disconnectedness from their emotional selves. In the context of image, this detachment or disconnectedness may place a greater focus on the body and the physicality of the body in the way that men define their sense of value or worth.

Holistic or 'individual health'

Tommy (a 38 year old teacher) describes a more holistic understanding of health, one that is more reflective and that has evolved in the context of his perceived 'individual' needs. In order to care more effectively for himself, Tommy describes a new sense of self that is more accepting and trusting of his own limitations:

I think there is a kind of an individual health that, that I developed for myself too like...I know when I need to go off and take a guitar and I'll really belt it out and I'll feel much better afterwards and I see that as a really integral part of health so there's the physical, mental, social, I think there is a kind of, that last one I was talking like art and music, I think that's kind of the spiritual health that really needs to be looked after as well. I suppose what I've really learned the last couple of years, coming out of different situations is to trust myself...what my mind is saying to me, to trust what my body is saying to me, to trust my instinct, to trust my feelings. Tommy 38

This notion of harmony and connectedness is in marked contrast to the more utilitarian concept of health described at the outset of this Section, which together perhaps serve to underline the broad continuum along which men's concept of health is based.

Sense of control over health

Throughout the narratives, there was a strong sense that staying in control of one's health was very much within one's own grasp. While conceding that fate can conspire against them, Mark (a 39 year old business manager) and Ray (a 47 year old accountant) nevertheless assert that their health status is very much within their own hands, the product of their own health behaviours or preventative health behaviours:

...there are different things that you can't prevent like, the big C...if your time is up, your time is up...there's an amount you can do...you can look after your fitness...not smoking...eating the right foods Mark 39

...other than that [hereditary diseases], I'd say its very much in my own hands Ray 47

Other accounts however suggest that aspiring to optimal health was subject to a number of constraints, and in

certain contexts was beyond one's own control. There was for example a tendency or willingness on the part of some men to detach or separate themselves from the consequences of their own unhealthy behaviours. This willingness to divest themselves of such responsibility was rationalised in a number of ways. Not being in control was an issue for some men – the notion for some overweight men for example that 'I have to eat whatever she gives me'; to outright denial of any sense of responsibility or cause and effect for other men – e.g. being overweight/obese despite 'never' eating the wrong things. Indeed, it may also be, that Irish society is complicit in this 'cop-out', by deflecting responsibility from the individual to forces outside the individual- e.g. 'he's a martyr to the drink. These findings are important in the context of the transtheoretical model of health behaviour change (Prochaska and Velicer, 1997), since it is unlikely that men will act to change unhealthy behaviours, if they do not have a sense of ownership of the behaviours in the first instance.

Physical decline with age

Throughout the narratives of middle-aged and older men, there was an acknowledgement of a sense of physical decline with age. As Peter, a 63 yr old pharmacist reflects: *I'm sixty-two now...and by and large I never felt any health problems until I reached sixty, and after, well then from sixty, you know, things began to creak a little bit, the bones and the joints and what have you. Peter 63* This finding has also been found in previous research. Aoun, Donovan, Johnson and Egger (2002) for example, noted that as men grow older they are likely to become more health conscious.

Married with kids – letting things slip?

Both marriage and fatherhood were identified as being hugely positive influences on men's health, specifically in terms of adopting positive health behaviours, improved preventative health behaviours and lower risk taking (See Section 7.10). There was however some evidence of marriage and fatherhood coinciding with a physical decline in men's bodies. Tom (a 38 year old plumber) identifies both as important life events for men in the transition to loss of physical fitness and increased body weight. In the same way that Watson describes these life events as precursors to 'letting go' or 'losing' the physical body (Watson, 2000, p89), Tom ponders whether marriage and fatherhood change men's sense of their 'need to impress anyone':

I see some of my friends say it doesn't bother them putting on weight, they're married now and settled down with kids...and maybe they don't feel like they need to impress anyone...so what if they're carrying a little bit of weight. Tom 38

Joe (a 38 year old social worker) identifies factors other than complacency that lead to a 'letting go' of the physical body. The stress of juggling family, domestic and work responsibilities are cited as a significant barrier to managing a healthy weight.

...time is the big one, stress, eh, its like I get up in the morning early, organise kids, out to school, all the hassle that goes with that and then into work and you know, be that in the office or out to, out on the road, and then come home in the evening and its organising dinners and there's a course on or you know, whatever it is, and it seems to be very little time to go and do some exercise...and the side effects are that you put on weight and I feel bad about myself and sluggish and tired and its like a never-ending cycle. Joe 38

Joe attributes this 'never ending cycle' to what he sees as an almost inevitable slippage of both body and mind by the time he reaches his late 30's, and does so once again against a backdrop of youthful invincibility.

...as a young person you can keep on going and you have youth on your side. I no longer have it on my side and its beginning to tell on me [pats abdominal region] and not just on my body but on my mind and my outlook on life...the cycle of being tired and stressed and running about...and I suppose the rescue remedies I go for are eating and drinking. Joe 38

Significantly, Joe acknowledges that the short-term 'rescue remedies' that he reaches for, may in fact be making additional compromises to his health. The use of potentially health-damaging behaviours to manage stress is highlighted in Section 7.6.4. In Joe's case, he is caught between an awareness of the limitations of his own body, and being immersed in a modern-day hectic lifestyle in which work, family and domestic responsibilities leave little time for meaningful self-care practices.

...it is not good to be going all the time without looking after the engine, and looking after the mind and, yeah, there is an alarm signal going on inside of me...and I suppose I don't want to get to a stage where the alarm signal is a heart attack or a breakdown or whatever it is... but I think its very difficult in today's society to actually make the time, or not only to make the time, but to find the time. Joe 38

Sexuality and Men's Health

Brookes (2001) highlights that for many men, sexuality and sexual activity is synonymous with masculine prowess. This gives rise to the notion of detachment between the physical on the one hand, and the emotional and mental aspects of one's being on the other. Jim (a 38 year old administrative officer) reflects in a very frank way on feeling deprived and betrayed by the manner in which he feels that his sexuality was stifled as a boy. The suppression of self and

of sexuality that Jim describes is consistent with the notion of a celibate masculinity that was/is an integral part of the Catholic Church's ethos, and that appears to be intrinsically at odds with the language Jim struggles to find – understanding, owning or accepting his sexuality. The consequences in Jim's case are highly significant, as he recalls the far-reaching impact that this had:

...sexuality wasn't talked about, we [boys] weren't in any way facilitated to understand it or own it or accept it or see it as being something positive... like it was always for me, something like that was very covert, very secretive... I think that whole area of sexuality affected my communication skills, affected my confidence, my self esteem, even in class it affected my speech like you know, if I was asked a question in class I would just dry up, I'd, you know, I'd almost, I'd develop a stutter...and relationship-wise, like you know, I was always conscious when I came back from a disco that I hadn't met somebody or I hadn't approached somebody and the terror that that instilled in me, like if someone tried to organise me to meet somebody or whatever, and that was because I just had absolutely no belief in myself. And the bottom line would have been like you know, well God even though I'd love to be with that person or whatever, I mean, what would they see in me. Jim 38

7.1.3 Summary & conclusion

The evidence from this study strongly suggests that health has largely been excluded from the culture and context of Irish men's lives. As a result, it appears that many Irish men can pass through their 20s, 30s and perhaps 40s without ever really being conscious or proactive about their health. Sadly, it seems to require the experience of a health crisis, in relation to either oneself or someone close, to act as a 'wake-up call' to an increased health-consciousness. There was no overall consensus amongst participants as to what constituted health. Most participants' accounts were consistent with the notion that health was synonymous with physical and mental/emotional well-being. There was a strong sense of health being tied in with constructions of the 'ideal' male body, and of health as an 'embodied' experience. Many men described the pressures of combining work and family life as a barrier to maintaining health, and more specifically to sustaining health behaviours and a healthy lifestyle. In such pressurised situations, the healthy 'choices' may not always be the easy choices. The diverse and in many cases more holistic concepts of health that participants articulated offer much to challenge the portrayal of the male body as a machine, a portrayal that has come to be almost synonymous with men's health and men's health promotion literature. While such measures may be the hook to get men more involved in their own health, there is clearly a need to define men's



health within a much broader and holistic framework

7.2 Male Patients Views on GP Care

As outlined in Section 2.7, it has been reported in the literature that men appear to be reluctant attenders at primary care settings, and generally consult their GP at lower rates than women. This Section will examine how Irish men approach the subject of going to their GP, how they view a range of aspects of GP care, and will explore the perceived barriers for Irish men in terms of accessing GP care.

7.2.1 Men do attend their GP!

Three out of four men (77.4%) reported having consulted a doctor within the past 6 months, with nine out of ten men (89.9%) having consulted their GP within the past year (Table 5.2.1). The latter compares with 75% of men who attended a 'well man' clinic in a Dublin general practice (O'Keffe, 2000) and 76% of American men (Commonwealth Fund, 2000) who had visited their doctor in the past year. As expected, older men were significantly more likely than younger men to have consulted their GP in the past year.

7.2.2 Women continue to play a key role in the help-seeking behaviour of men

Although men are sometimes less than gracious in acknowledging women's role, women continue to play a key role in the help-seeking behaviour of men. As Dave, (a 35 year old married factory worker) rather graciously notes *I'd eventually go just to shut her up. Dave 35*

Of the overall sample, 32.1% (97.8% of 'reluctant attenders'; n=180) cited a female close relative or friend as the person most likely to influence their decision to go to the doctor. This compares with 40% of men in the North Western Health Board area who reported going to the doctor at the prompting of a woman (Denyer, 1998). Norcross, Ramirez and Palinkas (1996) reported that American men were three times as likely as American women to list encouragement of the opposite sex (P=.0004), as the reason for visiting a primary care physician (in the case of respondents listing only one reason for the clinic visit). The authors concluded that it is women who are the principal brokers of health services in the American family, which may at least in part account for the gender difference in the health benefits accruing from marital status. As highlighted earlier in the context of mental health, men in relationships with women generally experience better health than single men, whereas women in relationships with men tend to experience poorer health than single women. Clearly, the more traditional

connotations of women as the caregivers and nurturers have not been lost in the context of Irish men. Inevitably this would appear to have implications for targeting women as gatekeepers from which to develop men's health initiatives, and in particular to increase men's utilisation of primary care services. Whether women should, or would wish, to be burdened with such a responsibility is of course questionable. Perhaps more importantly, as Baker (2002) points out, it does not encourage men to take greater responsibility for their own health and fails to cater for the high (and growing) proportion of men who are not in relationships with women.

7.2.3 Men prefer male GPs

Whilst men are overwhelmingly more likely to turn to women as a source of support in times of ill health, almost two out of three men (63%) expressed a preference for a male GP in relation to a private or personal matter, with older men being significantly more likely to express such a preference (Figure 5.2.7). Indeed, 93.5% of the sample reported that their usual doctor was male, although it should be said that the majority of GPs in the southeast region are male. Almost three-quarters (72.4%) of men stated that they would be equally happy with a male or female G.P. for a routine matter. Almost two-thirds of the sample group expressed a preference for a male doctor for a private/personal matter, This finding was borne out in the qualitative data, as Ned (a 65 yr old businessman) reports *I suppose one could feel a little embarrassed if it was a female, it depends on how important the issue was like. Well, it would be more difficult to open up to a lady doctor I'd say, for me rather than for a man. That's the way I feel about it, maybe once I'd get, become confident in the lady doctor, that inhibition would probably disappear, but initially I think I would probably I think I'd feel a little bit embarrassed maybe. Ned 65*

Barry (a 54 yr old unemployed man) believes that older men in particular would find it difficult to go to a female doctor with problems of a personal nature.

Some of them wouldn't go no matter what it was, others would probably not go, especially the older fellows I would think if it was something to do maybe with the prostate or all that sexual area or anything like that, they definitely wouldn't go near a woman, and they would even find it hard going to a man, you know. Barry 54

Whether men, and older men in particular, have less confidence in female doctors or are shy or more embarrassed perhaps, is a question for further investigation. These findings are particularly noteworthy in light of the growing number of women and declining number of men entering medicine in Ireland. Approximately two-thirds of all admissions to medicine in Ireland at present are female, with an even higher rate of

entry of female doctors to general practice medicine.

7.2.4 It may still be with reluctance that men go to their GP

Despite an overall pattern of satisfaction generally with GP services (Section 5.2), and that the vast majority of men reported attending a GP within the past year, over half of the sample (51.5%) expressed varying degrees of reluctance to attend their GP (Figure 5.2.6). This reluctance was more likely to be found among younger, less well-off and less-educated men.

7.2.5 Why are men reluctant attenders at their GP?

A range of factors emerged from both quantitative and qualitative studies, which may serve to explain men's reluctance to attend their doctor.

7.2.5.1 Factors associated with reluctance to go to a GP

The top three factors associated with reluctance to attend a doctor (Table 5.2.9) were playing down the problem (64.1%), cost (42%) and missing out on work (37.9%). Younger men were significantly more likely to play down medical problems and to cite work as a barrier, while work was also significantly more likely to be cited as a barrier amongst both less well-off and more highly-educated men. Other factors cited included a lack of after-hours service (31.1%) and excessive waiting times (26.1%). These and other factors associated with reluctance to go to the doctor also emerged as strong themes in the narrative data.

Late presentation – 'outdated hard drives'

A consistent theme to emerge from the qualitative data was a reluctance to seek help for medical problems, with many men preferring to delay for as long as possible before seeking medical advice. Dave (a 40 yr old factory worker) speaks of ignoring a problem and denying its existence rather than getting it attended to.

I wouldn't go down I'd have to leave it to the last minute to go down. its like as if you wouldn't believe that you're sick. I don't want to be sick, so I'm not sick even though you are sick. Have your head in the sand. Dave 40

While Dave's apparent pragmatic approach to dealing with illness may be quite plausible, this delayed help-seeking behaviour may be placing his health in serious jeopardy. Previous research has shown that early presentation as well as engagement in preventative health check-ups can play a vital role in the preservation of good health (Fletcher & Higginbotham, 2002). A number of participants intimated that they felt they would be wasting the doctor's time unless they had a 'real reason' for going. Chris (a 70 yr old estate agent) expresses this sentiment.

The fear that I'm wasting his time... because they're busy

men now these doctors, or women whichever, but, I would feel conscious that I was wasting their time unless I had a real reason for going. Chris 70

In Chris' case, help seeking is framed very much against a 'sickness' model of health. In other words, one has to be sick to look after one's health, as distinct from seeking health as a resource to protect.

Cost – '€40 to go and see him and another €40 for the tablets'

'Cost' (42%) was identified as the second most important factor that was associated with reluctance to go to the doctor (Table 5.2.9). Indeed, just under six out of ten non-medical card holders were dissatisfied with the cost of visiting a doctor (Section 5.2.3.2). The issue of money also emerged particularly strongly as a barrier for less well-off men, in the men's narratives. Tony (a 38 year old bouncer) states:

I'm not going down there, that would cost me a hundred Euros. Between the doctor and the chemist...I think finance, its not the only reason, but I think it does matter. Tony 38

Senan (a 19 year old building labourer) concurs with this: *€40 to go and see him and another €40 for the tablets...and he might say you have to go to hospital, and you have a lot of money to pay out then...and a couple of days in bed and you are going to be better anyway. Senan 19*

Trevor (a 52 year old community worker) identifies the double cost: the expense of acquiring health care, and also the time lost from work

If you cut your finger, and you have to go to the hospital, you could be sitting there for 3, 4 or 6 hours, and that's 6 hours of work lost, and you might only need two stitches in the finger...so its time, work and money. Trevor 52

Implicit in Senan's view is the notion of a self-healing ability that he will get better with or without the doctor's assistance. Both Trevor's dismissal of an injury that 'might only need two stitches', and his disquiet with cost rather than any concern for his own health, both suggest collusion with a working class masculinity in which foregoing safety and denying pain are central to upholding that masculinity. Niall (a 28 year old self-employed business man) expresses further annoyance at the cost of a visit to a GP, in the context of having already paid private and public health insurance:

...you have your private health care, pay for your public health care and then when you go to the doctor you have to pay again...they come in and see you, its (clicks his fingers) thirty-five euros or forty euros or whatever, its a scam like, and you're waiting there for hours to see them. Niall 28

Time off work

The need to seek time off work also appeared as an obstacle to seeking medical help throughout the men's narratives. Ian (a 47 yr old butcher) mentions his employer's dissatisfaction when he requires time off work to attend the doctor.

*Mine don't be too impressed when I'm going to the doctor, you know, and on the Monday I walked in and the usual greeting, good morning, how are you and all the rest of it, I'm alright but J**** I was often better, I had that all over the weekend, and did you go to the doctor, was that first thing straight away, as much as to say did you go on your own time like. Ian 47*

7.2.5.2 (Dis)satisfaction with GP Services?

There was somewhat of an anomaly between the general high level of satisfaction with GP services found in the quantitative study, compared with an overall pattern of dissatisfaction that emerged from the qualitative studies. The majority of male patients reported being satisfied with the specific measures of GP care that were assessed in the quantitative study (Section 5.2). Among the specific issues and perceived barriers to accessing GP services that emerged from both quantitative and qualitative studies were:

A desire for more flexible opening hours, notably during evenings and weekends

Although the majority of respondents were satisfied with practice opening hours (Table 5.2.2), over a quarter cited additional opening hours at evenings (28%) and weekends (25%) as being desirable. Indeed almost a third of respondents (31.1%) cited 'no after hours service' as a factor associated with reluctance to go to the doctor (Table 5.2.9).

A more male-friendly waiting room

14.5% identified doctors' surgeries being more oriented towards women and children as a factor associated with reluctance to go to the doctor (Table 5.2.9). There was a strong consensus throughout the narratives that GP waiting rooms were designed around the needs of female patients, and that the literature available, the décor and the very ambience of the waiting room were all oriented towards female patients.

Jason (a 45 year old unemployed man) contends that doctors' surgeries have become feminised in response to the disproportionate number of female patients:

The point is women go to the doctor, so doctors cater for that...so that's why they are not going to change their magazines or their pink wallpaper or anything. Jason 45

Ray (a 47 year old accountant) expresses very clear disquiet

and actively seeks to dissociate himself from 'falling in' with this system:

I certainly hate sitting in a doctor's waiting room... without being sexist, like there would be a lot of women and children and noise and nattering and I just wouldn't feel comfortable...you can't help feel that an awful lot of people in the surgery are wasting the doctors time... I'm not like them when I go in there but I have to fall in with that whole system and I'm treated the same. Ray 47

To subscribe to a 'system' that embraces 'noisy children' and 'nattering women' is clearly a challenge to the kind of masculinity that Rory wishes to embrace. He is quite explicit in his assertion that he is 'not like them', and even questions the authenticity of some patients' reasons for going to the doctor relative to his own. This desire to separate himself from the 'noise and nattering' of women and children, is at the same time an attempt to avoid being consigned to a subordinate or lower status masculinity.

There was also a sense that male patients simply didn't belong in this female stronghold. Jim (a 38 year old administrative officer) observes a degree of paranoia in what he describes as other men's torturous experience of the GP waiting room, and of their sense of being the focus of curiosity from other patients:

I've often picked up this foreboding brooding, almost, of men sitting there and they're saying nothing and all the messages say to me like don't go there, don't ask me why I'm here...and that made me feel very uncomfortable myself... there is a perception out there too that because men haven't gone to GPs that if they're at the GP they must be there for something quite serious. Jim 38

Calum (a 38 year old community development worker) similarly describes feeling under the gaze of his fellow (female) patients in a waiting room. In the absence of any overt signs of illness or injury, Calum projects his own discomfort onto suspicion on the part of female patients.

The last time I was at a doctors, I was the only man in the waiting room...and I didn't look like I had broken anything...if you go in and your arm is in a sling, people are looking at you and saying well obviously you broke the arm...but if you are sitting there and looking fairly healthy they are probably thinking it is the lump on your balls [earlier reference to testicular cancer]. Calum 38

A decrease in waiting times for consultations to begin

38.7% of respondents were dissatisfied with the duration of waiting times for consultations to begin (Table 5.2.4). 26.1% also cited 'excessive waiting times' as a factor associated with reluctance to go to the doctor (Table 5.2.3.2). The duration of waiting times emerged as a significant barrier throughout the men's health narratives, and indeed was cited as a source of frustration and anger

for some men. Nick (a 29 year old technician) and Ray (a 47 year old accountant) both express annoyance in relation to waiting times, and draw parallels with other professions: *...you get your lunch break at two o'clock, you get down to the doctor, half an hour later you're still sitting there, I mean, what are we running here, like I mean, someone makes an appointment to come and see me, by God, I'd better be there at five to two.* Nick 29

if you want to go and see a solicitor or an accountant or some other professional, well generally you don't have to sit in a room with forty other people and wait two hours over your appointment time... Ray 47

This may be particularly significant in the context of power relations between doctor and patient, and more broadly between men. Whilst the requirement to conform to a perceived feminised service is in itself challenging, to do so with the added demand of waiting for lengthy or unspecified periods confers a much lower status to the male patient in the overall construction of the doctor-patient (power) relationship. The issue of waiting times was highlighted as a particular barrier in the context of 'open' GP surgeries. A number of men reported frustration at being unable to get a GP appointment 'when you really need it', and instead having to attend a 'first-come first-served' open surgery system which inevitably resulted in extended waiting times.

Communication and inter-personal issues between doctor and patient

While two out of three men rated as 'good' or better different aspects of communication with their GP (Figure 5.2.1), men from lower social classes were significantly more likely to be dissatisfied with aspects of doctor-patient communication. Whether this is due to middle/upper class men being less honest in their appraisal of this aspect of GP care, or due to more deep-rooted class barriers between less well-off men and predominantly middle/upper class GPs, is a matter for further investigation. The same issues arose in the qualitative studies in relation to communication and interpersonal aspects of the doctor-patient relationship. Mick (a 47 year old electrician) describes being received by the doctor as a 'nuisance', while John (a 41 year old barman) bemoans the lack of trust or communication:

You're treated as if you're a bit of a nuisance and maybe they have to deal with a lot of nuisances, you know... you do get the impression that you're just another head, you know. Mick 47

...you could go to the doctor with a problem but you might have another problem that you'd like to bring up, that you might feel is a bit of a taboo or whatever, you have smelly feet or a headache or rash or whatever...but because of his manner... there's no relationship, there's no trust, there's no communication. John 41

John alludes to his own sense of embarrassment in confronting certain issues with his GP, which he feels is compounded by the lack of any meaningful relationship with his GP. Mick similarly seems resigned to being treated as a nuisance or as 'just another head'. This data also highlights the issue of class as a very real barrier in terms of how less well-off men communicate and develop relationships with their GP.

It is of particular concern that four out of ten men acknowledged leaving their GP's surgery (at least some of the time) with unasked questions, with younger men being significantly more likely to do so (Figure 5.2.2). Approximately one in three men identified a serious relationship problem with partner/spouse, suspected symptoms of an STI and impotence as issues about which they would find difficulty in talking to a doctor (Table 5.2.7). In the case of the latter, it is estimated that approximately 10% of men are living with impotence/erectile dysfunction (ED) in Ireland, although the majority of men may not seek medical help (Wagner and Tejada, 1998). Whilst the issue of men suffering in silence with ED is in itself of serious concern, ED can also be symptomatic of other illnesses such as diabetes, heart disease, high blood pressure, depression and alcohol misuse. It is also of particular concern that a third of men cited difficulties in talking to their GP about STI symptoms. Delayed help seeking in this context may have more serious repercussions not just for the men with STI symptoms, but also for their partners. Just over one in five men also identified a 'problem with back passage' as an issue that they would find difficult to talk over with their doctors. This may have implications in terms of late presentation as a factor in the higher incidence in Ireland of both colon and rectal cancer in men compared to women. For example, the number of deaths between 2000 and 2003 inclusive (CSO Vital Statistics, 2000-2003a) was 1.2 times higher for colon cancer (1361 male and 1166 female) and 1.7 times higher for rectal cancer (692 male and 404 female).

A number of participants in the qualitative studies commented that they would be likely to delay seeking help if their medical problem was of a personal nature. Chris (a 70 yr old estate agent) in answer to a question about a tendency to delay help-seeking states simply:

I suppose there are certain parts of the body that men eh, don't like discussing or being examined. Chris 70

A number of other participants reiterate this notion of male patients feeling uncomfortable dealing with medical problems of a personal nature.

Ned (a 65 yr old businessman) comments on men's innate shyness and traces their reluctance to discuss personal issues to their upbringing.

There's an innate shyness in a lot of Irish people, Irish men in particular. That goes back to the way we were brought up, again as I said to be seen and not heard. The men just don't want to discuss their personal problems unfortunately. Ned 65

Courtenay (2004, p6) refers to the American Medical Association, which recently described as a 'health hazard' for many men the lack of clinician-patient communication, and called on health professionals to overcome the barriers that men's embarrassment about health issues can create. Courtenay also notes that poor communication is linked with inaccurate diagnosis, poor compliance, poor outcomes, low patient knowledge and low knowledge retention. The data from this study highlights the need to improve the communication and inter-personal aspects of GP-male patient relationships, particularly in the context of lower social class and younger men. By seeking to improve aspects of GP-male patient communication, the issue of men's reluctance to attend their doctors, or to present late during the course of an illness may begin to be addressed.

7.2.5.3 The incongruity between going to the doctor and adhering to traditional notions of masculinity

In a number of participants' accounts as to why men reluctantly seek help there is the implicit belief that help seeking is almost to admit a defeat of some sort. As Peter (a 63 yr old pharmacist) notes, going to a GP can almost be seen as a sign of failure.

But they feel that its a sign of failure to have to be rushing away to a GP, that you're not, you know, there must be something wrong with you if you have to do that. Peter 63

John (a 38 year clerical officer) identifies the presence of traditional notions of masculinity as the principal barrier associated with men going to the doctor:

...growing up, males learnt that to be male is to be strong, not to show weakness, its almost as if sickness robs us of our power and our strength and our ability to provide... because of that its a lot more difficult for a male to first of all see the need to go, secondly to actually to have the courage to overcome what others might think or feel about me going to a doctor, and thirdly in some sense its an admittance that I've failed or something or that I'm not strong as a male. John38

That men may not 'see the need' to go suggests a denial or suppression of that need rather than any objective assessment on their part. Jim (a 38 year old teacher) proposes that the language of 'looking after' oneself is incompatible with men of his father's generation:

The language of looking after...its almost like trying to put software into a computer that just won't receive that

software...like a computer his age, and I suppose the present thinking that males should look after themselves, its as if that piece of software is just not compatible with males of his generation. Jim 38

The analogy of outdated hard drives that are simply incompatible with new software powerfully depicts Jim's sense of despondency that his father can ever overcome the barriers to self care that compliance with traditional masculinity demands. Although Jim is hopeful that men are beginning to change, he is still acutely aware of the link between traditional masculinity and the denial or rejection of self-care practices:

I think males are beginning to come through a little bit that we should look after ourselves but I still think the message is, you deal with it yourself, you hide it, you work it off...you suffer on, its almost as if you don't deserve to look after yourself...or that if you do look after yourself you're not really truly male. Jim 38

To go to the doctor is to be perceived by others as a failure and to be experienced within oneself as a failure. Weakness and failure are constructs that contravene a traditional hegemonic masculinity, which positions men as strong and resilient. For a man to declare himself to be vulnerable or in need of help is seen not just as 'non-masculine' behaviour, but even as effeminate behaviour. The risk of being labelled feminine or effeminate is perhaps the most critical barrier that stands between men seeking help for a problem sooner rather than later.

Thus, it would appear that this prevalent construction of the masculine ideal may be damaging to the health of men, by constructing positive health behaviours such as help-seeking as contrary to this restrictive notion of masculinity. Clearly, therefore, one of the major challenges within 'men's health' must be to set about reversing the premise that being sick or going to the doctor somehow represents failure or personal weakness in men. It is worth noting for example that the opposite is the case in Japanese culture, where it is seen as honourable and 'manly' for Japanese men to seek help rather than to risk more serious ill-health in the long run, thereby losing out in more lost days from work etc. As Bonhomme notes, healthcare needs to be portrayed as a strong ally of modern day constructions of masculinity –

"... men taking charge of their health can help them attain, maintain, or regain their greatest potential productivity, vitality, strength, virility, stamina, attractiveness – all the things that make men 'feel like men'" Bonhomme (2004, p5)

7.2.5.4 Men are very often afraid to seek help

Fear of seeking help or of confronting health issues

emerged as a very prevalent theme in both qualitative studies, and was also explored in the quantitative study. John (a 41 year old publican) describes fear, mixed with a strong sense of fatalism, as how he views men's reluctance to consult doctors to seek help:

...its the way we were brought up like, you have fear of the guards, fear probably of the teachers, you have fear of the priest, and you have fear of the doctor, and they could all send you to a different place John 41

Guards, teachers, priests and doctors are categorised as one homogenous group that John and his generation were taught to 'fear'. Going to the doctor therefore was not seen as a support or as a resource from which to seek help, but rather as a means of being divested of autonomy and power. The key to this threat was the perception on the part of boys and men that they were being divested of their autonomy and power, and that the doctor was in complete control of their fate. This seems to have left a legacy in the way that John still views the subject of going to the doctor: **...we always expect them [doctors] to send you to hospital, there's not going to be any good news...John41**

The quantitative study also explored issues that may have contributed to fear or anxiety about going to the doctor (Table 5.2.10). The top three factors associated with fear or anxiety about going to the doctor were concern about having a serious condition diagnosed (32.6%), concern about being admitted to a hospital as a result of the visit (25.3%), and the prospect of having private parts examined (20%). In the context of the latter two, less well-off and less-educated men were more likely to express fear or anxiety. The many guises of fear – silence, denial, procrastination, fatalism, - emerged in the second qualitative study, and are evidence of men's struggle to openly acknowledge and allow fear as a perfectly normal part of coping with sickness and seeking out medical help when sick.

Ray (a 47 year old accountant) suggests that fear of what 'might be' may paradoxically be the reason for him not to seek help:

if it is really going to be very bad news, kind of, I really don't want to know about it, there's a fear factor. Ray 41

Another mechanism is to deny the very possibility of becoming ill. John (a 41 year old publican) states:

...you know somebody else who will get it, its never going to be you. John 41

Jim (a 38 year old teacher) implicates men's denial of illness with Irish martyrdom, which has very strong connotations with notions of traditional masculinity. The 'manly' thing to do is to keep going in spite of ill health, with fear having been programmed into the 'hard drive' (see reference in previous section):

...its almost like you know, big boys don't cry, instead of going to the GP, you join the never-ending line of martyrdom, martyrs like, here in Ireland, like you suffer on, you know, and I think that's something that we learn, as a male you put up with your pain or you put up with your illness. Jim 38

Richard (a 47 year old clerical officer) is at best optimistically naive in the way he views men's procrastination about going to seek help:

...yeah, we push stuff under the carpet... its the procrastination scenario, we'll leave it now until six months, 'ah sure I'll get that checked out in six months', it comes to six months, hmm, nothing happens and 'ah it'll be alright'.. maybe it'll get better. Or maybe, maybe it'll heal itself or something. Richard 47

This is linked to what Calum describes in a somewhat angry tone as men's fatalistic approach to ill health:

In all of us, there can be a quiet, fatalistic kind of thing...men are more inclined to say 'when you're time's up, you're f*ing gone like' ...and that's shite talk.**

Calum 38

All of these issues – fear/denial of symptoms, 'soldiering on' in spite of ill health, a sense of fatalism, the notion of a self-healing ability – are likely to be highly significant factors in the context of men's late presentation in a range of health issues. This, as highlighted earlier, has been strongly implicated in the rather grave morbidity and mortality data on men's health.

Barry (a 54 yr old unemployed man) speaks of his fear of discovering that he might be seriously ill, a fear that prevented him from visiting his doctor until six months after he initially noticed his symptoms.

But I know sometimes myself I can get a bit frightened about going about a thing. I remember the time I had one little tiny scab on my back, it took me six months to go to the doctor about it to mention it, and she said that's only a hair she said, it keeps breaking and its nothing to worry about. If she had to say it was a skin cancer growth, but it wasn't. But there was I, for six months in torture, mental torture over that and wouldn't go. Barry 54

This latter account highlights that it may not so much be the reality of ill health itself that is at issue, but rather conjecture on the part of men themselves, of pondering what might be wrong in the absence of confirming what is wrong.

7.2.6 Summary & conclusion

Although the vast majority of respondents to Study 2 reported having consulted their doctors within the past year, it is nevertheless with reluctance that over half of men approach the subject of going to their doctor. Playing down symptoms, cost and losing out on work were attributed

most to this reluctance. Although men prefer male GPs, it is most likely at the behest of a woman that 'reluctant' men end up going to the doctor. Areas identified for improvements to GP care included more flexible opening hours, a more male-friendly waiting room, decreased waiting times for consultations to begin, and improved communication between GPs and male patients. Fear of going to the doctor, and more specifically fear in pondering what might be wrong, emerged as a very salient theme in the men's narratives.

One of the most important challenges facing men's health must be to reverse the premise that being sick or going to the doctor somehow represents failure or personal weakness in men. Healthcare needs to be portrayed as a strong ally of modern-day constructions of masculinity.

7.3 How Men Cope With Illness

7.3.1 Coping with illness – a sliding scale of acceptability

There was evidence throughout all three studies of men feeling constrained in being open and honest in dealing with illness. The nature of the illness or problem strongly influenced the extent to which men felt that they could be open. The issues discussed in this section should be considered in light of the findings from Section 7.10.1, which were that three out of four men reported adopting strategies of 'avoidance' or 'silence' in terms of how they managed themselves through an emotional or mental health issue.

In Study 2, a number of health issues were highlighted as being perceived as difficult for men to communicate to their doctors (Table 5.2.7). For example, one in four men cited 'problem with back passage' and one in five 'stress or a mental health problem', as issues about which they would have difficulty in talking to their doctors. Throughout the men's narratives there was a consistent theme of certain illnesses/ conditions being seen as less acceptable to men than others. John (a 41 year old publican) distinguishes between medical conditions that he feels have different degrees of acceptability for men:

...if a woman has a headache, you say well that's fine, it's a woman's thing, you know, but if a man has a headache, you kind of say [extended laughter], 'a man shouldn't have a headache...he shouldn't be complaining about it'...if we have a broken leg or a broken arm, that's simple, it's black and white, and you go to the hospital or you go to the doctor but I think we kind of deal with an illness differently to an injury. John 41

Similarly, Tom (a 38 year old plumber) points out that

problems that may arise from feats of masculine prowess are deemed to be much more acceptable to men:

...lads don't mind showing scars...or stitches, oh yeah, they're war wounds, that's alright like. Tom 38

Against a backdrop of traditional constructions of masculinity, this raises the proposition of a sliding scale of acceptability, in terms of conditions or ailments that are deemed to be appropriate for men to acknowledge. Whilst scars, stitches or broken limbs might command a high degree of acceptability or even respect, a number of men were adamant that to acknowledge sexual-related problems or problems associated with mental health such as stress or depression, were simply taboo for men. James (a 48 year old teacher) struggles both literally and metaphorically to find the language to talk about testicular cancer:

*...Testic-, yeah, again that's a boo-boo, people don't want to talk about that, do you know what I mean... I mean if you had a lump on your scrotum or whatever like that J**** C****, 'I cannot go in to the doctor with that, you know'. James 48*

Tony (a 38 year old bouncer) suggests that men's preference for dealing with stress is to ignore or conceal it: *definitely men don't want to talk about stress...they don't want to deal with stress, they don't want to admit stress, I think they relate that to a mental illness and that's a big no-no...you're a man, you should handle this... and if you can't there is something wrong like. Tony 38*

Gordon (a 52 year old unemployed man) similarly believes that concealment is the only viable option for a man who is suffering from depression:

I would not tell anyone that I was depressed...I'd just hold it back in there [thumping his chest] and go on about my business. Gordon 52

Even amongst younger college men, there is a strong sense of not feeling able to confide in a doctor (Garret, 20), and of maintaining a shroud of secrecy around a problem such as depression (Kian, 20).

Yeah like if its just sort of, you know, physical, yeah, I'd go to the doctor, but God no, seriously... I can't picture myself telling him I'm depressed like... Garrett 20

...if I was going to have to go to a counsellor or something like that I wouldn't tell anybody like. Kian 20

Cian (22) perceives that there is a stigma associated with depression. A man's 'failure' (as defined by help-seeking behaviour) to grapple with a mental or emotional health issue, strikes at the very heart of his 'manliness'

I think there is a stigma attached to going [to seek help for depression]... yeah, less of a man like because he's just not been able to deal with his own problems, has to go looking for help like...Cian 22

Courtenay argues that men's unwillingness to seek help reinforces the social construction of their invulnerability to depression.

...denial of depression is one of the means men use to demonstrate masculinities and to avoid assignment to a lower status position relative to women and other men

Courtenay (2000a, p1397-8)

Schofield et al, (2000) note that men are much more likely than women to focus on physical problems and less likely to report concerns relating to mental or emotional problems. The question remains as to whether this is due to a comparatively lower incidence of mental or emotional problems, or to reluctance on the part of men generally to broach such problems because of the influence of hegemonic masculinity. Brookes (2001) cites evidence to indicate that male depression is far greater than previously suspected, being suppressed and manifested through more 'acceptable' male outlets, such as alcohol abuse and aggressive behaviour. It is worth noting in the context of Brookes' findings, the rise in recent years in Ireland in both the scale and pattern of alcohol consumption and in the incidence of violent crime. This paradoxically is against a backdrop of a lower incidence of reported depression in men. It has also been posited in this report that 'being aggressive and argumentative' (56.2%) and 'drinking' (46%) were behaviours used at least occasionally by respondents to manage stress (Table 5.5.6). This data strongly supports Brookes' case, that suppression of depression is indeed an issue for Irish men, and that alcohol and violence may be seen as more acceptable means of managing the condition.

Tony (a 38 year old bouncer) suggests that the pub may indeed be a coping mechanism for some men who are suffering from stress, and also implies that other men may be less than supportive of the man who is feeling stressed:

...a lot of the time, fellows would go to the pub, and have a drink... more so to forget about it [stress] than actually talk about it... rather than sitting down talking about it, and again, I think, 'ah he's a whinger'... you know, and then no one likes a whinger. And everyone seems to feel sorry for him for a week or two after that then its... 'like I'm not listening to him anymore'. Tony 38

Harry (a 23 year old student) cites aggression and possibly violence as a means of coping when one 'snaps' as a result of what one suspects may be more than simply a 'bad mood'.

...like if you're in a bad mood about something, you know, you're going to take it out on someone else maybe, if someone says something to you you're just going to snap...and then if there's friends with you, like they're not going to stand there and watch someone hit you...especially with a few drinks on them. Harry23

In summary therefore, there is clearly a taboo or stigma associated with both mental health and sexual health issues for men. In the case of the former, it may be that 'self-medication' with alcohol, and/or resorting to violent behaviour, may present more of a 'first-refuge' for many men, than to run the risk of being consigned to a lower status masculinity. Anger attacks and substance abuse have been associated with the management of depression in men (Kluger, 2003).

7.3.2 A desire for certainty when facing illness

A number of participants expressed a desire for certainty when confronted with illness. Ian (a 47 yr old butcher) spoke of his desire for a concrete diagnosis when he was admitted to hospital with chest pain and being content once he had received this.

There's just a lot of basic things like you know so once the angina was confirmed in *** I said... I was happy enough, I was yeah, I was'. Ian 47**

Cathal (a 44 yr old unemployed man) expressed a similar desire to be well informed about his condition and that obtaining this information helped him to deal with his diagnosis.

I actually knew nothing about it [chronic arthritis], so, and then I just picked it up as, as I was receiving medication, was basically how I got to grips with it and speaking, as I said, to my GP, and consultants or nurses or doctors down below in *** , that's how I coped with it. Cathal 44**

Both extracts are indicative of a sense of relief and comfort that men seem to experience when they make the transition, from the sense of uncertainty experienced prior to presentation to health services, to the sense of certainty experienced post diagnosis. As highlighted in Section 7.2.5.4, it appears to be the fear and uncertainty of 'what might be' that poses a bigger threat to men's health than the reality of ill-health itself. Men's desire for certainty in the face of illness would appear to be compromised however by: (i) men's poor knowledge/awareness of issues relating to health and ill-health (Section 7.8); (ii) men's hesitancy about seeking help (Section 7.2.5) or to seek support from others (Section 7.10.1); and (iii) the fact that sickness may dislodge them from their full strength or masculinity (Section 7.2.5.3)

7.3.3 The 'strong, silent' type – putting things off for as long as possible

"...(men) bottle it up...that's just the way we are"

Strong parallels emerged between men's attitudes to going to the doctor and how they coped with illness, with both being associated with constructions of traditional notions

of masculinity. Ray (a 47 year old accountant) grapples with the nature-nurture question as he attempts to explain the veil of silence that descends around men during time of sickness:

...men keep the problem to themselves, very much. Women talk among themselves better than men would among themselves so you probably bottle it up...that's just the way we are...maybe we're conditioned that way... its the macho bit or its some sort of weakness that you're admitting to or something like that. Ray 47

Ned (a 65 yr old retired businessman) raises the point that he believes men who do not discuss problems openly (including himself) are not able to cope as easily with problems as men who do discuss issues openly.

I'm not inclined to talk a lot about my personal health or my personal situation and I'd say people who are not prepared to talk about it openly are not as easily able to cope we'll say when something goes wrong. Ned 65

Ned goes on to explain that he believes that men do not reveal their feelings easily.

Well, men in general I, don't like to reveal their feelings as much as women, you know, it is obvious. That men, sort of have that self-contained image that they try to deal with their own problems, whereas I think women are able to talk about it even more and I suppose get more support from their friends as a result. Ned 65

Both Ray and Ned present an interesting construction of men in general. They are independent and stoic: in dealing with problems alone. This construction of men is made all the more powerful when contrasted with that of women (and perhaps 'weaker' men) who are free to share their problems with others and thereby gain support. From Ned's account there is a sense that men are constrained by this 'self-contained image'. By asserting that women are 'able' to talk about problems, it is implicit that men on the other hand, are 'unable' to or cannot talk.

Men's 'inability' to be open in Ray's opinion also creates an impasse in terms of men supporting other men through ill health:

Yeah, you don't even help them out [male friend with medical problem], not only can you not talk about yourself but you can't even help the person who is talking...

...not only are you a bit embarrassed about talking about a health problem yourself to other men, but they nearly feel you're embarrassing them and try to change the subject or try to ease you out of it and 'ah you'll be alright or get it seen to. Ray 47

Although Ray makes these assertions in the second person, he appears to reflect his own struggle to openly support other men during times of ill-health, and also to overcome what he sees as other men's reticence in terms of offering

him support at such a time.

Participants raised a variety of reasons why men are unlikely to openly discuss health problems. Ned asserts the influence of background and cultural and societal expectations.

I think its a fault in men generally, its something that we inherit or wherever we get it from, a lot of men at least...I think its an Irish trait because, maybe because we were downtrodden in the old days or something, but I imagine, you know, say my American friends now are more open and can talk of things more freely than we do. I'd say we're influenced by our background to a great extent, and the macho thing. Ned 65

Ned suggests that Irish men's reticence about being open is in fact an inherited Irishness. The idea of the effect of societal norms on men's health behaviours is again echoed when Ned mentions 'the macho thing'. This would seem to indicate that cultural influences that characterise a macho (Irish) identity as the desired embodiment of masculinity influence men's health behaviours, and in particular their willingness to seek help. There is therefore an apparent impasse between recognising and acknowledging the benefits of openness, but feeling constrained from being open by more traditional constructions of masculinity.

'... and some of its a Clint Eastwood approach'

Calum (a 38 year old community worker) suggests that men like to think that they are impregnable, and that their ability to survive difficult situations in the past will stand them in good stead for dealing with any illness in the future:

...and some of it is a Clint Eastwood approach – whatever comes, I've been here before. Calum 38

This sense of compulsion to present a brave front and to suffer in silence during times of illness can lead to men feeling isolated and alone. This is relayed by Eoghan Cahill, who established a help line (MAC – Men Against Cancer) following his own recovery from prostate cancer. During his hospitalisation, Cahill reports:

I saw big strong men who were garrulous and full of jokes about the 'waterworks department' when they arrived. When they left with nothing but a plastic bag of elephantine nappies under their arm, I saw broken men who didn't know how to cope.

Cited in O'Kelly-Browne (2002, p18)

Cahill bemoans the lack of support networks after surgery and concludes that

Men need to become more radical in terms of demanding that their health needs are met. (ibid)

The dilemma men face is that by speaking out or becoming 'radical' in relation to their health, they are acknowledging in a very public way their vulnerability, 'weakness' and their need for help, which is of course at odds with the

preservation of a 'masculine' identity. The apparently more attractive or safer alternative is for men to reconstruct or at least be complicit with hegemonic ideals of masculinity, which uphold health care utilisation and positive health beliefs or behaviours as forms of 'idealised femininity' (Courtenay, 2000a).

Resilience

A frequent response of participants, when asked how men cope with illness was to say they just 'get on with it'. This resilience and display of strength in the face of illness is on the one hand a means of constructing hegemonic masculinity, which defines masculinity in terms of displaying strength and denying weakness. On the other hand, it is also in keeping with what Macdonald and Crawford (2000) describe as a 'salutogenic' approach to men's health, an approach that places trust in the resilience of the human spirit to overcome adversity. Cathal (a 44 yr old unemployed man) speaks of his shock and disbelief at being diagnosed with rheumatoid arthritis, an illness he had thought affected only those older than himself. He clearly displays resilience in the face of his illness commenting that he 'just gets on with it'.

How I could get it, you know, so young? Well people say I'm young but I'm, I feel young but I'm forty-four this year so, but I always thought like there was only, only older people got it... I'm just, I just get on with it, I just have to. I just have to. It can be, it can be a sort of burden at times to get around, to do this, that and the other, but I just have to get on with it. If I don't I'm just going to be sitting in a seat and not ever moving again, so. Cathal 44

Barry (a 54 yr old unemployed man) demonstrated a similar resilience when he underwent a serious heart operation. He demonstrates his desire to deal with his health problems alone, refusing offers of help and preferring to travel for treatment alone.

Well I, I went up on the train myself, I brought no-one with me, I didn't want to be bothering anyone, I knew deep down I was going to come back, I came home then the ten days after and a friend came up and collected me alright, I got a taxi from the Blackrock into the railway station, he came home with me and I know that then I really was getting going downhill, no strength, no nothing. And, but I went home, I had offers to stay at this house, that house, 'no' I said 'I'll stay on my own' and I managed. My sister-in-law would come and do the shopping and my cousin's wife used take me here or take me there, they were all good that way. And, I pulled through. Barry 54

Emotional response to coping with illness

Section 7.10.3 highlights how some men seek to 'control'

their emotional responses to difficult situations, particularly in relation to issues that cause them sadness or despair. Section 7.2.5.4 also highlights the many guises of fear that emerged from the men's narratives, as they described their reticence to seek help for different problems. It is against this backdrop that a greater appreciation can be felt of Dave's (a 40 yr old unemployed man) plight, as he speaks of withdrawing and shutting himself off from those around him in order to deal with his illness.

I just kind of slipped away on everybody, just shut myself down. That's how I coped with it. Yeah that's how I got through. I remember actually the day that I just gave up on it all was when I was all built up. I was in such terrible pain, even with lying down, I couldn't move at all like. I just shut myself down from everybody, I just closed my eyes and let it all go and that's when they got the ambulance you know. Dave 40

There is a poignancy about Dave's isolation, and the huge emotional burden that his illness had upon him. There is also a sense of the energy-sapping nature of having had to suppress his pain for so long, and of 'shutting himself down' from the support of others. Although he uses language of having 'coped' and 'got through', he nevertheless seems to acknowledge both the futility of 'coping' in such a way, and the inevitability of finally having to 'close his eyes and let it all go'.

7.3.4 Men may opt to accept a modified or curtailed lifestyle rather than seek help

The consistent theme running through the previous section is that many men choose not to seek support when faced with an illness, and to put up a 'front' for as long as possible. A number of participants spoke about adjusting to or putting up with impaired physical functioning rather than seeking help. Kian (a 20 year old student) describes putting off going to the doctor until he was compelled by pain to do so.

I remember I got an in-grown toenail and it just got worse and worse and I just wasn't doing anything with it like because you could still walk and it was grand like...it was swollen and I used to play soccer as well, it was on me left foot so I kicked with me right foot so I wasn't too bad like and it just got worse and worse and worse and I had to just go in the end [to the doctor], but I just kept putting it off like... Kian 20

Although Kian describes a relatively innocuous condition, it raises an important question about the way men possibly adapt to and evolve with illness or disability over time, rather than addressing and confronting the illness or disability at the outset. It may well be that some men choose to cope by adapting to a modified or curtailed lifestyle, which over time becomes redefined as their

'normal' lifestyle. This may appear to be a more attractive coping strategy than running the risk of being labelled effeminate by declaring one's vulnerability and seeking help. This is a question that is worthy of further investigation in the future.

7.3.5 An acknowledgement of the need to change

Many men acknowledged the need to change their perspectives on coping with illness and seeking help. Robert (a 42 year old sales manager) recognizes the 'silent suffering' trait that has been inherited from past generations, but concedes that men need to be more open and more honest in the way that they react to illness:

It is the culture of the country...I mean if you go back to our parents or our grandparents and you know, the male side of our generations past, I mean those people suffered and suffered tremendously... they would, you know, work, work, work... males and females suffered but the females were nursed through their illness whereas the male just suffered through his illness... that was the honorable way to do it. Robert 42

I think there is still an element of this kind of silent suffering ...if we were honest enough and open enough to go when the early warning starts coming, that's the difference... its actually acknowledging and accepting the problem is where the big bottleneck is. Robert 42

There is a sense therefore of an impasse between recognising and acknowledging the benefits of openness, but feeling constrained from being open by traditional constructions of masculinity. John (a 41 year old publican) stresses that if men did not feel compelled to remain silent about ill-health before their friends or peers, that it would enable them to act more readily and to go to their doctor when they needed help:

If you do kind of share your problem with somebody else then it becomes demystified and kind of you're much happier then to actually go off and get a medical opinion on it. John 41

The key steps in 'demystifying' men's health, would appear to be in bringing men's health issues out in the open, raising the public profile of the issues and raising the level of acceptability that is accorded to men discussing these issues with one another. Such efforts are likely to challenge and contest more traditional constructions of masculinity that are associated with keeping these issues hidden.

7.3.8 Summary & conclusion

There remains a prevailing sense of men feeling compelled to maintain a 'manly' silence and stoicism in the face of illness. For many men, there appears to be a sliding scale of acceptability in terms of how they cope with different illnesses. The maintenance of a stigma that is perceived to

be associated with mental health issues in particular may prompt some men to 'self-medicate' with alcohol, and/or to resort to violent behaviour, rather than run the risk of being consigned to a lower status masculinity. Men's desire for certainty in the face of illness is driven by an apparent innate fear of that which is often uncertain about being sick or unwell. There is evidence of men being resilient and wanting to be resilient in dealing with illness, of overcoming adversity and 'getting on' with things. Where such resilience, however, results in 'blocking out' emotional responses to illness, there remains a large vacuum for men who attempt to cope in such a way. Some men's reticence to seek help may result in them 'putting up' with impaired physical functioning, which over time may for some men become defined and accepted as their 'normal' functioning. Finally, men appear to recognise the need to be more open in confronting illness, but are conscious that by so doing, they run the risk of stepping outside the boundaries of more traditional constructions of masculinity.

Raising the profile and level of acceptability of men's health issues, as well as contesting traditional constructions of masculinity that demand stoicism and silence in the face of illness, are crucial steps in supporting men to cope more effectively with illness.

7.4 Self-Reported Health Status and 'Health Neglect'

7.4.1 Self-reported health status

The level of self-reported 'poor' health (39.6%; Table 5.3.1) was higher than that reported elsewhere (CSO, 2001; Kelleher et al 2003), but differences in Lichart scales and the older age profile of men in this study may have been contributory factors to the higher levels here. It should be noted, however, that no significant relationship ($p > .05$) was found between self-reported health and age, which may be indicative of a surprisingly high level of self-reported 'poor' health among younger men. A significant and inverse relationship was found between self-reported poor health and physical activity level (Figure 5.3.1). Previous studies (e.g. Wankel and Sefton, 1994) have demonstrated an association between physical activity and other health behaviours, including a small negative association with smoking behaviours, better nutritional habits, and a small positive association with some preventative health behaviours such as seat belt use. At a time of growing concern about declining physical activity levels and increasing levels of overweight/obesity among Irish men (Kelleher et al, 2003), this is further evidence of the need for targeting increased levels of physical activity among Irish men.

7.4.2 'Poor' health status attributed to health neglect

Almost half (46.8%) of those reporting 'poor' health identified neglect of health as a reason for their impaired health status (Figure 5.3.2), with younger men (<30) being twice as likely as older men (>50) to so report (Section 5.3.2). This suggests that while young men can acknowledge that neglecting their health can contribute to poor health, it nevertheless is unlikely to curtail their negative health behaviours (high level of risk-taking and health-damaging behaviours). Overall, this has clear implications for introducing measures that will increase men's level of awareness of their health, and that will encourage and support men to be more proactive and responsible in relation to curtailing health damaging behaviours and increasing preventative health behaviours. The challenge in relation to younger men in particular is to highlight health neglect as an issue that may compromise young men's (and not just older men's) vitality, strength, virility and attractiveness. In other words, building clear and strong connections between health neglect and poor health outcomes is critically important in the context of the issues that matter most to men, and that have a relevance to their lives in the present and not just the future. Targeting young men may also be important, since patterns of health neglect that begin early in men's lives may become embedded and be far more difficult to reverse in later life.

7.4.3 Self-reported long-term illness/disability

One in three men reported a long-term illness, health problem or disability (Figure 5.3.4), with older and less-educated men being more likely to so report (Figure 5.3.5). While the aetiology of such impaired health status may be quite complex, this finding is noteworthy in light of the higher levels of non-fatal but limiting injuries in males compared to females (21% v 14%; Kelleher et al, 2003). It is also striking in the context of the comparatively high level of non-fatal but limiting injuries in specific occupational groups. For example, McNamara et al (2002) reported that disability continues to be a major concern among the farming community. 19.5% of farm households reported one or more persons with a disability, with 75% of farmers from such households considering that the disability impacted on the operation of the farm business.

7.4.4 Late presentation a contributory factor to self-reported long-term illness/disability

Just 6.3% of respondents to an open question identified late presentation as an example of neglect that led to health problems (Table 5.3.2), and just 2.8% identified

'earlier presentation' as something that could have helped them to manage health problems more effectively (Table 5.3.4). Yet, almost one fifth (17.7%) of those reporting a long-term illness, health problem or disability attributed late presentation as a contributory factor to the illness/disability (Figure 5.3.5). Whilst this figure should in itself be a cause for concern, it may well be that the issue of late presentation may not have been reported (or not recognised as a reason to report) by many other respondents. These figures are set against (i) the findings from Sections 5.2-5.6, which highlight a range of barriers that may prevent men from seeking timely help; and (ii) playing down symptoms ('problem is rarely serious enough') was identified as the factor most likely to be associated with reluctance to go to the doctor (Table 5.2.9). It seems reasonable to hypothesize that men attribute little importance to late presentation in the wider context of men's lay concept of health neglect. One can conclude that men's tendency to minimise health problems, may in turn cloud their judgement of the extent to which they themselves may be responsible for neglecting their own health.

7.4.5 Men's own perceptions of how they neglect health

The most common areas of neglect that were identified as having resulted in health problems (Table 5.3.2) echo those already identified at the level of public health and health promotion. The top four factors associated with neglect of health were smoking (38.7%), poor diet/overeating (28.8%), excess alcohol consumption (20.9%) and sedentary lifestyle/lack of exercise (16.8%). Indeed, smokers, excessive drinkers, binge drinkers, inactive men and those who reported as ineffective at managing stress, were significantly more likely to report having neglected/paid little attention to their health over the course of their lives (Table 5.3.3). This confirms that men who engage in negative health behaviours do attribute such behaviours to health neglect. This is an important precursor to getting men to take responsibility for acknowledging their part in the neglect of their health, and is a basis for setting about achieving behaviour change. It cannot, however, be assumed that change will follow, and measures to counteract health neglect must for example take cognisance of the Health Belief Model. This is based on a framework for motivating people to take positive health actions that uses the desire to avoid a negative health consequence as the prime motivation. It may also be worth considering Bandura's social learning theory, which, to take smoking as an example, is based on making a negative health behaviour socially unacceptable (Bandura, 1978). This has particular relevance for young men, where in the

case of alcohol consumption for example, enjoyment, loss of inhibition, increased confidence, a sense of invincibility, sexual freedom and most importantly a sense of 'fitting in' present a very powerful rationale to young men to drink, and to drink excessively or to binge drink (See Section 7.5.1.4). The challenge must be to: design interventions that target peer group norms, that are introduced before the targeted behaviour has been adopted as a core part of the peer culture. To cite the example of young men and drinking, it is imperative to start introducing interventions in the early teenage years. The use of sporting role models could also play a key role in preventing a drinking culture being adopted within the peer group

7.4.6 Men's own perceptions of what would have been needed to manage health more effectively

The issues identified by respondents as being necessary to manage health problems (Table 5.3.4) echo those areas identified as being the cause of neglect, with abstinence from/curtailed access to smoking (13.4%), improved dietary habits (11.3%), and increased physical activity/exercise (9.2%), being amongst the top four. The factor identified by most men (improved information/education/awareness: 21.8%), adds substance to the assertion made in Section 7.1 that there has been an overall absence of men's health initiatives in Ireland, and that men have not been well supported to take responsibility for their own health. Indeed, the high percentage of young men in particular who identified their own neglect as contributing to the 'poor' state of their health, emphasizes the absence of a consciousness around health, particularly in relation to young men. This does appear to change as men get older, which points towards a need to support older men who may want to change. It also highlights the need for more innovative and relevant interventions that target young men specifically.

7.4.7 Summary & conclusion

Whilst the focus in the literature tends to be on the rather stark mortality and life-expectancy figures for men, there is a danger that morbidity data, and in particular, factors that contribute to morbidity among men, might be overlooked. Half of those reporting poor health attributed impaired health status to neglect of health. Neglect of health was attributed to negative health behaviours. It appears however that men attribute little importance to late presentation in the wider context of their lay concept of health neglect. This data suggests that in order to reduce male morbidity levels, men, and in particular 'reluctant attenders' at GP services, should be supported to overcome

their difficulties in attending their doctor, to present early rather than late in the course of an illness or health problem, and be encouraged to take greater responsibility for their own health.

7.5 Lifestyle/Health Behaviours

7.5.1 Alcohol

7.5.1.1 Levels of alcohol consumption

18.6% of men in this study (Table 5.4.1) reported consuming 21 units or more of alcohol per week (excessive drinkers), compared to 30% among men who reported consumption in excess of 21 units from the recent SLÁN survey. The comparatively lower level in this study is most likely attributed to the older age profile of the sample. Excluding non-drinkers, 24.8% of the drinking population in this study were excessive drinkers. One third of the sample reported at least weekly binge drinking (Table 5.4.2). Men aged 18-29 were significantly more likely to be excessive drinkers and to binge drink, and the sharp drop in both excessive drinking and binge drinking in the 30-39 year age group is noteworthy. This may coincide with a change in men's marital status and/or parental status, which have been shown to have a positive impact on men's health behaviours (See Section 7.10). Half of men in the 18-29 years age group reported weekly binge drinking, adding substance to the assertion by Ramstedt and Hope, (2003), that binge drinking has become the 'norm' in Irish society. Binge drinking was also more likely to be associated with less well-off and less-educated men. The backdrop to these drinking patterns is that increased alcohol consumption at a population level is associated with increased alcohol-related harm, while the extent of the harm is strongly influenced by 'binge drinking' patterns in the culture (Ramstedt and Hope, 2003).

7.5.1.2 Consumption and culture

Patterns of alcohol consumption synonymous with a 'drinking culture'

Throughout the men's narratives, there was evidence that a strong culture exists in Ireland around the notion of 'manliness' and 'drinking capacity', and both excessive alcohol consumption and 'binge drinking' are often used as a very public display of allegiance to male peer groups. The presence of a drinking 'culture' or pub 'culture' is evident from Cian's (a 22 year old student) perception of an inherited pub culture, and John (a 41 year old publican) who raises the somewhat paradoxical association between the Church and the nurturing of an Irish drinking culture, quite literally from the cradle to the grave!

People in Ireland seem to drink for everything...there's a pub culture that's been there for years. Cian 22
...all the important things that happen in life, kind of funerals, baptisms, Holy Communions, Confirmations, weddings, are all drink related. John 41

Young college men also describe how the culture of drinking is an integral part of young men's lives. Gavin (a 20 year old student) asserts that this culture is nurtured even before young men leave school:

You're missing out if you don't drink. I remember back in school...if I didn't go out with my friends (drinking), they probably wouldn't have ended up being my friends...I'd have missed out on a whole social scene. Gavin 20

This is a very powerful assertion that drinking was essentially a rite of passage for entry to the peer group, a resource for the active construction of masculinity and a means of defining collective gender practice (Connell, 2000). Although excessive and binge drinking levels decline with age, the following extract would suggest that attitudes to such drinking behaviour, and in particular the association between this type of drinking behaviour and 'being a man', is much slower to change, and retains a sense of glorification.

Self-proclaimed modest drinkers at this stage, Ron (a 47 year old accountant) and Robert (a 41 year old sales manager), recall with some pride their indestructible drinking youth, when their ability in particular to recover from heavy bouts of drinking was at its peak:

About twenty-five, thirty years ago I could go out and have a basin of drink and I'd still get up for work the next day and by the next night I'd be back to normal but that doesn't happen anymore. Ron 47

...its fine when you're young and you're fit and you can take that, and tomorrow I'm ready to go for another gallon.... Robert 41

The scale of the drinking is noteworthy, with the terms 'basin of drink' and 'another gallon' clearly depicting large scale sessional drinking. It is also apparent, however, that this youthful capacity for drinking also enabled them to repeat the pattern on successive nights. Ron describes having recovered sufficiently by the next night to be 'back to normal'; and Robert concludes that 'its fine' once you 'can take that'. Whilst there is a clear acknowledgement that time and ageing have curtailed their youthful capacity to drink, there is nothing to suggest that they now believe this behaviour to be inherently damaging to health, nor that they are now ready to condemn such drinking behaviour. Their own drinking behaviour may have changed, but their attitude and outlook on drinking still suggests complicity with traditional constructions of masculinity that bestow certain value and bravado on heavy and persistent drinking behaviour. This is noteworthy in light of Dr Mary Cunningham's (National Youth Council Director) recent

comments that:

...youngsters who abuse alcohol are holding up a mirror to their elders.

McArdle, 2004

Young men and drinking

Colm (a 22 year old student) describes the sense of enjoyment that he gets from drinking and being drunk:

its comfortable to be drunk as well, its a nice feeling...everything seems funnier...any situation that you are in seems much, much better...you never have any nights as good as the nights when you are out drinking...it accentuates the positive of the night.

Colm 22

This loss of inhibition and perceived increased confidence is also evident in Kian's (a 20 year old student), Erick's (a 21 year old student) and Ger's (a 20 year old student) attitudes to drinking:

People are a lot more relaxed [after alcohol consumption], they don't really care...people are more open ...the quiet guy who mightn't say anything will stand up and crack jokes. Kian 20

Ah you're much braver, braver when you drink. Erick 21
its [drinking] to meet girls as well like...its easier to talk to them like... well it kind of lowers inhibitions... its a confidence trick, you know...and its where you meet the drunk girls as well [laughter from the group]. Ger 20

Young men's sense of being more relaxed, more open, braver and more confident – particularly in negotiating relationships- constitutes a very powerful rationale in favour of drinking for these men. There also appears to be an air of invincibility around young men and drinking. These accounts confirm the findings of a recent report on the impact of alcohol advertising on teenagers in Ireland (Department of Health and Children, 2002b). The report found predominantly positive beliefs among older teenagers towards alcohol, and these beliefs related in particular to 'affective enhancement and social facilitation' (p36).

7.5.1.3 Impact of alcohol advertising – 'no parent or teacher can compete'

There is a very strong endorsement of various alcohol products through sport in Ireland, and the association between alcohol and traditionally masculine codes of behaviour is particularly marked. Connell (2000) contends that alcohol advertising consistently attempts to connect alcohol use with prominent displays of masculinity. This is borne out by Jack's (a 38 year teacher) description of the impact of alcohol advertising on young people, and the challenge that this poses to parents and teachers. Jack raises the fascinating and perhaps daunting prospect of parents and teachers having to vie with a major drinks company to

influence the attitudes that children in their care develop in relation to drinking:

*...people are learning like you know, you cannot have fun without alcohol. Alcohol will make you powerful and strong, alcohol is associated very much with sport and with glory and heroism and its associated with kind of being clever and getting you places in relationships and all these messages are going out and young people are very very vulnerable and they very much model themselves and they imitate you know...and I mean its very hard to compete with that and I mean no parent or teacher can really compete with that because we don't have as much resources as ***** or any of these other companies... Jack 38*

Connell (2000) suggests that the advertising used by the drinks industry frequently addresses anxieties that are most acute in adolescence, and attempts to connect alcohol use with prominent displays of masculinity. These include clear connotations of sexual freedom and sexual prowess, and the achievement of optimum performance in elite sport. The banning or at least serious curtailment of such advertising is a measure that needs to be urgently addressed.

7.5.1.4 Harmful drinking-related consequences

Drinking and increased risk behaviours

There is also strong and unequivocal evidence from this study linking both excessive drinking and binge drinking to an increased likelihood of risk behaviours. Excessive and binge drinkers were significantly more likely not to wear seat belts in the back of a car; not to observe speed limits; to have driven having had two or more alcoholic drinks; to have been a passenger with a driver who was drunk; to have engaged in unsafe sex; and to report 'drinking' as a means of managing stress. (Section 5.4.1/5.4.2). Ramstedt and Hope (2003) reported that the level of 'harmful drinking related consequences' in Ireland is approximately twice as high as that reported in most other European countries. It is also well documented that increased alcohol consumption is associated with increased alcohol-related problems, including drunkenness arrests, street violence, assaults and domestic disturbances (Garda Siochana, Annual Report 2000/2002).

'Young men, full of drink, full of bravado, sticking their chest out'

Whilst the following account (Tony, a 38 year old bouncer) still suggests that the pint glass is still in vogue for young men, its contents marks a dramatic shift from the more traditional Irish male drinking habits:

There is lads getting like three vodkas in a pint glass and putting a Smirnoff Ice in on top of it, which is a vodka based drink... or the double vodka and Red Bull, that's another one in a pint glass...and the shorts thing, I mean I explain to them a lot of times, 'lads go out and drink pints all night, it'll keep you out of trouble', when they drink the shorts, then they get to their blackout stage and they get to that angry stage... Tony 38

It is with chilling frankness and acceptance that Tony describes the transition to 'blackout' and 'angry' stages that almost inevitably results from such drinking behaviour. It is against this backdrop that his advice ('drink pints all night, it'll keep you out of trouble') is perhaps less preposterous than it might seem. Nevertheless the condoning and indeed encouragement of 'all night' drinking reinforces once again how embedded drinking is within the culture. It is not the level of drinking but the type of drinking that is being questioned.

The 'angry stage' to which Tony refers almost inevitably spills onto the streets, and Tony is categorical about what prompts and who is responsible for late night street violence:

...the majority of times it would be drink-related, definitely... the problems on the streets after alcohol, its mainly eighteen to twenty-five year olds, the young men, full of drink, full of bravado, sticking their chest out ...Tony 38

As well as lowering inhibitions for example in relation to social interaction, it appears that drinking also has the effect of lowering inhibitions to public and very outward displays of hegemonic masculinity. Violence is perhaps the most powerful means of asserting or sustaining dominance over others, and upholding the norms and standards of the hegemony. The clear insinuation of a link between drinking and violence is also evident in Colm's and Harry's accounts:

...like you'd back away from a fight at any time except when you have drink on you... you'd snap, you don't have the same control... its stupid because your man could be twice the size of you, but you think in your mind, like I'll take him, its ridiculous. Colm 22

...its a pride thing as well, you seem to be able to rationalize it properly to yourself when you're not drunk, but if you're drunk then you just say well 'he's after hurting me pride like I'm not going to take that'.

Harry 23

Colm acknowledges a blurring of reason and of normal decision-making ability as a result of alcohol. This appears to dramatically increase the likelihood of engaging in aggressive or violent behaviour, even when there is little chance of matching up to an opponent. Harry similarly concedes a diminished ability to rationalise as a result of alcohol, and describes a heightened sense of compulsion to

act from a position of wounded 'pride'. This sense of obligation to uphold 'honour' or to reciprocate violence appears to be magnified considerably under the influence of alcohol.

Jack (a 38 year old social worker) identifies a link between binge drinking amongst young people and the void left by consumerism and individualism, and suggests that such drinking can be a means of unleashing unresolved emotions and surrendering to impulsive behaviour:

And its the binge drinking I think is reflecting a society of trying to blot something out. I think for young people... part of it is just being saturated with life and fed up with life, its almost like there is no new experience for me out there...so I'll just be drunk. And unfortunately being drunk and drinking too much alcohol just brings out all the different emotions that are under the surface and... for anybody who has a problem and finding it difficult like all alcohol is going to do is impair their judgement even further and impair their problem solving ability... it also increases the likelihood of impulsiveness. I think that's a real danger with young people. Jack 38

Clearly, therefore, excessive and binge drinking patterns are synonymous with impulsive and irrational behaviour, and with impaired decision-making, and are a very powerful trigger to engaging in a range of risk behaviours.

7.5.1.7 Men's perception of their own drinking patterns at odds with public health guidelines

Respondents' perceptions of their own drinking patterns appeared to play down the seriousness of heavy or binge drinking, which is in keeping with the notion of a 'drinking culture' discussed earlier. For example, half of those consuming over 50 units per week (i.e. 25 pints and over twice the recommended maximum limit) considered themselves to be 'moderate' drinkers, while nine out of ten weekly binge drinkers similarly considered themselves to be 'light' or 'moderate' drinkers (Figure 5.4.3). There was also evidence throughout the men's narratives of a genuine scepticism in relation to current guidelines for safe drinking limits. Mike, (a 37 year old building contractor) questions the validity of current binge drinking criteria, and makes a very salient point about current guidelines not distinguishing between different scales of 'binge' drinking:

I read somewhere that binge drinking is anyone who drinks over three pints (LAUGHTER). Are you trying to tell me that a fellow who drinks four pints is a binge drinker the same way as a fellow who drinks twelve pints.

Mike 37

These findings have important implications for the targeting of any future initiatives at reducing either the scale or pattern of drinking behaviour amongst men. There is clearly a huge void at present between what is considered

excessive or binge drinking at a public health or health promotion level, and what men, and more specifically, 'excessive' or 'binge' drinking men consider these terms to mean. Clearly, the majority of excessive and binge drinking men cannot make a connection between their behaviour and their health. In the context of the transtheoretical model of health behaviour change (Prochaska and Velicer, 1997), it is unlikely that many of these men will take seriously any initiatives aimed at curtailing their alcohol intake, if they do not see their drinking behaviour as being harmful to begin with. A focus on making such drinking patterns more culturally unacceptable may prove to be more effective.

7.5.2 Smoking

The incidence of smoking at 26.4% (Table 5.4.2) was very similar to the levels reported in the recent SL?N surveys (Males: 27.6% in 2002; 32% in 1998), and coupled with the high number in this study who 'used to' smoke (19.7%), is further evidence of an overall downward pattern of smoking amongst men in Ireland. This is a very welcome trend in light of the very well established evidence that attributes smoking as the single most important preventable cause of death. (Department of Health and Children, 2003). Smokers in this study were significantly more likely to be excessive drinkers, to binge drink and to report sedentary lifestyles (Section 5.4.2). This is one important example of an overall pattern of association between health-damaging behaviours in this study. This raises at least the possibility of achieving positive spin-offs in other health-damaging behaviours, through engaging in initiatives targeting a specific health damaging behaviour. Smokers were also significantly more likely to report having neglected or paid little attention to their health over the course of their lives. It is a matter for further investigation whether smokers attribute in part the neglect of their health, as they perceive it, to their smoking habit. It is noteworthy that 60% of smokers did not associate smoking with impotence, which may have implications for future smoking prevention campaigns aimed at men. In the context of interventions designed to enable smokers to quit, almost half of smokers reported as having tried but not succeeded in stopping smoking, while only one in ten smokers indicated that they would 'not' like to stop smoking. It was also worth noting that half of all smokers, and specifically 84% of heavy smokers, reported regularly using smoking as a means of managing stress. This suggests a strong openness among male smokers to quit, reinforces the validity of smoking cessation initiatives, and identifies stress as a significant barrier in preventing men from quitting.

7.5.3 Physical activity levels

Declining physical activity levels and increasing levels of overweight/obesity have been highlighted in the most recent SLÁN survey, and have been found to be particularly pronounced amongst men. Three out of four men in this study did not meet the recommended type and amount of physical activity for health gain, with older, less well-off and less-educated men being significantly more likely to be in this category. The most noteworthy trend in this data was the marked decline in moderate/vigorous physical activity within ages 18-29 and 30-39, coupled with the noticeable increase in sedentary men between these age groups. One possible implication from these findings is that men who 'retire' from competitive strenuous sport in their 30's may 'fall into' sedentary lifestyles, and may not look to other forms of physical activity as a means of remaining physically active. This period in men's lives may also coincide with getting married and not feeling the need to make an effort with physical appearance, and with new demands to juggle family and work responsibilities (both factors that have been identified in Section 7.1.2). The growing level of physical inactivity among men (Kelleher et al, 2003) is compounded by their poorer dietary habits (Kelleher et al, 2003), and by apparent anomalies between what is considered 'normal weight' or 'overweight' at the level of public health and what men consider these terms to mean. As highlighted in Section 2.4.3, there is evidence that many 'overweight' men may not see themselves as overweight (McCreary and Sadava 2001) and that some normal weight and moderately overweight men may want to gain weight and enlarge body shape (McPherson, 2004). There is also evidence to suggest that men are less likely than women to avail of weight control/weight loss programmes if they are overweight (Watson, 2000; Toomey, 2004, unpublished thesis).

These findings highlight the need to perhaps broaden the concept of 'physical activity' for men over the age of 30, to something much broader than vigorous activity or competitive sport. In other words, what appears for many men to be a prevailing attitude of 'competitive sport or nothing' needs to be reversed when men reach 'retirement' age (in their 30's). At the same time, there is clearly a role for governing bodies of sport to harness 'retired' men's interest in competitive sports, in ways that do not revolve around traditional and formal fixture lists. A structure based on a more informal, less regimented approach, which nevertheless taps into the inherent attraction of competitive sport for many men, is to be recommended. There is also a need for increased education measures that target appropriate weight levels for men.

7.5.4 Stress

One in three men reported feeling regularly/constantly stressed, with levels of stress being significantly higher in men aged 30-39 and in more highly-educated men. Work was cited as the principle source of stress, with both the working environment and striving to achieve a work/life balance contributing to this stress. Financial pressures and poor health were also cited as prevalent sources of stress. Throughout the men's narratives, the issue of combining work with family and domestic responsibilities also emerged as a very prevalent source of stress. In both SLÁN surveys, management of stress was identified as the top requirement for improving general health for men (41% and 34% in 1998 and 2002 respectively). Section 7.6.4 highlights how stress can potentially and additionally compromise men's health in ways that many men may resort to health-compromising behaviours as a means of managing stress.

7.5.5 Summary & conclusion

Data from this study adds further substance to existing evidence that the scale of excessive and binge drinking among Irish men is alarmingly high. There was a strong consensus running through the men's narratives in both qualitative studies that a 'drinking culture' imbues Irish society. Excessive and binge drinking have for young men in particular become adopted as a means of defining their masculinity and as a way of displaying, in a very public way, allegiance to male peer groups. Unlike smoking, perhaps, there is no evidence of a rejection of such drinking patterns as being socially unacceptable, but rather the 'drinking man' continues to be upheld with considerable honour even by his more abstemious male peers. The pervasiveness and cleverness of alcohol advertising was highlighted, particularly in the way that such advertising connects alcohol use with prominent displays of masculinity, such as connotations of sexual freedom and sexual prowess, and the achievement of optimum performance in elite sport. There was compelling evidence of a strong association between alcohol and impulsiveness among young men, specifically in terms of an increased likelihood of engaging in violence or other risk behaviours. The qualitative data highlighted young men's heightened inclinations to forms of violent expression after drinking. Finally, it was clear that the majority of 'binge' or 'excessive' drinkers, as defined at the level of public health, did not themselves classify their drinking in such terms.

The incidence or reported smoking represents further evidence of an overall downward trend in smoking among

Irish men in recent years. Smoking was significantly associated with other health-damaging behaviours, and smokers were significantly more likely to report having neglected or paid little attention to their health over the course of their lives. There was an apparent willingness among the majority of smokers to quit, with almost half of current smokers having failed in the past to quit. The majority of smokers used smoking as a means of managing stress.

Three out of four men in this study did not meet the recommended type and amount of physical activity for health gain, and there was a marked decline in physical activity levels among men in their 30s. For many men it appears that retiring from competitive sport coincides with retiring from physical activity in general. The significance of this data is set against a backdrop of increasing overweight/obesity levels among Irish men generally, and an apparent propensity for overweight men to consider themselves to be normal weight. Levels of reported stress were also significantly higher among men in their 30s, with work, and combining work with other responsibilities being cited as the principal sources of stress.

There is clearly a need to challenge the drink culture that is endemic in Irish society. Whilst there is considerable justification for focusing alcohol measures on young men, to do so in a disproportionate way runs the risk of masking the widespread acceptability of alcohol in Irish society. The shift in attitudes to smoking towards that of being socially unacceptable, coupled with a continued decline in smoking levels, highlights the importance of a change of culture to one aimed at bringing about behaviour change. The example of smoking may serve as a benchmark for alcohol. There is an urgent need to promote increased physical activity levels among Irish men, while increased stress management initiatives are also urgently required.

7.6 Preventative Health Behaviours

7.6.1 ‘...if it ain’t broken don’t fix it’

The above comment from James (a 48 year old teacher) is indicative of a recurring theme throughout the narratives, that of a ‘leave well enough alone’ attitude and an absence of a preventative health ethos among Irish men. Trevor (a 45 year old community worker) concurs with this view, and suggests that it is not until something goes wrong or that there is a sudden realisation that the body is no longer capable of managing ‘certain things’, that attention is drawn to health:

Most men don’t decide to do anything with their health until something goes wrong...you don’t think about it until then...when you start to realise there are certain

things you are just not able to do or to do to the same degree. James 45

Calum (a 38 year old community development coordinator) describes how an incident that affects someone else’s health can spark off a sudden realisation of the vulnerability of one’s own health, and is consistent with the notion of a wake-up call prompting an increased consciousness of health discussed earlier (see Section 7.1.1):

When something happens to someone who you thought was invincible. Calum 38

7.6.2 Monitoring alcohol consumption

In the contexts of high levels of both overall alcohol consumption and binge drinking, and an apparent propensity to play down or minimise ‘excess’ or ‘harmful’ drinking, only one out of five ‘drinkers’ reported monitoring their own alcohol consumption, with younger men being significantly less likely to do so (Table 5.5.1). This data is in keeping with Lader and Meltzer (2001) who found that although 80% of men had heard of measuring alcohol by units, only 13% kept a check of their alcohol consumption. Indeed, those for whom the need to monitor alcohol consumption might be considered most salient – excessive drinkers and weekly binge drinkers – were significantly less likely than non-excessive drinkers and non-binge drinkers respectively, to report monitoring of alcohol consumption. This data provides evidence of a lack of a preventative health ethos among Irish men, and more specifically of a tendency among Irish men to minimise the potentially damaging effects of excessive and binge drinking behaviour.

7.6.3 Male-specific preventative health

Male-specific preventative health was also found to be low, with three out of four men aged 50 or over reporting never having had a DRE (Table 5.5.2), and just one in ten men reporting monthly practice of TSE (Table 5.5.4). Those men that did report having had a DRE in the past were significantly more likely to be well-educated and to be married/cohabiting. This does suggest that education and spousal/partner support may be key indicators in the preventative health-seeking behaviour of men. The importance of spousal/partner support is borne out by the fact that 98% of ‘reluctant attenders’ acknowledged going to the doctor at the behest of a woman (Figure 5.2.6). It has also been found in this report that male-specific health issues were high on the list of factors that appear to cause men to be reluctant to go to their doctors in the first instance (Table 5.2.7). It should be acknowledged that the efficacy of prostate screening measures (DRE and prostate specific antigen (PSA) tests in particular), remain the source of much debate at the level of preventative health for men.

In the case of some men therefore, it may not have been deemed appropriate by GPs to offer a DRE as part of a prostate screening. Nevertheless, the low level of testicular self-examination amongst young men in particular, is indicative of an absence of a preventative health ethos amongst Irish men generally. This is most likely the result of a general failure in the past to target preventative health initiatives at men. Declan (a 48 year old teacher) suggests that more careful attention needs to be directed at how such initiatives are delivered and how they are likely to be received

I think health is almost packaged in kind of a real negative way at times...you read in a newspaper if you are feeling this way, or if you've noticed this, it could be cancer so, you know, straight away, you are feeling those symptoms even though they might be not remotely related to what you have.... Declan 48

The sense of fear or even paranoia described earlier that some men may experience when faced with illness (Section 7.3), is just one example of what would need to be considered in developing cancer awareness or cancer prevention programmes specifically for men.

7.6.4 Stress management

While almost two out of three men felt that they were 'somewhat/very effective' at managing stress (Table 5.5.5), the behaviours used to manage stress in some instances could be described as potentially health-damaging for men themselves or for others (Table 5.5.6). Although men were more likely to report physical-exertion type activities or communicating with others as stress-management techniques, being aggressive or argumentative (56.2%), drinking (46%), eating (43.4%) and working more/longer hours (34%), were also reported as ways of managing stress, at least occasionally. Excluding eating, each of the aforementioned 'stress management' behaviours were significantly more likely among younger men, while younger men were also significantly more likely to report being ineffective at managing stress. Those (22.9%) who reported as ineffective at managing stress were significantly more likely to self-report poor health and overall neglect of health, and to turn to health-compromising behaviours as a means of coping (albeit ineffectively) with stress (Table 5.5.7). This highlights stress management as a key element of men's health, not just in terms of the lessening of the negative impact of stress on men's lives, but also to support men in choosing behaviours and techniques to manage their stress that are not likely to further compromise their health.

7.6.5 Summary & conclusion

This Section highlights the general absence of a preventative health ethos among Irish men. Just one out of

five 'drinkers' reported monitoring their own alcohol consumption, which is indicative of a tendency among Irish men to minimise the potentially damaging effects of excessive and binge drinking behaviour. Three out of four men aged 50 and over reported never having had a Digital Rectal Examination, while just one in seven men aged 20-29 reported practicing Testicular Self Examination monthly. Both statistics point to a serious lack of awareness among Irish men of male-specific preventative health issues. While six out of ten men reported being effective at managing stress, there was strong evidence of potentially health-compromising behaviours being used in the management of stress. In particular, those who reported being ineffective (as distinct from effective) at managing stress were significantly more likely to report having neglected their health, to engage in risk behaviours and to cite potentially health-damaging behaviours as their likely means of coping with stress. This highlights the potential indirect consequences of stress on men's lives, and the need to offer to men alternative and more health promoting stress management techniques.

In conclusion, the evidence from this section points towards a general lack of a preventative health ethos among Irish men, particularly among young men. The latter tend to see themselves as invincible, and are not inclined to connect current health-damaging behaviours with long-term harm. The lack of a preventative health ethos is consistent with an overall lack of health consciousness that was discussed in Section 7.1.1. That health is seen as something that should be fixed and not preserved also appears to be linked to a narrower and utilitarian concept of health (See Section 7.1.2). This ethos may also be driven by a culture that very often is at odds with prevention (e.g. drinking), and by poor levels of knowledge/awareness of health (See Section 5.7). This highlights the importance of raising the profile of men's health issues, and targeting specific health-education initiatives at men. Further research is necessary to determine the efficacy of health promotion or health information initiatives for Irish men. As highlighted earlier (Section 2.6), the effectiveness of written health-education and health-promotion materials needs to be researched more thoroughly in the context of men, with particular focus to whom and under what circumstances health education is given.

7.7 Risk Behaviours

7.7.1 "...he'll stick his chest out and have a go at it"
Connell (1998, p33) notes that the practice of risk behaviours in men is not just gender-specific, but is an

integral part of the active construction of masculinity. Tony (a 38 year old bouncer) describes how young men in particular feel compelled to square up to challenges:

...ask any man can you ride a horse; 'of course I can'. 'Did you ever ride a horse?'; 'no but I'd be able to'...they won't say they can't do stuff like... he'll stick his chest out and have a go at it...there is a big pride thing with them, with lads...especially with younger men...yeah, they can't be seen to be not being able to do something. Tony 38

In this study, younger men were significantly more likely to engage in risk behaviours than older men, whilst marriage/cohabiting and fatherhood were associated with lower levels of risk behaviours (Table 6.1.3). Davies et al, (2000) reported that a belief in their own invulnerability seems to be particularly prevalent among young men, and is linked to underestimating various risk behaviours, and failing to connect long-term risks with current habits.

7.7.2 Use of seat belts

The high level of seat belt usage (as a driver/passenger – Table 5.6.1) is further evidence of increased adherence on the part of Irish drivers to wearing seat belts (Kelleher et al 2003), and to the apparent effectiveness of legislative measures to enforce and encourage such behaviours. A lower level of adherence to wearing seat belts in the back of a car suggests that existing education and advertising measures are not enough, and that additional legislative measures are required to raise compliance in this area. Older men, married/cohabiting men and fathers were found to be significantly more likely to wear seat belts in the back of a car.

7.7.3 Drink-driving

Just over a quarter of respondents who drive reported driving having had two or more alcoholic drinks, with younger men (18-29) and older men (60+) being significantly less likely than other age groups to report as such. This is borne out in the men's narratives.

In the context of drink-driving, James, (a 48 year old teacher) a self-professed non-drinker, is incredulous at the behaviour of some of his peers:

I've seen it with very very good friends of mine, who certainly wouldn't give a damn whether they had ten pints or twelve pints getting into a car. These guys are educated they're not thick, I don't know what their mentality is. James 48

John (a 41 year old publican) and Harry (a 23 year old student) both contend that young people are more responsible than older people about drinking and driving: *I would say the situation is actually improved and young people are much more responsible now about drinking and driving in comparison to older people. John 41*

...people my age, like when I started driving the laws were there anyway...so like when I drive, I never drink and drive. Harry 23

The lower incidence of reported drink-driving among young men is particularly noteworthy in light of the generally negative health behaviours of this age group. Once again this reinforces the importance of measures that, as Harry describes, discourage the behaviour from beginning in the first instance, as distinct from as, James highlights, trying to change existing behaviours. In the context of drink-driving, it may also be that sanction is more effective than education.

Legislative measures - targeting prevention rather than behaviour-change

While younger men were significantly less likely to drink and drive, it was also noteworthy that younger men were significantly more likely to have in the past year been a passenger with a driver who was drunk (Figure 5.6.1). This apparently contradictory data does point to the greater effectiveness of legislative measures over advertising in dissuading young people from drinking and driving, without necessarily curbing their propensity to accompany drunk drivers. In other words, it may be the fear of getting caught that is more likely to curb the behaviour, rather than any fear of causing injury or death to themselves or others, to say nothing about any guilt feelings for creating the possibility of such tragic consequences. It also highlights, as Harry describes, the effectiveness of legislative measures in dissuading young people from adopting a risk behaviour (in this case, drink-driving), compared to the more difficult challenge, as John highlights, of modifying what may be an existing behaviour among older people. It has been shown for example in the context of smoking cessation that interventions are most effective, if commenced before youths are likely to take up smoking, than if they are targeted at getting young smokers to quit (Vartianinen et al, 1998). Preventing rather than curbing drink driving behaviour may be all the more significant when placed in the context of traditionally *laissez-faire* attitudes to drink driving within Irish culture. This points towards the desirability of harsher legislative measures, and the importance of such measures being seen to be enforced.

The role of advertising in challenging prevailing attitudes to drink driving

Whilst acknowledging the perhaps more significant role of legislative measures, it should nevertheless be acknowledged that a number of participants did cite 'scare tactics' advertising as effective in the context of drink driving. Brian (a 39 year old business manager) and Garrett (a 20 year old student) highlight that the realistic and graphic nature of a recent series of such ads underpin their effectiveness:

...they [TV drink driving adds] are pretty gruesome... And you relate to it because they're so realistic... and it does curb your behaviour, you know. Brian 39

...they're pretty hard to watch. They really get the message across. Garrett 20

Nick (a 39 year old retail owner - Australian, living in Ireland) draws attention to the significance of such advertising in redefining attitudes to drink driving in Australia:

...changing people's attitudes... and saying that the guy that drove home drunk isn't just a lad, he's a dick-head, you know. And that's what they are saying on the TV advertising - If you do this, you're a dick-head... its like you'd be an outcast [in Australia] if you'd be so stupid to drink and drive...a quarter of the beer sales in Australia now are low alcohol beer, and there's the designated driver. Nick 39

Whilst the marketing success of alcohol advertising has in the past been based on connecting alcohol use with prominent displays of masculinity, this Australian perspective suggests that drink-driving behaviours can be changed by challenging the 'lad' mentality (or 'he-man masculinity', Connell, 1995) associated with traditional constructions of masculinity. It also contests the notion that men are 'programmed, that their masculinity is fixed and that therefore they 'cannot change'. Whilst alcohol advertising highlights the potential for influencing traditional constructions of masculinity, drink-driving advertising on the other hand emphasizes the scope for challenging and contesting this masculinity. This also highlights the scope and the potential for challenging other constructions of masculinity that have been seen to negatively impact on men's health. For example, there is an obvious and pressing need to challenge the 'manliness' of suffering in silence, and instead to portray the Irish 'man' as someone who is not afraid to seek help.

'Drinking and driving versus drunk driving'

Brian (a 24 year old post graduate student) raises a number of factors that appear to be associated with common flouting of the laws in relation to drink driving. In a rural area where public transport may not be available, and where the enforcement of the law is seen as negligible, a disregard for drink-driving laws becomes the 'norm':

...where I come from, a little rural village, it is completely the norm to go out and have five of six pints and drive home and your chances of getting pulled by a guard are virtually non-existent. Brian 24

This 'norm' seems to take on a level of acceptability at societal level, as Brian makes a somewhat subtle distinction between 'drinking and driving', and 'drunk driving':

...there is kind of drinking and driving and then there's drunk driving, if you can understand what I'm saying...

There's no problem having four or five pints, people will see a problem if you've ten or twelve pints, so its acceptable to a stage. Brian 24

The type of reasoning in both of these extracts highlights the importance of changing the cultural mentality of what volume of drink is 'acceptable'. It also highlights the importance of legislative measures, and more specifically the enforcement of such measures, in curbing drink driving.

The proposition that Irish laws on drink driving are more of a guide to behaviour and open to interpretation, is a view shared by Robert (a 42 year old sales manager) as he contemplates the concept of risk-taking:


I'd probably drink three pints...and when you're in a rural village, I know how to get into my car and I'm going to tip back down the road, and I'm not going to, you know, go wild and I'll get home safely...so that's not risk-taking in my book. Robert 42

It is with total confidence, both in language and tone, that Robert describes driving whilst over the legal alcohol limit. The rural factor re-emerges as part justification for driving after drinking. What is most significant however, is that his disregard for the law governing this behaviour appears to be framed against his genuine belief that six units of alcohol will in no way impair his driving ability, though he acknowledges the need to drive more slowly. As he sees it, the law is essentially for 'drunk' drivers rather than responsible and relatively abstemious citizens such as himself. This raises the notion of a threshold of risk, in which driving whilst over the legal limit is rationalised as acceptable up to a point, particularly when framed against more obvious flouting of drink-driving laws. This separation of himself from the law is reinforced by Robert's later and somewhat ironic call for changes in the enforcement of and attitudes to laws:

...both our enforcement of laws and our attitude to laws is a major problem in Ireland...until this country seriously implements laws and rules and regulations, the thing [drink-driving laws] will be flaunted and there will be casualties as a result. Robert 42

While the state is severely reprimanded for not enforcing laws (and thereby not changing prevailing attitudes and adherence to the same laws), there is no sense of personal acknowledgement in Robert's comments that he may be part of the problem. In other words, someone else should take responsibility for his behaviour. John (a 41 year old publican) is more candid and forthright as he acknowledges the links between alcohol, lowered inhibitions and speeding, confirming the association between these risk behaviours.

...you do put the boot down when you have had a few drinks, and you get a kick out of speed... drink is definitely a huge factor. John 41



I think women are more responsible for that [using condoms] than the men, because lads won't care, if they've drink involved they won't care, they'll just go and do what they're going to do... a lad will just do whatever he gets away with. Tony 38

7.7.4 Speeding

Men aged 40-49 and 18-29, and more educated men showed the highest level of non-adherence to speed limits (Figure 5.6.3). It should be noted that at the time of data collection, the 'penalty points' system for driving offences was not yet then in place, and that adherence levels to speed limits may have improved since then. The fall in numbers of road traffic deaths following the introduction of penalty points appears however to have regressed in recent times, which once again highlights the importance of legislation enforcement. In the context of speeding, the North Eastern Health Board found that young men were pragmatic about the 'adrenalin buzz' versus the associated risks:

The buzz was guaranteed, whereas the injury was only something that could or might happen.

North Eastern Health Board (2001, p28)

The unacceptably high level of mortality from transport accidents among young men (Figure 2.2.2), highlights the urgent need for measures to curb speeding, particularly among young male drivers. In addition to legislative measures that are properly enforced, there is an urgent need for increased advertising that challenges the notion of young men being invulnerable, and that examines and questions the type of rationale, that for young men, legitimates risk-taking through speeding on the road.

7.7.5 Use of sunscreen

Over half of respondents reported at best infrequent use of sunscreen when exposed to the sun for extended periods (Table 5.6.4), with younger, less-educated, unmarried/not cohabiting men and 'non-fathers' being significantly less likely to use sunscreen. These figures are noteworthy (i) in the context of the high prevalence of non-melanoma skin cancer (NMS) amongst men in Ireland – approximately 2,700 new cases annually (National Cancer Registry, 2004); and (ii) the steady increase in both the incidence (5.9% annual increase) and mortality rate (10% annual increase) from melanoma skin cancer among men between 1994 and 2002 (ibid). While similar increases in NMS mortality rates have been reported among Irish women, the pattern prior to 2000 had been one of higher incidence of the disease amongst women, but a higher risk of dying from the disease amongst men. The Irish Cancer Society has adopted a very proactive approach on skin cancer prevention in recent years (e.g. 'sun smart' campaigns), and there have been specific initiatives directed at particular occupation groups such as farmers (e.g. North Eastern Health Board). Further research is needed on the effectiveness of such preventative measures with men.

7.7.6 Unsafe sex

There has been an alarming increase in the rate of reported

sexually transmitted infections (STIs) in Ireland in recent years (National Disease Surveillance Centre 2004). Courtenay (2000c) reports that the spread of STIs is associated disproportionately with men's unsafe sexual practices. The relatively low level of reported unsafe sex in this study is perhaps not surprising in the context of the older age profile of the sample population. As expected also, younger, unmarried men and non-fathers were significantly more likely to have engaged in unsafe sex (Table 5.6.5). Courtenay (1998) cites a number of studies which confirm that college men in the United States consistently engage in high-risk sexual behaviours. They begin sexual activity at an earlier age, have more sexual partners, are more likely than women to have sex while under the influence of alcohol or other drugs. As well as this, only one third to half of sexually active college men use condoms. Sabo (2000) states that by using sexual behaviour, and in particular the pursuit of multiple sexual conquests to establish masculine adequacy, young men are putting both themselves and their female partners at risk for STIs. In the case of young men in particular, engaging in frequent sex, with multiple partners and with minimal emphasis on intimacy or emotional attachment, is deemed not just to be acceptable, but also to bestow greater masculinity (Brooks, 2001). Whilst both men and women are sexually active outside of marriage, men are far more likely than women to engage in casual or 'nonrelational sex', and to consider their sexual activities as 'solely physical' (Shibley-Hyde, 1993 in Brooks, 2001).

In the same way that risk behaviours are framed against 'feminine' behaviour, Tony (a 38 year old bouncer) in this study contends that men divest themselves of responsibility for safe sexual practices, and see this as the woman's responsibility:

I think women are more responsible for that [using condoms] than the men, because lads won't care, if they've drink involved they won't care, they'll just go and do what they're going to do... a lad will just do whatever he gets away with. Tony 38

This indifference to risk is consistent with the sense of invincibility described earlier in relation to young men, and again seems to be heightened in the presence of alcohol. As highlighted in Section 2.5.4 (Rundle et al, 2004), 54% of men (and 26% of women) agreed that drinking alcohol had contributed to their having sex without using a condom. It has also been found (Crisis Pregnancy Agency, 2004) that men were more likely than women to 'sometimes or never use contraception', with 65% of those reporting unprotected sex being men. Women's increased 'liberation' and control of reproduction is also linked to an increased likelihood of unsafe sexual practices, a fact that emerged consistently in the young men's narratives. Garret (a 20 year

old student) describes how young women are likely to take the initiative and control of a sexual encounter:

A lot of girls would say they're on the pill...just tell the guy 'I'm on the pill' and its OK. Garrett 20

In the context of sexual health (for men and women), this also suggests that the priority for some young people may primarily be on pregnancy prevention, and that prevention of sexually transmitted infections may be seen as less important.

7.7.7 'Adrenalin Junkies' & the impact of the peer group on risk-taking

Eoghan (an 18 year old student) and John (a 41 year old publican) both highlight the immense significance of the peer group in defining collective gender practice, and in not taking responsibility for their own actions:

...its who you are hanging around with... you're going to do the same things they're doing like so you mightn't necessarily want to do it but just because the crowd is doing it you're going to do it ...not so much when you get older but growing up say in secondary school. Eoghan 18 ...to take risks, from a male point of view its seen as macho and you're seen as great... you get attention and you get praise... women actually can talk things out and can get acknowledgement from friendships...with men, its more from their actions and their deeds. John 41

The focus on 'actions' and 'deeds' is consistent with the construction of a very traditional masculinity, a masculinity with connotations of valour, heroism and fearlessness. In a focus group with college men, Eoghan uses the term 'adrenalin junkies' (Eoghan 18) to describe young men's propensity for risk-taking. The tone in which he uses the term is clearly meant to confer a high degree of status to the notion of young people being addicted to the adrenalin rush of risk-taking. Whether the adrenalin arises from the risk-taking or from the conferral of recognition and higher status from the peer group may be worth further exploration.

Jim (a 38 year old social worker) reflects on the potent combination of allegiance to the peer group and low self-esteem as he reflects on the impetus for his own risk-taking in his youth:

I would have done reckless things when I was a lot younger...because my self-esteem was low and because I didn't feel confident with myself...and the way to actually feel, I suppose, important, or feel strong and tall and male in front of the group...was to do something exciting and reckless, because I didn't feel strong in myself. Jim 38

Jim's experience suggests that lack of confidence and low self-esteem may be a powerful impetus for risk-taking behaviours among young men, who may feel a need to

'prove' themselves. Jim similarly attributes male violence and the sense of compulsion to reciprocate male violence, to an essential lack of strength or self-confidence in men, but acknowledges also a male 'primal' instinct for violence: ***...a lot of it comes from a lack of strength in oneself and a lack of self-esteem... if somebody attacks me or whatever, I must respond in the same way...I don't have the strength maybe to step back from this behaviour its almost like a very primal thing kicks in...kind of an unchecked behaviour, an unchecked aggression, and obviously alcohol exaggerates that raw primal stuff, that's in us as males. Jim 38***

This raises the nature-nurture debate in relation to men's greater propensity for violence. John (a 38 year old teacher) recalls how being outfought in the schoolyard caused significantly greater damage to his sense of honour and manliness compared to the actual physical damage:

I can remember like getting into a fight at school and getting hammered and the humiliation, I mean I wasn't at all concerned about the fact that I got the crap beat out of me, but it was the fact that like you know, that my pride was completely hammered...I may as well have been carried out in a coffin because that was the end of me. John 38

For a male to be defeated in a physical confrontation such as this is to be consigned to a lower or more marginalised status within the peer group. There is considerably more at stake, according to Conor (a 19 year old student), if a male refrains from supporting a friend who is engaged in violence:

if my friend stood by and watched me get beaten up, I'd have to consider about being friends with him. Conor 19

For men, violence appears to be an integral part of defining collective gender practice, which as Jim describes may degenerate to a 'mob mentality':

I think its the mob mentality, you know, people in groups and mobs do things that they would never ever do as individuals. Jim 38

Whilst it must be acknowledged that male violence is complex and multifactorial in origin, it does seem to be an obligatory way of defining and sustaining allegiance to male peer groups.

Ray (a 47 year old accountant) suggests that behaviours that are deemed to bestow acceptability within a group can also have consequences for behaviours that occur outside the group:

I do think that the risk-taking is involved with getting acceptability among your peers or even to yourself, I mean sometimes as a young lad, I would have been speeding on me own...Ray 47

The implication that behaviours that develop initially within a context of group conformity, but subsequently or

concurrently develop an impetus outside that context, is highly significant. To cite Ray's example, young men may initially engage in speeding to win favour with their peers, but may end up adopting that behaviour away from the peer group. Whether this is due, as appears in Ray's case, to a need to seek reassurance for oneself, or from the positive experience gained from the behaviour itself, needs further investigation. It is worth noting that while young people's initial experiences of alcohol, cigarettes and illicit substances may be quite negative, peer group pressure may nevertheless sustain these behaviours until they become more appealing as behaviours in their own right. It may be extremely difficult to alter such behaviours in later life, when dependency or addiction has replaced the initial appeal.

Risk taking to avoid the ridicule of being labelled feminine or effeminate

Risk behaviours may be used by some men not just to prove their own masculinity, but also to avoid the ridicule or stigma of being labelled feminine or effeminate. Colm (a 22 year old student) describes the attraction for him of the recent successful TV reality show **JACKASS** which features all-action risk-taking, with volunteer participation. Its appeal for him is based not just in terms of stupidity or fun, but in the way that it defines collective masculine practice and excludes women:

Its like with that programme Jackass, they do some stupid, stupid things like but you love it like, lads kind of stuff, I think there is no woman on that programme, obviously only lads would do that kind of thing like and they just think its funny. I think its funny anyway...

Colm 22

Garret (a 21 year old student) proposes that a key motivation for men to break rules or laws is women's adherence to such rules or laws. Indeed his incredulity at women's propensity to be law-abiding highlights his own collusion in this:

I think rules scare the hell out of them [women], (group laughter)...I just don't know why but its just any rules or laws... the majority of them will abide by them, the lads just won't you know... Garret 21

The bluntness of Kian's (a 20 year old student) suggestion as to why men choose to break rules is offered both literally and metaphorically, in a relational way to women:

Because they [men] have the balls. Kian 20

It is because of this 'manliness' that Kian also describes danger as being fun and controllable, and as a means of living life to the full:

Putting yourself in danger is good fun especially when you know you can get out of it like... yeah, makes you feel kind of alive you know. Kian 20

John (a 41 year old publican) suggests that it may be the

culture of being Irish that underpins Irish people's predisposition for law breaking:

Irish people are very disrespectful of laws and get a kick out of going and breaking the laws. John 41

Although not perhaps uniquely Irish, 'getting away with it' and the thrill of not getting caught appear to be very much a cultural phenomenon and are consistent with attitudes to drink driving discussed in Section 7.7.4. 'Getting caught' may indeed be the key to changing the behaviour. This highlights once again therefore the need for legislative measures in conjunction with social marketing as a means of counteracting this ethos.

7.7.8 Summary & conclusion

The data from this study strongly implicates risk-taking behaviour, particularly among young men, as an integral part of the active construction of masculinity, and as a necessary means of avoiding the ridicule of being labelled feminine or effeminate. Male violent behaviour for example, was found to be an obligatory way of defining and sustaining allegiance to male peer groups. The findings from the study also highlight how the enforcement of legislative measures, coupled with social marketing strategies, are central to curbing men's risk taking behaviour. This is particularly important, for example in the context of drink driving, where the law on drink driving appears to be the subject of interpretation rather than adherence. The comparatively low level of reported adherence to speed limits among young men, must be acted upon in the context of the unacceptably high mortality rate from road traffic accidents involving young men. The low level of reported sunscreen use is of continued concern against a backdrop of the high prevalence of non-melanoma skin (NMS) cancer, and the steady increase in both the incidence and mortality rate from melanoma skin cancer amongst Irish men. Although the overall reported incidence of 'unsafe sex' was quite low, young men's indifference to the risks of unsafe sex, their willingness to divest responsibility for contraception use to their partners, and the focus on pregnancy prevention as distinct from STI prevention, are all areas of men's sexual health that need to be addressed. Finally, it should be stressed that risk-taking behaviours may affect not only the health of the men who engage in them, but can also potentially compromise the health and well-being of others. It has been demonstrated in the United States, for example, that the spread of STIs is associated disproportionately with men's unsafe sexual practices, while men are at fault in nearly 8 out of 10 automobile accidents (Courtenay 2000c). The quantification of the effects of Irish men's risk-taking behaviour, over and above the impact on the risk-takers themselves, may help to

copperfasten intensified measures to tackle this aspect of men's health.

7.8 Knowledge/Awareness of Health

7.8.1 *Are Irish men knowledgeable about their own health?*

Previous studies have generally shown that men's knowledge/awareness of health issues tends to be poor, a pattern that was unequivocally borne out by the findings from this study. Because of the large volume of data on men's knowledge/awareness of health in Section 5.7, a summary of the key findings only will be presented in this Section:

- Men were twice as likely to overestimate than to underestimate their life expectancy.
- Less than half of respondents knew what the function of the prostate gland was, while almost one in four men were unable to correctly identify its location. Between a third and a half of respondents were not aware of some of the most common prostate cancer symptoms. This poor knowledge of prostate health may indeed be consistent with a fear of broaching 'private' male health issues with doctors (Table 5.2.7); with fear of the unknown sometimes being a greater source of distress than the reality of illness (See Section 7.2.5.4)
- Three out of four men aged 18-29 were not aware that young men are at highest risk of developing testicular cancer, with almost half of the same age category never having heard of testicular self-examination (TSE). It is hardly surprising, therefore, that just one in seven young men reported monthly practice of TSE.
- Protein was incorrectly identified, at the expense of carbohydrate, as the nutrient that should constitute the bulk of a balanced diet, despite the fact that the recommended daily allowance (RDA) of protein is less than half that of carbohydrate. This finding is noteworthy for two reasons: (i) in the context of a 'men's health' protein supplement industry, which attempts to connect protein supplementation, at levels far greater than the RDA, with the 'sculpting' of male bodies; (ii) as a possible means of explaining why normal weight or moderately overweight men may want to gain weight and enlarge body shape (see Section 2.4.3.) It should also be noted that excessive protein intake has been associated with increased risk of cancer (e.g. colorectal cancer), and may in the long-term cause damage to the kidneys. Almost half of men either underestimated or were unaware of the recommended daily number of fruit and vegetable servings.
- Against the reality of growing overweight/obesity levels among men in Ireland, less than one in three men correctly identified 15-20% as a healthy percentage

body fat range for men. This finding is of particular relevance in light of men's poorer dietary habits compared to women (Section 2.4.3).

- In the context of declining physical activity levels among men, almost three out of four men were not aware of the current recommended type and amount of physical activity for health gain. It also appears that 'retiring' from competitive sport for many men does not coincide with a sense of responsibility to remain active for the sake of their health.
- Almost three out of four men either did not know or did not correctly identify '21 units' per week as the sensible drinking limit for males. It is therefore, perhaps unsurprising that eight out of ten 'excessive' drinkers and nine out of ten weekly 'binge' drinkers regarded themselves as no more than 'moderate' drinkers (Section 5.4.1)
- Less than a third of respondents, and just four out of ten 'smokers' were aware that smoking was linked to impotence

7.8.2 **Summary & conclusion**

These findings confirm the assertion made in Section 7.1.1 that health has never been on the agenda for men, and that as a result, Irish men's lack of knowledge of fundamental health issues continues to be a key area of concern in the context of their own health. They also highlight the need for increased education and awareness-raising of men's health issues, which should be targeted at both boys and men. The findings are also consistent with the fact that men in this study identified improved information/education/awareness as the most important factor that would have been needed for them to have managed health problems more effectively (Table 5.3.4). It should be pointed out that there has been a general absence of health promotion literature targeting men specifically, while it is only in more recent times (e.g. Irish Cancer Society) that national health awareness campaigns have begun to have a focus on men. It is also disappointing that the introduction of International Men's Health week in recent years does not appear to have created an impetus for men's health initiatives to be introduced within Ireland. Increasing awareness does not of itself mean that desirable behaviour change will follow. Meillier et al (1996) concluded that strategies aimed at improving men's health might be placing too much optimism, and forming unrealistic expectations of the impact of more traditional written health educational material on alterations to health behaviour. Indeed as pointed out earlier (Section 7.1.2), images used in health advertising or health promotion material may have the best intent, but may paradoxically constitute a form of resistance among many men towards adopting health-promoting behaviours or to develop

'healthy bodies' (Watson, 2000). The effectiveness in particular of written health education and health promotion material needs to be researched more thoroughly with men, with particular focus on the social and cultural contexts in which they are presented. There is also a need to carefully look at the media used to present health messages, and to ensure that such messages are used not in isolation, but as part of wider and more holistic men's health initiatives.

7.9 Emotional/Relational Health

7.9.1 'Men's process'

'Men's process' refers to how men operate in terms of dealing with emotional or mental health issues. Three out of four men reported adopting strategies of 'avoidance' or 'silence' in the way they managed themselves through an emotional or mental health issue (Table 5.8.1). Those men who adopted such strategies were significantly more likely to be 'reluctant attenders' at their doctors; to have neglected or paid little attention to their health over the course of their lives; and to perceive themselves as ineffective at managing stress (Section 5.8.1). The notion of traditional masculinity is typically associated with limits imposed by the male psyche, pertinently manifested in this study by a front of stoicism and the confessed unacceptability of self-revelation of feelings of pain or anguish. O'Dowd (2004) implicates the lack of language for expressing emotional distress as a factor in the higher rate of suicide among men. It is therefore pertinent to question the extent to which so many men 'choose' to avoid or remain silent in the face of emotional/mental health issues. It may be that they genuinely struggle to find a language to seek help or feel compelled to collude with a notion of masculinity that demands such a response.

7.9.2 Applying 'logical' solutions to emotional problems

Colm (a 22 year old student) struggles to deal with an emotional problem in a 'logical' way:

I remember when I broke up with my girlfriend now, I was pretty, pretty wrecked over it...like emotionally, and I would have felt depressed for a while afterwards like, well I would have felt down a lot you know, and there wouldn't necessarily be anything wrong with me, everything seemed to just be on top of me at the time... well what I tried to do at the time, was just break it down like and just look at it more logically than emotionally, and just well like this is the way it goes, what can you do, but it still didn't kind of take the sting out of it for a long time like...so I just did the best I could like and I was a bit disappointed myself that it took a while you know... I

couldn't detach the emotion from it like, just, it just got too much. Colm 22

Whilst he recognises the emotional nature of the problem and acknowledges feeling 'depressed' and 'down', he is quick to dismiss its significance, and sets about 'breaking it down' and attempting to solve the problem in a rational way. He appears to allow himself little space to own his own feelings of sadness and despair, and even rebukes himself for not getting through this difficult time quickly enough. The use of the verb 'detach' in the final sentence is quite poignant, in that despite the openness and honesty of his struggle between the head and the heart, he appears to be 'stuck' in a place where emotions are to be controlled rather than felt.

7.9.3 'Controlling' the emotional self

This 'control' or denial of the emotional self is also very apparent in the way Harry (a 23 year old student) describes feeling 'down' as a result of what appears to be a failure to deal with emotional issues at an emotional level:

...I think it just takes one big thing to just make you focus on all the other little negative things that were bothering you but you kind of let slide beforehand and then you just, you get into that kind of a mind-set and its hard to, hard to dig yourself out. You get into the mindset where you just see all the negative whereas before if you weren't down, you knew things weren't right but they didn't bother you. Harry 23

He describes what seems like a certain capacity to ignore or deny things that 'weren't right', and as a result to be untroubled or unaffected by such problems. He also acknowledges, however, that this in essence is a time bomb waiting to go off. The 'one big thing' can open a can of worms with respect to other unresolved emotional issues, resulting in a situation in which he acknowledges that it is much more difficult to 'dig yourself out'. Connell (2000) highlights the sense of isolation that inevitably surrounds the suppression or 'control' of emotion and the denial of vulnerability that have come to be associated with traditional constructions of masculinity. Although Garret's (a 20 year old student) tone is more upbeat than Harry's, the following passage is further evidence of an attempt to control the emotional self:

I try all the time to be in good mental condition, not to let little stupid things get me down or annoy me

Okay. So what kind of things do you do to look after your mental health? (INTERVIEWER)

*I just try and look at things positively and...even if I am having a s*** time, like try and buzz and say right if I'm having a s*** time its not because there is s*** things going on, its just because I'm being stupid about it, if I was in a better mood, I'd be enjoying myself here or whatever. Garret 20*

Whilst Garret endeavours to maintain a positive outlook on life, the effort of 'trying' to be in 'good mental condition' appears to be a way for him to deny or at least to distance himself from acknowledging issues that might cause him to feel sad or angry. He assigns the label 'stupid' both to the things that might cause him to experience sadness or anger, and also to himself for allowing himself to be sad.

7.9.4 The struggle between resisting and yielding to depression

The following account of Tony's decision to seek help from his GP for 'stress' encapsulates many of the issues raised in connection with men's struggle to deal with emotional/mental health issues.

I was maybe burning myself out, maybe I was doing that little bit too much. ...eventually, I said I can't keep doing this, so I went in, I said I'd get a tonic or what-have-you, so and the doctor explained to me; he asked me what hours I was doing studying, what hours I was doing working, and he said 'that's too much', you're stressed now, your body is run down and he recommended I take Xanax, I thought ah Jesus, no, I don't want to be taking tablets now because its for me head.

I went to a male friend and he was upset... 'yeah, there is nothing wrong with you, you don't be taking tablets like that'. He says, 'you're okay', and I said 'I know I'm okay, but the doctor thinks I need to take this so I can get sleep and relax'. 'No, there is nothing wrong with you, you're not taking tablets like that'. He has this thing of, again, mental thing and 'you're my friend and you're a grown man and you can cope with this or I can help you cope with it, you don't take tablets', it really upset him... Yeah, I'd be a strong person for him and he'd be a strong person for me, you know like Tony 38

Would you see strength as being able to block it ['stress'] out and get on with it or would you see strength as being able to talk about it? (Interviewer)

Both. I mean there is a time when you need to just switch off and get on with your life, because you won't be able to function otherwise. But there's definitely a need for strength to be able to say 'look, I'm not coping much better now with this, I need to actually go see someone about this'. Tony 38

His acknowledgement that on the one hand he was 'burning himself out' but was doing so by 'doing that little bit too much', is evidence of his own struggle between confronting and colluding with traditional constructions of masculinity. It is clear at the outset that Tony's decision to seek help was not taken easily and followed a long period of procrastination. The expectation that a 'tonic' would solve the problem suggests a degree of avoidance or denial about the true nature of his problem. The doctor's decision

to prescribe an anti-depressant medication for 'me head' is met with genuine unease and agitation on Tony's part. Having 'succeeded' up to now in blocking out or at least containing his problem, the tangibility of the medication now forces him to confront his problem in a very real and concrete way. At no point however does Tony refer to the word depression, 'stress' being a more tolerable and less stigma-laden term. He also refers to the doctor's diagnosis as 'stress', which may be indicative of continued avoidance of the true nature of his problem, or perhaps of collusion on the doctor's part with the stigma that traditional masculinity has consigned to depression.

The reaction of Tony's friend appears at one level to echo the conclusion drawn by Ray earlier (Section 7.3.1) about men not supporting other men in times of ill health. In this case, however, it appears to be with genuine concern for Tony, but also perhaps for himself, that his friend urges him to ignore the doctor's prognosis. His support appears conditional on Tony not conceding that he has a 'mental' problem that necessitates relinquishing his 'strength' and handing over control to conventional medicine. Connell (1995) describes how the construction of masculinities is marked by collective practice and very often defined within the peer group. In this context, the 'Tony' that goes to the doctor and that is prescribed anti-depressant medication marks a departure from the 'Tony' that 'was' perceived as strong, independent and invulnerable by his friend. To offer support to the 'new' Tony is seen by Tony's friend as a threat to the very essence of his own masculinity. The final part of the passage highlights Tony's continued struggle with on the one hand squaring up to stress/depression and being 'strong' in the way that he has been taught and in the way that the peer group continues to demand. On the other hand, he clearly acknowledges a different and what seems like a more evolving understanding of 'strength' that of allowing himself to be vulnerable and to ask for help.

7.9.5 Re-connecting with emotional self

James (a 38 year social worker) is more forceful in seeking a way for men to reconnect with their emotional selves. Crucially, he proposes that men's capacity for feeling and for expression of feeling is not inherently any less than women's, but has been stunted by 'learning' to conform or to be complicit with hegemonic constructions of masculinity:

...you know males are as much human beings as females and all the bits and pieces and the mechanisms are in there...we are communicators, we have the same kind of capacity for feeling and expression of feeling and communication and yet we have learned you know, that's a department that we'll keep on hold, we'll keep it cold and we've learned like you know, the departments

for us are the physical and providing, being aggressive and showing that we're strong and in fact what we end up doing actually is burning out and I mean males are affected by stress and by trauma and by pain and by depression and all these things in the same way females are, but unlike females we don't have the ability to talk about it and...

Well maybe, is it more permission than ability? (Interviewer)

Permission yeah, as society, yeah. Permission is a better word yeah. James 38

While nature provides all the 'departments', nurture rules over which ones we are allowed to access.

James himself describes a very different perspective, of having also 'learned' how to connect with, to articulate and to be strong in relation to his own feelings, even when there was pressure to be otherwise:

...but I've kind of learned the importance of actually talking and to be able to say, that really, even though they sound simple they're actually profound things I think for men, at least they were profound for me to be able to say like you know, 'can I talk to you, I'm upset, I'm distressed, do you understand this when I say this to you', they were skills that were totally alien to me or mechanisms that were totally alien to me and that I had to learn through I suppose being in a place that I was totally unhappy. James 38

The transition to finding and utilising these 'skills' of communication and openness was clearly a difficult one for James. Courtenay (1998) concludes that in order to make the transition from boyhood to manhood, boys are actively discouraged from seeking help by parents, other adults and peers, and indeed may be ridiculed by their peers in particular when they do seek help. Harrison and Dignan (1999) defined this male gender culture as 'pathogenic' rather than protective of health. Since sickness may be seen as a manifestation of weakness, many men may actively decide not to seek help, and instead to present a stoical, brave and unflinching front to the outside world. James recognises the stifling influence of this 'pathogenic' male gender culture, but is also acutely aware of the price that has to be paid in rejecting the status quo in favour of being more open:

And there's huge manipulation and there's huge pressure on, like basically I would consider myself to be a fairly good communicator, I'd have no problem talking to anybody about how I would feel and I've learned how to articulate it. But I mean I've been slagged about it and a lot of pressure has been put on me and I've been called all kind of things because of that and I'm conscious of that but it's just that I've learned to be strong in this because if I'm not strong in it I'm not prepared to put up with the

price of it...and I think some males have learned that but I think a lot of males feel they have to stay in that place of non-articulation. James 38

This active construction of an oppositional masculinity has come at a 'price' and has not been without considerable resistance from those who adhere to or are complicit with hegemonic constructions of masculinity. It must be stressed, however, that there is also a 'price' to be paid for accepting the 'stiff upper lip' approach. A fundamental issue for all men must be to weigh up the 'price' of talking, of being open, of acknowledging vulnerability, as more worth paying than the 'price' of being consigned to a place of 'non-articulation'.

7.9.6 Source of support for emotional/mental health issue

Table 5.8.2 highlights how men are overwhelmingly more likely to turn to women than to other men as a source of support when faced with emotional/ mental health problems. Indeed, men were almost twice as likely (Table 5.8.3) to cite 'wife/partner' (75.2%) as having had a positive affect on their overall mental health and well-being than either male close friends (43.4%) or male close relatives (42.5%). As noted earlier (Section 2.3), the statistics on admission rates to psychiatric hospitals would suggest a positive association between marriage and men's mental health. Women also play a key role in the help-seeking behaviour of men (Figure 5.2.6). Apart from acknowledging the key role that women play in supporting men, these findings also beg the question as to what prevents men from being more supportive of other men. Earlier in this section of the report, it has been proposed that more traditional constructions of masculinity are associated with men concealing their feelings and adopting a manly silence when faced with problems of ill health (Section 7.3.1). Such an approach appears to be exacerbated in the context of mental health or sexual health problems (Section 7.3.2). The clear implication from Section 7.9.5 has been that being more open and perhaps more honest with other men can come at a 'price', and be judged to be stepping outside the boundaries of traditional constructions of masculinity. It is also worth considering the following points in the context of why men appear to struggle when it comes to finding ways of supporting one another:

Men the providers, women the nurturers?

Section 7.10.2.1 describes how the majority of Irish men continue to identify with and to act out the male provider role, a role that traditionally has tended to be constructed in an oppositional way to the more caring (and feminine) nurturing role. Many of the men's narratives also recounted traditional constructions of masculinity that appear to have

had a stifling influence on the way men of generations past constructed relationships. Patrick (a 48 year old teacher) recalls the clear delineation that was evident between that of father/provider and mother/nurturer in the case of his own parents.

...when I was a child, the father took very little, he took no action whatsoever in rearing the children, none. He provided the money for the bills. I don't think I ever did, have a deep conversation with my father, ever in my life, I never did, you know. Any time I was going through a hard time or that, it was my mother was always the person that you'd talk to...any emotional stuff, anything like that, 'that's your mothers department', do you know what I mean. [laughter]. Patrick 48

This clearly, as Patrick recollects, constrained the level of intimacy that was possible in the relationship between him and his father. The void that existed between Patrick and his father highlights the great loss of nurturing and of being nurtured, for both father and son. Nevertheless, there is no sense of blame in Patrick's tone, but rather an implicit understanding of the culture of that generation. Harry (a 22 year old building labourer) similarly describes how he learned from his father to conceal his emotions and to 'sort out' his own problems:

He [father] never showed his emotions in front of any of us... he was the one providing for the woman...if anything happens, he don't want to be going back and annoying her about it... he'd rather sort it out himself...I never seen him down...if he was down, he'd probably go into another room, he'd never show it in front of us, he never did...I just picked it up from early; 'don't bother anyone else about my problems, I'll sort it out my own way'. Harry 22

The notion of concealing vulnerability and suffering in silence is highly consistent with a utilitarian concept of health that is grounded in the need to meet one's 'obligations' to work and to provide for one's family (See Section 7.1.2). Patrick's account of his relationship with his father is in stark contrast, however, to the level of involvement and intimacy that Patrick has actively pursued and experienced with his own children:

...but that has changed utterly now... like I would be totally involved with the bringing up of my family, always have been...and that's the way I wanted it. Patrick 48

Mark (a 23 year old student) also identifies a generational shift in the way that he constructs masculinity compared to his father's generation. :

I think its changed...being masculine...I'd say its easier for me to talk to my friends about problems than it would be for me Dad like when he was younger, I would say that. I have a much more open relationship with the people I'm

friends with like, I find if something is bothering me I feel like I can tell them, do you know what I mean. And I wouldn't feel like I'm being weak or whatever just for telling them. Mark 22

Clearly, therefore, there is evidence of a blurring of the more traditional provider/ nurturer roles, with some men more than others embracing more open relationships.

Fear of being seen as weak or effeminate

Despite evidence throughout the narratives of a perceived shift towards more openness and intimacy in men's relationships, or as Connell (1995) describes as 'new-model relationships', it was also clear that barriers still exist in terms of the level of intimacy that is possible between men. In a focus group with college men, Conor (21), Eoghan (19) and Garret (20) highlight some of these difficulties:

...I think girls, they talk about it to each other. Whereas a lad would have to be very very like close to another male, like you know, really good friends like and they still wouldn't be giving the same amount of information. Conor 21 ... Yeah, men are just a little more secretive I think Eoghan 19... and you don't want to be bothering people so you say like you know, its my problem I'll deal with it. Garret 20

This exchange raises the question differing degrees of demonstrated masculinity (and possibly homophobia) as a very real barrier to friendship between men, and that openness in talking about feelings or problems to other men may be quite measured or curtailed because of fear of appearing weak or possibly effeminate. This difficulty with intimacy between males even extends to a perceived contrast in the level of intimacy that is possible between brothers compared to between sisters. Patrick (a 48 year old teacher), who earlier described being 'totally involved' with his children, is content to ascribe the lack of intimacy between he and his brothers to 'human nature' and 'women's talk':

I have to say sisters in a family have much more of a strong bond than lads do, you know what I mean...they'd be closer, I mean I have five brothers and there's four of us that share the same interests, but we don't talk that much about our marriages and that, do you know what I mean... I mean the women I'm sure that every flipping period pain is discussed and every flipping row with the husband discussed, do you know what I mean, between them, but again that's human nature I suppose... lads are not into that, I mean men as a rule don't discuss it because they always thought God that's women's talk like... Patrick 48

Although the 'modern man' may have freed himself from the shackles of being 'strong' and stoic like his predecessors, to be open or intimate with other men still runs the risk for some men of appearing weak or possibly effeminate.

Impact of child sexual abuse revelations on men

The revelations about child sexual abuse and paedophilia that came to light in Ireland during the 1990s are by now well documented. Understandably in the aftermath of these revelations, there has quite rightly been a clear focus on implementing a broad range of policies and child protection measures to safeguard the welfare of children in the future. As yet however, there has been a general absence of discourse in relation to the wider impact of these child protection measures on 'men'. In this study, there were a number of references throughout the men's narratives of a heightened sensitivity to the issue of paedophilia, and of men feeling compelled to be more measured and staid in their relationships with children (other than their own children). Whilst acknowledging the necessity of protecting children 'at all costs', Frank (a 48 year old business man) describes as 'destructive' the barriers that child protection measures have placed between him and how he relates to children:

But in a way there is actually something quite destructive that has happened as a result of that [measures to combat child sexual abuse]. If you've any fondness for children or affection for children, you cannot touch a child. Frank 58

Alan (a 56 year old banker) describes hugging a child and being subsequently rebuked by the child's father:

*Well I would always be quite spontaneous with children, you know, you're much less inhibited than you would be with people [adults] because, and I was doing something with J*** during the year and we were moving stuff... and this chap who had the van took his children with him and one of them was three or four, turned around and like this and I gave him a big whoosh, you know...well, twas like a grey cloud came over us...I mean the father's face if you saw it... Alan 56*

Connell refers to the 'constant threat of accusation' that hangs over 'men', arising out of the political handling and media portrayal of paedophilia.

"Under the cover of child protection, this has turned into an attack on gender reform, child care outside the family, and the unmanliness of men who might have an interest in children" (Connell, 2000, p192).

Whilst there can be little argument with measures that are designed to protect children, it is nevertheless important in the aftermath of child sexual abuse revelations and the child protection measures that have followed, to consider the wider position of men and the new constraints within which men now relate to children. It may well be that further barriers have been placed in the way of men being more open in relationships. These findings are also noteworthy at a time when there has been an overall 'feminisation of childhood', as men are completely absent from public childcare provision, and decreasing numbers of

men are entering primary school teaching and caring professions (Ferguson, 2001).

Summary & conclusion

Three out of four men reported adopting strategies of 'avoidance' or 'silence' in the way that they managed themselves through an emotional or mental health issue. The qualitative data also highlighted a tendency for men to deny or 'control' emotions, and to distance themselves from acknowledging issues that might bring to the surface their own vulnerability. This is inevitably associated with a cycle of unresolved emotional issues alone being suppressed and then resurfacing. Fear of being labelled as unable to 'handle' emotional issues is associated with a lower status or subordinate masculinity. Depression is seen by some men as perhaps the ultimate 'failure' to sort out emotional issues. In keeping with the stigma or taboo associated with certain illnesses (See Section 7.3.1), dealing with depression can also be seen as a powerful threat to a man's masculinity. The dilemma for men is whether to confront or collude with this 'pathogenic' male gender culture; and to weigh up the 'price' of being open and allowing vulnerability against the 'price' of being stoic and silent. Men are much more likely to turn to women than to other men to seek support for an emotional or mental health issue. Identification with the traditional male provider role, the fear of being seen as weak or effeminate, and the wider impact of child sex-abuse revelations on men in society, are factors that may act as barriers to intimacy between men.

These findings highlight the importance of education initiatives such as 'SPHE' (social, personal and health education) in primary and secondary schools that challenge boys to be more reflective on the potentially damaging effects of traditional constructions of masculinity, and that support them to be more aware of how they process emotional issues.

7.10 Impact of Marriage/Cohabiting and Fatherhood on Health

7.10.1 Marriage/cohabiting

The majority of married/cohabiting men reported that marriage/cohabiting had a very positive influence on a range of practices that impacted upon their health (Table 5.9.1). Approximately two out of three married/cohabiting men attributed a heightened awareness of health, taking fewer risks and eating a healthier diet with being married or cohabiting. Half of the men reported having more medical check-ups, reducing alcohol intake and exercising more. Eight out of ten married/cohabiting men reported their

marriage/cohabiting had resulted in them becoming more caring and sensitive and more fulfilled as a person (Figure 5.9.1). These self-report measures are also borne out by other findings in this study, which support the hypothesis that a positive association exists between being married/cohabiting and men's health.

Married/cohabiting men were significantly more likely to meet the recommended type and amount of physical activity for health gain (Section 5.4.3). They were also significantly more likely to understand the term 'DRE' (Section 5.7.2.1) and to have had a DRE in the past (Section 5.5.2). Married/cohabiting men were significantly more likely to report seat belt usage in the back of a car and to the use of sunscreen when exposed to the sun. They were significantly less likely than unmarried/not cohabiting men to have in the past year been a passenger with a driver who was drunk or to have engaged in unsafe sex at least occasionally (Section 5.6). As discussed in Section 7.9.6, women are reported by men to play a key role in getting them to go to the doctor, and to support them through emotional or mental health issues. It should be noted that no significant relationship was found between marital status and other selected variables (See Table 6.1.3). This may have been due to the diversity of the category 'married/cohabiting', which consisted of a very broad range of men in terms of age and social class for example. Further analysis of this data is necessary to control for other socio-demographic factors.

In summary, these findings add considerable weight to the assertion that Irish women continue to play a very positive and supportive role in Irish men's health. As indicated earlier, married men are less likely than married women to be admitted to a hospital for a psychiatric illness, while widowed and divorced males are more likely to be admitted than widowed or divorced females. Norcross, Ramirez and Palinkas (1996) cite a number of studies showing that health benefits accruing from relationships, and from marriage in particular, appear greater for men than for women. This gender difference is most pronounced when a marital relationship is disrupted through divorce or the death of a spouse, when the consequences are more detrimental to the health of men than women. The authors propose that a key reason for this may be that women are far more likely than men to be the principal brokers or arrangers of health care for their spouses, a factor borne out in the present study, and are more knowledgeable about health than men. While women are 'good' for men's health, it appears that the same cannot be said of men in relation to women's health!

7.10.2 Fatherhood

In addition to addressing the impact of fatherhood on overall health and health practices, this section also examines how men report combining the roles of provider and father and the extent to which they identify with the traditional male provider role.

7.10.2.1 Juggling 'provider' and fatherhood roles

Implicit in the notion of traditional constructions of masculinity is that of father as provider and mother as carer/nurturer. In the case of the former, 68% of 'younger' Irish fathers (i.e. fathers of 'younger' children) continue to see themselves as being either solely or mostly responsible for providing for their children (Figure 5.9.2). Of 'older' fathers (i.e. fathers of 'older' children), 84% saw themselves in this role. While there is evidence of a shift towards more shared responsibilities among younger fathers, it appears that a large majority of Irish men continue to assume responsibility for the provider role. The corollary of the male provider role is of course that the majority of fathers report their spouse/partner as being principally responsible for childcare (Figure 5.9.3). Indeed, whereas there was some evidence of a move towards more shared provider role responsibilities among younger fathers, there were negligible differences between younger fathers and older fathers in terms of managing and caring for children. Brooks (2001) identified the post-industrialisation as a time when fathering became associated in a very limited way with the provision of material resources. He argues that the extent to which fathers become preoccupied with work is directly related to the amount of intimate contact and quality of relationships they will have with their children, as indeed it is to optimal mental health.

Fathers' comparative 'hands-off' approach to childcare is borne out by the division of parental responsibilities in relation to specific childcare tasks (Table 5.9.2). Although there is some evidence of younger fathers being more proactive in childcare, mothers are still largely responsible for tending to day-to-day childcare tasks. Approximately two-thirds of all fathers stated that their wives/partners were solely responsible for taking children to the doctor. Whilst this may quite simply be due to mothers being 'freer' to do so, it does add some weight to the argument that both help-seeking behaviour and care-giving are seen as a woman's responsibility. At a more practical level, it is perhaps a chance missed in terms of offering opportunistic health care to fathers who bring their children to the doctor. These findings reinforce previous studies (Kiely, 1996 in Ferguson 2001; Fine-Davis and Clarke, 2002), which have shown that women continue to be responsible for the bulk of child-care and domestic labour within the home. The

increased participation of women in the workplace has not, Ferguson (2001) argues, brought about a corresponding reconfiguration of men's roles as carers or as sharers of domestic labour. This point is reinforced by Valiulis who states that:

If the entry of women, especially married women, in increasing numbers into employment outside the home was the major challenge in the late 20th century, then one of the challenges of the 21st century is the entry of men, especially of fathers, into the home

Valiulis (2002, p9)

7.10.2.2 Provider-role identity

While the majority of men in practice still appear to be drawn towards the traditional provider role, there was evidence of a shift in the way that older fathers identified with what could be described as traditional male provider and female nurturer roles, and with concerns relating to work/fathering balance (Figure 5.9.4). Younger fathers were much more likely to reject such traditional roles, and to support change in favour of more active fatherhood. It could be said that an anomaly existed between men's reported 'practices' on the one hand and their attitudes in relation to work and childcare on the other. For example, while 76% of fathers reported being solely or principally responsible for providing for their families, only 40% endorsed the proposal that the father's sole/principal role is to provide and the mother's sole/principal role is to care for their children. Fathers of older children were more likely to endorse this view. It was also noteworthy that with 72% of fathers reporting that their wives/partners were primarily or more frequently responsible for caring for their children, 69% stated that they would rather work less in order to spend more time with their children. These findings add considerable weight to the contention that it is more out of necessity than choice that many fathers combine their roles as providers and fathers.

Approximately two-thirds of fathers felt that in trying to get on in their jobs, no allowances were made for them as fathers, and that the provision of paternity/paternal leave was inadequate (Figure 5.9.4). Ferguson (2002) cites the negative attitudes of employers and colleagues as the biggest barrier to creating family-friendly workplaces, and as a reason why approximately 90% of fathers have never availed of parental leave. As Jeff (a 38 year old administrative officer) notes in the context of making a request to his line manager for one day per week of parental leave:

I went in and offered to cover the five days work in four days. The first thing he said was 'does this mean we should only have been paying you for four days all along', and he laughed...I was rippin. Jeff 38

Supporting men to change requires a fundamentally challenge to a culture whose dominant institutions place significant barriers in the way of men who want to change. It is also worth noting that 15.3% of men identified 'losing out on work or not getting promoted' as a factor that would cause them anxiety about going to the doctor (Table 5.2.10), with younger men being significantly more likely to so report.

7.10.2.3 Striking a balance between work and fatherhood

While it appears that Irish men continue to act out the traditional role of provider, there is clearly a desire on the part of many fathers to achieve a better balance between work and being an active father. Attempting to redress the disparities arising from traditional influences on male/female roles, the focus rather understandably tends to be on the continued gender gap in earnings, and on ways of facilitating increased numbers of women into senior management positions (Department of Justice, Equality and Law Reform in Ireland; in Coulter, 2003, p6). What tends to be taken much more for granted however is fathers' absence from child caring and child rearing as they tend to the world of work. Ferguson (2001) notes how the evolution of 'masculinity' in Ireland centred on the hard-working man and the 'good-provider' role. While the role of the traditional Irish woman has been constructed as a carer, nurturer and home-maker – a role enshrined in the Irish constitution – the male role has been constructed as breadwinner, a role which Ferguson notes required many Irish men to leave their families during times of recession to travel abroad to seek work in order to continue 'to provide' for their families. The absence of any explicit mention of fathers in the Irish constitution is restrictive for men and adds to the compartmentalising of 'men' and 'women' into very traditional and outdated roles. It also remains a central and emotive issue in the case of Irish family law, particularly in what is perceived by many as the 'automatic' rights of mothers compared to fathers – an issue described recently by Bob Geldolf (in the context of British law) as 'state-sanctioned kidnapping' (Channel 4 Television, 2004).

With one third of Irish fathers of young children working over 50 hours per week, and spending longer commuting to work than most of their European counterparts, Ferguson (2002) argues that it is not men's willingness to get involved in child care but their availability to do so that is at issue. Fine-Davis and Clarke (2002) have also cited long and inflexible working hours, and long commuting times as important constraints in providing fathers with a choice to be more active as fathers. Indeed, the potential for reform may not simply be a question of choice for men, but influenced more by the material circumstances in which

they find themselves. Ferguson argues that the economic prosperity brought about by the 'Celtic Tiger' during the 1990s has resulted in an even stronger depiction of the 'good family man' as a hard-working man.

The introduction of paid paternity and paternal leave, as called for by The National Women's Council of Ireland (Corcoran, 2002), and the creation of more family-friendly workplaces, would serve as important steps in allowing fathers to be more available as fathers. Corcoran cites an IBEC (2001) national survey of pay and conditions of employment, in which only one company in five had any form of paternity leave in place, and for which the average number of days of paid leave was one to three. In a recent European-wide study carried out on behalf of the European Commission (Eurobarometer, 2004), it was found that 75% of fathers knew of the right to parental leave, but only 16% had taken it up or intended to take it up. The principal factors that deterred fathers from staying at home were (i) financial, with 18% saying they could not afford to and 42% citing insufficient financial compensation; (ii) lack of information (34%) and (iii) concerns about their careers, with 31% saying their careers would be affected and 20% not wanting their careers to be interrupted. Comparing Europe, it is worth noting the much more liberal structures of paternity/parental leave in particular in Scandinavian countries. In Norway for example, fathers are entitled to four weeks paid paternity leave. In Sweden, a country with the highest male life expectancy in the world, paid leave (parental allowance) is seen as a family entitlement, with the provision of a 'use it or lose it' incentive for fathers (Childcare and Family Statistics Sweden, 2004).

7.10.2.4 Relationship between fatherhood and health

There were indications from the men's narratives of an increased consciousness about health arising from fatherhood. As Ray (a 47 year old accountant) indicates, this was associated with a sense of obligation to his children and reinforced by the logical deduction that healthier fathers were probably better providers for their children: *when you've kids, it dawns on you that you have a responsibility to them, and you'd like to maybe be involved with them while they grow up as opposed to having a poor quality of life yourself.* Ray 47

The strongest association from the quantitative study of the effect of fatherhood on health practices was in terms of reduced risk-taking (Figure 5.9.4). Approximately two-thirds of all fathers attributing the taking of less risks with their health to the reality of them becoming a father. This finding was also borne out from Section 5.6, where it was found that fathers were significantly more likely than non-

fathers to report seat belt usage in the back of a car and to use sunscreen when skin was exposed to the sun. They were also significantly less likely to have in the past year been a passenger with a driver who was drunk, or to have engaged in unsafe sex at least occasionally. Indeed, a number of fathers who participated in the qualitative studies also cited a reduced propensity towards risk-taking as a result of becoming fathers. For example, Cathal (a 39 year old business manager) attributes his responsibilities as a father to a profound change in his attitude to drink driving. He is now acutely aware of the potential consequences for his own children of him putting himself at risk.

*...when I was in college in *****, I don't know how I often got home in the car, you know, I was invincible, but that is something [drink and drive] I would never do now. Basically because I have kids now.* Cathal 39

In the contexts of alcohol consumption, diet, exercise and stress management, between a third and half of all fathers reported that fatherhood had a positive influence on these lifestyle behaviours (Figure 5.9.4). One in three fathers also reported having more regular medical check-ups on becoming a father. The extent of these associations was greatest in relation to fathers of younger children. It is worth noting from Section 5.4.1 that men in their 30s were half as likely as men aged 18-29 to be categorised as excessive drinkers, and almost half as likely again to report weekly binge drinking. These lower drinking patterns may be associated with a change in fatherhood status between the two age categories.

7.11 Men's Health Composite Scores

The purpose of developing composite scores was to compile collective data on different dimensions of men's health that would enable an examination of overall trends in the data. This was carried out by: a) cross-tabulating composite scores with socio-demographic variables; and: b) exploring the inter-relationships between composite score variables.

7.11.1 Relationship between men's health composite scores and socio-demographic factors

This section will examine the relationship between men's health composite scores and age, social class and education. Marital status and parental status have previously been discussed in Sections 7.10.1 and 7.10.2 respectively.

Age

Significant correlations ($p < .05$) were found between age and five of the seven composite scores (Table 6.13). As

expected, older men were significantly more likely than younger men to report poor health and a long-term illness/disability. However, younger men were significantly more likely than older men to engage in 'negative' self-care practices; to have 'unhealthy' health behaviours; to report a low level of preventative health; and to engage in a high level of risk behaviours. These findings are supported by earlier reported findings from this research, which can be summarised as follows:

- In relation to accessing GP services, younger men were significantly less likely than older men to report overall satisfaction with their general practice. Younger men were significantly more likely to report shorter consultation times and to leave their GPs' surgeries with unasked or unanswered questions. Young men were also significantly less likely to be satisfied with a range of aspects of GP care, including interpersonal care, their GPs' knowledge of them as patients and feeling 'enabled' to manage their health problem(s) or illness(es) after a visit to their GP. These findings have implications for improving the way that doctors relate to young men, and point to the need for improved education and training of doctors in this area. Younger men were significantly more likely to identify work as a barrier to going to their doctors and to play down symptoms as a reason for not going to the doctor.
- In the context of health behaviours, young men (18-29) were significantly more likely to drink excessively and to binge drink weekly; the incidence of smoking was highest among men aged 30-49; older men were significantly less likely to meet the recommended type and amount of physical activity for health gain; the level of reported stress was highest amongst men in their 30s, and declined with age.
- In terms of health behaviours, men under the age of 40 were three times less likely than men 60 and over to report monitoring of alcohol consumption. Younger men were significantly more likely to report being ineffective at managing stress
- In the context of risk behaviours, young men were significantly less likely to use seat belts in the back of a car, to report compliance with speed limits or to use sunscreen to protect their skin. They were significantly more likely to have in the past year been a passenger with a driver who was drunk and to have engaged in unsafe sex at least occasionally.
- One in two men aged 18-29, the age group at highest risk of developing testicular cancer, had never heard of TSE.

Despite the rather negative health profile that was

associated with young men, men in their 20s paradoxically were significantly less likely to report neglect of their health compared to men in their 30s or 40s. Courtenay (1998) reported that young college men perceive much less risk associated with the use of cigarettes, alcohol and other drugs, and risky driving practices, compared to young women. A belief in their own invulnerability and unrealistic perceptions of risk are widely reported as the underlying reasons for such behaviours and perceptions. He also states that college men also consistently score lower on indexes of health-protective behaviours that include safety belt use, sleep, health information, eating habits, exercise, use of sunscreen and testicular self-examination (ibid).

This apparent association of health neglect with age, or at least of younger men taking health for granted, is borne out in the men's narratives. For example, a very prevalent theme throughout was that of young men seeing themselves as invincible, and that health could simply be taken for granted (See Section 7.1.1). This in turn appears to foster the belief that young men have a licence to subject their bodies to different excesses (e.g. excessive and binge drinking) and risk behaviours, with a minimal sense of responsibility towards adopting positive health practices. It has also been proposed that young men may be far more likely to reject certain health behaviours (e.g. accessing health services/health screenings) that might have connotations for them of being feminine, and on the other hand to adopt risk behaviours or negative health behaviours (e.g. binge drinking) that might confer to them status or 'respect' within their peer group. While there was evidence of an awakening towards a greater health consciousness among men in their 40s, this was qualified by signs of a resistance to the changing of health practices and attitudes that have by that age become ingrained – the notion that you cannot teach an old dog new tricks.

In conclusion, while older men understandably tend to be prioritised at a health service delivery level, there is clearly a need to introduce measures that will address young men's propensity for high risk-taking and damaging health-behaviours.

Brian (a 37 yr old solicitor) highlights the importance of targeting boys early in life to help them to establish positive health behaviours rather than focusing solely on older men who may have become set in their ways.

I'd like to invest a lot of money in boys when they start off in life, when they get to a situation even if its in a playgroup or whatever, I think like that they should be taught the value of exercise, the value of maintaining a healthy diet, you know, encourage along those kind of things, because I think once you get to a certain stage there's no point in really trying to teach someone, you

can't go and teach a fifty-year-old man, he's not just going to change at that stage. I think I would put other resources really into, most of the resources into creating the right environment for boys, be it in school and families or whatever at the very start. Brian 37

'Creating the right environment' for boys presents a number of challenges, not least in terms of contesting traditional constructions of masculinity that confers status to health damaging and risk behaviours, and that infers weakness and femininity to positive health care practices. Educational and social marketing initiatives, coupled with proper enforcement of legislative measures, are key elements in reversing the paradigm that young men are invincible and that health doesn't concern them.

Social Class

Significant correlations ($p < .05$) were found between social class and two of the seven composite scores (Table 6.1.3). Poorer men were significantly more likely to engage in 'negative' self-care practices, and to have a low level of knowledge/awareness of health. These findings are supported by earlier reported findings from this research, which can be summarised as follows:

- Men from SC 5/6 were twice as likely as men from SC 1/2 to report having neglected or paid little attention to their health over the course of their lives.
- In relation to accessing GP services, men from SC 5/6 were significantly less likely than men from SC 1/2 to report overall satisfaction with their general practice. They were significantly less likely to be satisfied with different aspects of doctor-patient communication. They were also significantly more likely to identify going to their GPs only 'as a last resort'. In the context of being fearful or anxious about going to the doctor, men from SC 5/6 were significantly more likely than men from SC 1/2 to cite having private parts examined and being admitted to a hospital as factors that would cause them to be fearful or anxious.
- In the context of health behaviours, men from SC 3 to 6 were almost twice as likely to report weekly binge drinking than men in SC 1/2. Men from SC 5/6 were significantly less likely than SC 1/2 to meet the recommended type and amount of physical activity for health gain.
- In relation to risk behaviours, men from SC 1/2 were more than twice as likely as men from SC 5/6 to have in the past year driven having had two or more alcoholic drinks. On the other hand, men from the lower social classes (SC 3-6) were twice as likely as men from SC 1/2 to have in the past year been a passenger with a driver who was drunk. Men from lower social classes were significantly more likely to have engaged in unsafe sex

at least occasionally.

- Men in SC 1/2 were almost twice as likely as men in SC 5/6 to understand the term DRE.

Social class has been identified as a very strong predictor of mortality in men, and the risk of mortality differs throughout the full social class range (Vagero, 2000; Kraemer, 2000). The Institute of Public Health's statistics on all cause mortality for the island of Ireland during the period 1989-1998 (Figure 2.2.3) show that the mortality rate in the lowest occupational class was 100% -200% higher than the rate in the highest occupational class (Balanda and Wilde, 2001). Low social class status has also been linked to alcohol abuse, illegal drug use and smoking (Lindsay 2001). The National Alcohol Policy (Department of Health and Children, 1996) reported an over-representation from the 'unskilled manual' social class in admission figures to psychiatric hospitals for alcohol-related disorders. While the focus of social inequality in health tends to revolve around rates of mortality and morbidity, Blaxter (1987) has shown that there are also striking differences between social classes in self-defined health status, the reported incidence of illness and the prevalence of chronic disease. It has also been well established that where poverty is compounded with other forms of social disadvantage or marginalisation (e.g. Traveller men), the health consequences are even more remarked.

The findings from this research confirm that neglect of health, negative health behaviours and higher levels of risk behaviours are significantly associated with men from lower social classes. Clearly however, these findings should not be interpreted in a simplistic way as lower SC men making the wrong health or lifestyle 'choices' or 'failing' to access health services. Apportioning blame may in fact perpetuate the underlying problems and result in failure to acknowledge the structural and social changes that are necessary to address the health issues of poorer men. Government departments and local authorities must be encouraged to recognise the vital role that education, housing, environment, leisure and social services can play in addressing men's health, especially those in disadvantaged areas. It is only when deficiencies in these services are addressed that a proper understanding can be gained of why poorer men are for example more likely to binge drink, or to 'neglect' their health. Measures to change such behaviours can then be designed in a way that is sensitive to the context and culture of these men's lives. The findings highlight the need to prioritise men from SC 5/6 for any future resources that may be directed to men's health.

Education

Significant correlations ($p < .05$) were found between

education and three of the seven composite scores (Table 6.1.3). Poorly-educated men were significantly more likely to report poor health and a long-term illness/disability; to engage in 'negative' self-care practices; and to have a low level of knowledge/awareness of health. A significant association was also found in this study between education and social class (Chi-Square = 52.840; df = 6; p=.000), with men with third level education being over three times more likely to belong to SC 1/2 than men with no more than primary education (43.1% v 12.7%). Other notable findings in relation to education from this study are summarised as follows:

- In terms of accessing GP services, men with not more than primary education were twice as likely as those with third level to identify going to the doctor only as a last resort. In the context of being fearful or anxious about going to the doctor, they were also significantly more likely to cite concern about having a serious condition diagnosed, having private parts examined and being admitted to a hospital.
- In the context of self-reported health status, men with not more than primary education were twice as likely as men with third level education to report a long-term illness or disability, and almost twice as likely to report having neglected or paid little attention to their health over the course of their lives.
- In relation to health behaviours, men with less formal education were significantly less likely to meet the recommended type and amount of physical activity for health gain. Men with third level education were more than twice as likely as men with not more than primary education to report feeling regularly or constantly stressed.
- Men with third level education were almost three times more likely to have had a DRE than men with no more than primary education.
- In the context of risk behaviours, men with third level education were almost twice as likely as men with no more than primary education to have in the past year driven having had two or more alcoholic drinks. On the other hand, men with not more than secondary education were three times more likely to have in the past year been a passenger with a driver who was drunk. Men with third level education were over three times more likely as men with no more than primary education to report non-compliance with speed limits, but significantly more likely to report use of sunscreen when exposed to the sun.
- In terms of knowledge of health, men with third level education were almost twice as likely as men with not more than primary education to understand the term DRE, and significantly more likely to be knowledgeable

about TSE. They were also twice as likely to correctly identify carbohydrate as the principle nutrient in the diet.

Kelleher et al (1998; 2002) reported low level of education as a strong predictor of self-reported poor health status, of higher incidence of smoking and of being sedentary. The findings are also borne out by another, more recent, Irish study, which found education to be a strong predictor of inequalities in health (Balanda and Wilde, 2004, pp53-55). Compared to those with third level education, people with primary education or less were less than half as likely to report excellent/very good health, and significantly less likely (p<.0001) to be free of limiting long-term illness. The same study showed that poorly-educated people were significantly more likely to smoke and to be overweight/obese. The findings from this research add considerable weight to education as a strong predictor of health status and health behaviour among Irish men. Whilst poor education is broadly associated with other forms of disadvantage such as lower social class, further research is necessary to establish the exact nature of the relationship between low level of education and poorer health outcomes for men. Indeed it may be that low level of education and 'poor health' are products of more fundamental structural and social inequalities, and are a direct consequence of latter. The findings from this report confirm the importance of targeting and prioritising poorly educated men as part of any future initiatives or policy on men's health.

7.11.2 Inter-relationships between men's health composite scores

Section 6.8 outlines the interrelationships between the men's health composite scores, which are illustrated in this section in Figure 7.11.

Figure 7.11 Inter-relationships between men's health composite scores



The magnitude and complexity of the relationship between these variables is consistent with Courtenay's finding

(1998, p286) that unhealthy behaviours frequently occur in clusters, and that the interaction of these behaviours may well compound men's health risks. These clusters may in the author's view, represent "organised constellations of behaviours". For example, in this study, men who reported 'negative', as distinct from 'positive' self-care practices were almost twice as likely to have a 'low' level of awareness of health, three times more likely to engage in 'unhealthy' health behaviours, almost three times more likely to engage in 'high' risk behaviours, over twice as likely to adopt a low level of preventative health and half as likely to acknowledge problems and seek help when faced with an emotional/mental health issue. This is further borne out by other more specific findings outlined in this report, including the following:

- Men who engaged in vigorous physical activity were twice as likely to report good health compared to those who were inactive, while those who were inactive were three times more likely to report poor health compared to those who were engaged in vigorous physical activity.
- There was a significant association between both excessive and binge drinking and a high level of risk behaviours, including not using seat belts, speeding, drink driving and engaging in unsafe sex.
- Smokers were twice as likely to be excessive drinkers, almost twice as likely to report weekly binge drinking and twice as likely to lead sedentary lifestyles. Almost half of all smokers reported 'regularly' using smoking as a means of managing stress.
- Those men who reported having neglected or paid little attention to their health over the course of their lives were significantly more likely to smoke, to drink excessively, to binge drink weekly, to be sedentary, to attribute late presentation as a cause of a long-term health problem, and to report being ineffective at managing stress.
- Those men who reported as being ineffective at managing stress were significantly more likely to also report having neglected their health, to engage in risk behaviours and to turn to potentially health-damaging behaviours as their likely means of coping with stress.

There are a number of implications from these findings that are critically important in terms of men's health:

At one level, the prospect of intervention vis-a-vis that cohort of men who report the 'worst' pattern or profile of health behaviours is hugely challenging. Indeed, the merits of targeting a specific aspect of health (e.g. increasing physical activity among sedentary men) might seem futile when set against a backdrop of overall negative health attitudes. However, the evidence from this study suggests

that the inter-relationship between health variables runs in both directions. For example, those men who did not drink to excess or did not binge drink, were significantly less likely to engage in risk behaviours. This raises the possibility at least of wider health benefits accruing from specific health interventions. A physical activity intervention for example might bring about positive spin-offs such as improved dietary habits or better preventative health (See Section 7.4.1). Further research is necessary to establish if this might be a further outcome and to track the nature and extent of positive health behaviour change that may arise from specific health interventions.

This section of the report has highlighted the inter-relationships between men's health variables, but has not attempted to tease out the nature of these relationships. Further research is necessary to establish why negative or positive health behaviours occur in clusters, and more importantly to find out what is the impetus for associated behaviour change that might arise from a specific intervention. For example, there appears to be strong evidence to identify excessive and binge drinking as triggers for increased levels of risk behaviours, with impulsiveness and impaired decision-making linking the two. It is therefore reasonable to conclude that by reducing or altering the pattern of alcohol consumption, levels of risk behaviours will be reduced. There is, however, a dearth of evidence to explain the relationships between other variables, and in particular to identify those factors that are most significant in terms of providing an impetus for positive associated health behaviour change. In particular there is a need to establish the nature of the relationship between health awareness, attitudinal and health behaviour variables.

The inter-relationship between men's health variables highlights the importance of a holistic and inter-disciplinary approach to men's health. As health service delivery tends to be segregated across different disciplines, each with a different ethos and way of working, there is inevitably a fragmentation in the way that services are ultimately delivered on the ground. The data from this section strongly suggests the need for health professionals to work in partnership to work out ways of targeting multiple aspects of men's health in a more integrated and holistic way.



**CONCLUSIONS AND
RECOMMENDATIONS**

Section 8 Conclusion & Recommendations

The development of a national policy for men's health in Ireland and the mainstreaming of gender in health

Recommendation 15 of the current Health Strategy states that 'a policy for men's health and health promotion will be developed' (Department of Health and Children, 2001). The purpose of this report is to inform the development of that policy. The Department of Health and Children has committed to an extensive consultation process during 2005, that will also bring to the forefront the issues and concerns relating to men's health from the statutory, community and voluntary sectors. The development of a policy that is informed by research and based on extensive consultation is laudable. The policy can only be effective, however, if it offers a clear blueprint for targeted recommendations, and if it is resourced adequately.

Men's health is not just a men's issue. In the context of a gendered approach to health, it is argued that health problems affecting men may also have a profound impact on the welfare and quality of life of women and children. There may for example be economic or material implications for women and children through reduction or loss of family income, or increased medical expenses. As cited earlier, initiatives designed to support fathers to have increased involvement in childcare have been shown to result in the development of closer bonds with their partners and healthier relationships with their children. Indeed, some health issues are inextricably linked, as in the case of sexual health for example. Whilst there is therefore a need to focus on sex-specific and gender-specific health issues affecting men and women separately, the concept of 'gendering' health looks at health care in a relational way.

Recommendation 1 The development of a National Policy for Men's Health that contains specific timeframes for implementation and clear measures for monitoring and evaluating recommendations.

Recommendation 2 The 'mainstreaming' of gender in health that promotes the integration of gender concerns into the development and evaluation of policies and services, that ultimately leads to the best possible health status for men and for women.

Putting men's health on the political agenda

In order to raise the profile of men's health, it is vital that it finds a place on the political agenda. Schofield et al (2000) stress that the positioning of men's health in the realm of Australian politics and government was vital in terms of nurturing men's health as a theme of public concern. In the United States, *National Men's Health Week* is now an

established and highly successful event arising out of the National Men's Health Week Act that was passed by Congress in 1994 and signed into law by President Bill Clinton the same year. It has also been shown in the United Kingdom that the profile of men's health has been raised substantially following the introduction of an all-party parliamentary committee on men's health, which is chaired by the Men's Health Forum (UK).

Recommendation 3 That the joint Oireachtas Committee on Health and Children examine the issue of Men's Health that will support and foster men's health as a theme of public concern in Ireland.

Defining men's health in a holistic and 'salutogenic' way

Men's health must be understood as much more than the sum of male-specific illnesses or diseases. This narrow focus may result in dangerous public misconceptions that male health problems are limited to, for example, the prostate gland, and the subsequent mindset that; 'if the prostate gland is ok, there is nothing else to be concerned about'. A more holistic approach that focuses on men's quality of life, and that supports men to experience optimal social, emotional and physical health, is called for.

As described throughout this report, the literature on men's health tends to have a strong pathological focus, in particular on male-specific diseases, and what Macdonald et al (2000) describe as the 'social pathologies' (men's violence, men's limitations in expressing feelings, men's 'failure' to use health services). The discourse, in particular around masculinities and health, tends to rely on the 'negative' risk aspects of men's health, and less on the resources that men bring to their own health. Rather than addressing the underlying causes of these issues, there is a tendency to focus on blaming men, and at a service delivery level to see men as 'hard work'. In moving forward to a national policy on men's health, the challenge must be to re-orientate the focus away from a narrow 'pathological gaze' and instead to adopt a 'salutogenic' approach to men's health (Macdonald and Crawford, 2000). This approach focuses on human resilience, what is health enhancing in the context of people's lives, and which extends to their physical, emotional, economic and cultural environments. A salutogenic environment promotes in boys and men a positive sense of self, and affirms the inherent value of boys and men.

Recommendation 4 To adopt a holistic approach to men's health at both a policy and health service delivery level, that seeks to address the underlying causes of men's health issues. In order to work in a proactive way with men, there is a need for greater understanding and appreciation

of why men take risks with their health, why they are more likely to engage in health damaging behaviours than in preventative health behaviours, and why they are prone to present late during the course of an illness.

Recommendation 5 To orientate men's health policy and service delivery towards a positive outlook on men's health, that seeks to foster in boys and men a positive sense of self, and that affirms the inherent value of boys and men.

An increased and more integrated focus on research in the area of men's health

Much of the existing literature on men's health in Ireland tends to stop short at highlighting sex differences, without examining the potentially damaging effect of 'being male' on health. There has been a general failure to connect how men set about defining themselves as masculine with negative health consequences. It is strongly recommended that a key priority in the development of a national men's health policy would be to establish a National Men's Health Research Network. This report, together with such publications as *Men Talking* (North Eastern Health Board, 2001) and *Men's Health in Ireland* (McEvoy and Richardson, 2004), can serve as an impetus for this to occur. The establishment of such a network is vital in terms of developing a connected and integrated approach to future research that can support practical action with relevant community-based organisations, and in which the outcomes can be closely linked to healthcare policy and provision. Principally, there is a need to develop more multidisciplinary research teams that can link biomedical research with social scientific research. This means a broadening and diversification of research methods, and appropriate multidisciplinary programmes to facilitate the research. It may also require a review of how health research funds are disseminated, and in particular to question if biases exist towards the more tried and tested quantitative, biomedical methods.

It is also critically important to locate and construct future research initiatives in community, work, and other settings where men feel at ease, and where those men in most need are targeted. A healthy and respectful policy towards those men being researched should inform the research work, and their payment ought to be included when funding is being sought (as per Men's Development Network policy). Given the relational nature of gender, the development of a Centre for Gender and Health Studies (with appropriate focus on men and masculinities) may well be the way forward for the advancement of health issues for both women and men in the future.

Recommendation 6 The establishment of a National Men's Health Research Network that can link different

aspects of men's health together, and that more closely connects research to health care policy and provision. The main functions of this body would be (i) to promote increased multidisciplinary research initiatives; (ii) to promote gender and masculinities as key variables in reaching the criteria necessary to achieve research funding; (iii) to have an input into the prioritisation of men's health research questions; (iv) To promote increased community-based and community-driven research; (v) to ensure that research findings are disseminated in an appropriate way to policy makers, health workers and community leaders; (vi) to treat researchees as part of the research team.

Recommendation 7 The establishment of a Centre for Gender and Health Studies that focuses on gender-specific health issues affecting men and women separately, but that also considers health and health care in a relational way.

Raising awareness of men's health issues and harnessing an increased preventative health ethos amongst Irish men

This study has shown unequivocally that health has largely been excluded from the culture and context of Irish men's lives. Many Irish men give little serious consideration to their health, and are reluctant to identify as participants in health care. Sadly, it seems to require the experience of a health crisis, in relation to either oneself or someone close, to act as a 'wake-up call' to an increased health consciousness. Against such a backdrop, it is hardly surprising that Irish men's knowledge and awareness of fundamental health issues continues to be alarmingly poor. It has also been shown that there is an overall lack of a preventative health ethos amongst Irish men, particularly amongst young men, who tend to see themselves as invincible, and are not inclined to connect current health-damaging behaviours with long-term harm. The absence of a preventative health ethos is consistent with a culture that very often is at odds with prevention. There is therefore an urgent need for increased education and awareness raising of men's health issues, which should be targeted at both boys and men.

Recommendation 8 The expansion of 'boys and men's health' on the primary and post-primary school curricula (e.g. SPHE), that will include a focus on both 'male' specific health issues and on the relationship between masculinities and health.

Recommendation 9 An increased priority on men's health in the workplace, that embraces the workplace as a key setting for delivering men's health initiatives, and that involves both employers and representative bodies/unions working in a cohesive way on promoting men's health.

Recommendation 10 The co-ordination of a *National Men's Health Week* in Ireland, that will link with *International Men's Health Week*, and that will promote different aspects of men's health each year

Recommendation 11 The use of specific campaigns to target men's health issues, such as the Irish Cancer Society's 'Men's Cancer Week', that will promote increased awareness of men's health issues and the importance of men presenting early rather than late during the course of an illness. Similar campaigns should target, for example, cardiovascular disease, mental health and sexual health.

Recommendation 12 A thorough evaluation of the effectiveness of written health education and health promotion materials needs to be carried out in the context of men, with particular focus on the mediums used to present health messages and the social and cultural contexts in which they are presented. Particular attention needs to be paid to the appropriateness of written health materials for different social classes and different education levels. It is imperative that such materials are used not in isolation, but as part of wider and more holistic men's health initiatives.

Recommendation 13 The allocation of increased resources to the development of help lines and Internet sites as mediums of help seeking that are deemed to be attractive and acceptable to men (e.g. Irish Cancer Society, 2004). The availability of such supports also needs to be adequately publicised.

Recommendation 14 Increased efforts are necessary to educate men around the links between late presentation to health services and impaired health status, and to support men to be more proactive about their own health.

Making healthcare and health services more amenable to men

A tendency to play down symptoms, cost and losing out on work were the factors most likely to be attributed to an overall sense of reluctance on the part of men generally to seek help when sick. Late presentation to health services has been implicated as a key factor in men's higher mortality rates and lower life expectancy. There is a need to challenge what might be described as the traditional male gender script, that confers status to health damaging and risk behaviours, and that infers weakness and femininity to positive health care practices. The paradigm that being sick or going to the doctor somehow represents failure or personal weakness in men must be reversed.

Recommendation 15 Healthcare needs to be portrayed as a strong ally of modern day constructions of masculinity. The message must be clear that men taking charge of their health can help them attain, maintain, or regain their greatest potential productivity, vitality, strength, virility, stamina, attractiveness – all the things that make men 'feel

like men' (Bonhomme, 2004).

Recommendation 16 Health services, and in particular primary care services, must be made as convenient and as 'male-friendly' to men as possible. In particular, there is a need for more flexible opening hours, a more male-friendly waiting room, decreased waiting times for consultations to begin, and ways of improving lines of communication between GPs and male patients.

Recommendation 17 It is recommended that training in 'men's health' be developed and offered to all those working with men in health services, and that this training be included in the training curricula of all health professionals and allied health professionals.

Supporting men to cope more effectively and more openly with illness

Stepping outside the boundaries of the traditional man who is invulnerable and stoic, continues to be an issue for many men in terms of acknowledging and dealing with illness in an open and honest way. The sense of feeling compelled to maintain a 'manly' silence and stoicism in the face of illness, is manifested most strongly in the context of mental health issues. As a result, men learn to live with their fear, and may 'self-medicate' with alcohol or turn to violent behaviour rather than seek help

Recommendation 18 There is a need for increased education and awareness raising that challenges the culture that infers weakness or cowardice on those men who acknowledge feeling pain or fear. These feelings should be seen as intrinsic warning signals and as healthy tools of survival. Boys and men should be taught to distinguish between 'pain' which may be less harmful in a sporting or labouring context for example, and 'pain' which at specific times may require medical intervention (Bonhomme, 2004).

Recommendation 19 Continued efforts are needed to raise the profile and level of acceptability of men's health issues, and to open up channels to services for men who require help. This is particularly a priority in the areas of mental and sexual health. There is an urgent need to challenge the stigma that for some men continues to be associated with seeking help for depression.

Supporting men to find a language to deal with emotional/mental health issues

This report has shown a propensity for Irish men to adopt strategies of 'avoidance' or 'silence' in the way that they manage themselves through emotional or mental health issues. This can result in an attempt to deny or 'control' emotions, and to distance themselves from acknowledging issues that might bring to the surface their own vulnerability. This is inevitably associated with a cycle of unresolved emotional issues being suppressed and then resurfacing. Depression is seen by some men as perhaps the

ultimate 'failure' to sort out emotional issues.

Recommendation 20 That *SPHE, Exploring Masculinities* and similar initiatives (e.g. *Victory and Defeat*, Men's Development Network, 2003) for boys are given a high level of priority at both primary and post-primary level. It is imperative that boys are challenged to be more reflective of the potentially damaging effects of adhering to traditional constructions of masculinity, particularly in terms of having an impaired language for expressing emotional distress. It is also important that boys are supported to be more open and 'honest' about seeking help for emotional problems, without paying the 'price' of having stepped outside the boundaries of traditional constructions of masculinity.

Recommendation 21 That the forthcoming mental health strategy [currently in process] gives careful consideration to the issue of men's 'invulnerability' to depression, to men's propensity to use alcohol or aggressive behaviour as more 'acceptable' male outlets to deal with depression, and to what Courtenay (2000a) describes in an American context as a gender-bias amongst mental health clinicians in the under-diagnosis of depression in men. It is equally important that practical work currently being done on the ground with adult men should be supported to address these issues (E.g. Men's Development Network, 1995).

Challenging the 'drinking culture' in Irish society

The findings in this report add further substance to the assertion that a 'drinking culture' exists in Ireland. More specifically, it has been demonstrated that excessive and binge drinking have for young men in particular been adopted as a means of defining their masculinity and as a way of displaying in a very public way allegiance to male peer groups. Such patterns of drinking are sustained within a wider public acceptance of alcohol, and by alcohol advertising that connects alcohol use with prominent displays of masculinity, including connotations of sexual prowess and the achievement of optimum performance in elite sport. This may partly explain why those men who drink to excess or who binge drink generally do not see themselves as excessive or binge drinkers. Nevertheless, they are significantly more likely to engage in impulsive risk behaviours and violent behaviour.

The Strategic Task Force on Alcohol (Department of Health & Children, 2004) maps out a very comprehensive set of recommendations to tackle the issue of alcohol in Ireland, and does so using the ten strategy areas for alcohol action that were outlined in the WHO European Charter on Alcohol. This men's health report endorses these recommendations, and reiterates the importance of a holistic approach to challenge the apparent drink culture that is endemic in Irish society. Furthermore, it calls for increased recognition of the gendered nature of alcohol-

related problems, and specifically the following:

Recommendation 22 That the role of alcohol in the construction of masculinity amongst young men is considered as a fundamental principle in the delivery of any current/future SPHE module on alcohol and drugs to second level boys. In particular, the role of alcohol as a rite of passage to male peer groups needs to be challenged.

Recommendation 23 That counter-advertising measures are considered to challenge the association that currently exists between alcohol and prominent displays of masculinity. Specific measures should be considered such as the portrayal of the deleterious effects of excess alcohol consumption on sexual performance and on the achievement of optimum performance in sport. The involvement of top-level sportsmen as positive role models in such advertising should also be considered

Supporting smokers to quit smoking

In this study, smoking was significantly associated with other health-damaging behaviours. However, the incidence of reported smoking represents further evidence of an overall downward trend in smoking among Irish men in recent years, whilst there was also an apparent willingness among the majority of smokers to quit.

Recommendation 24 That evidence-based smoking cessation programmes, are delivered in a flexible and convenient way, in for example, the workplace.

Increasing physical activity and reducing overweight/obesity levels among men

For many Irish men it appears that 'retiring' from competitive sport coincides with retiring from physical activity in general. In the context of men's health, this is all the more significant when set against a backdrop of increasing overweight/obesity levels among Irish men generally, and an apparent propensity for overweight men to consider themselves to be normal weight. It has also been shown in this report that men's dietary habits are poorer than women's, while many men's awareness of basic nutritional information is also quite limited.

Recommendation 25 The endorsement of 'physical activity' for men, as something much broader than vigorous activity or competitive sport, and as an intrinsically valuable component of a healthy lifestyle. In the United States for example, its 'extramural sport' is participation based and designed to cater for all levels.

Recommendation 26 That National Governing Bodies for Sports are encouraged to harness 'retired' men's interest in competitive sports, in ways that do not revolve around traditional and formal fixture lists. A structure based on a more informal, less regimented approach, which nevertheless taps into the inherent attraction of

competitive sport for many men, is recommended.

Recommendation 27 Increased education and awareness initiatives that target men specifically, and that focus on correct nutritional habits and healthy weight ranges for men

Increased stress management programmes for men

The findings from this report present further evidence of the importance of stress as a health issue for Irish men, with work and striving to achieve a work-life balance being the most significant sources of stress. More importantly perhaps, it has been shown that it is not just stress itself that can impact adversely on men's health, but also the tendency for many men to resort to health-compromising behaviours as a means of managing stress.

Recommendation 28 That an increased focus is placed on more health promoting stress management initiatives for men, particularly in the workplace, and that more flexible and family-friendly work practices are made available in particular to fathers of young children.

Tackling risk-taking amongst men

The findings from this report strongly implicate risk-taking behaviour, particularly amongst young men, as an integral part of being a man, and as a necessary means of avoiding the ridicule of being labelled feminine or effeminate. The issue of male violence, for example was found to be an obligatory way of defining and sustaining allegiance to male peer groups.

Recommendation 29 Improved enforcement of legislative measures, particularly in relation to speeding, drink driving and the use of seat belts in the back of cars. This is a particular priority in relation to young men.

Recommendation 30 Increased uses of social marketing strategies aimed at curbing men's risk taking behaviour. In particular, there is a need for such measures to challenge the notion of young men being invulnerable and to explicitly connect risk to both short-term and long-term harm. Television programmes such as *Jackass* that promote and glorify risk-taking behaviours should also be challenged.

Recommendation 31 An increased focus on skin cancer protection initiatives, including a review of the effectiveness of existing preventative measures with men.

Recommendation 32 Increased measures that target men taking greater responsibility for their own sexual health, and in particular that distinguish between pregnancy prevention and STI prevention as distinct elements of sexual health

Targeting those men who are not in long-term relationships with women

It has been shown in this report that the status of being married/Cohabiting is associated in a very positive way with

men's health, notably for example in the case of mental health. Women continue to play a very positive and supportive role in Irish men's health, particularly as the principal brokers of health care for spouses/partners who may be reluctant to seek help.

Recommendation 33 To support men to take more responsibility for their own health and to prioritise and monitor more closely at a primary care level those men who are not in long-term relationships with women.

Supporting men in their role as fathers

The findings in this report confirm that whilst there has been a blurring in attitudes amongst men towards the more traditional male provider and female nurturer roles, the reality is that the majority of men continue to be drawn towards the former. It has been proposed that it may be out of necessity more than choice that many fathers revert to providing for their families, with the result that they adopt a less hands-on approach than they would like as fathers. There was also evidence of an increased consciousness about health arising from fatherhood, and of fathers being less likely to take risks with their health

Recommendation 34 The introduction of paid paternity and paternal leave (in line with Scandinavian countries), and the creation of more family-friendly workplaces, to enable men to adopt a more hands-on approach as fathers.

Recommendation 35 The development of practical initiatives, e.g. parenting programmes, that will support men in their role as fathers.

Targeting socially disadvantaged men

In the context of health inequalities, this report has highlighted in a very clear way how low social class and low education level are linked to impaired health status. This data highlights the wide-ranging structural and social changes that are necessary to address the health issues of poorer and less well-educated men. It has been stressed that government departments and local authorities must be encouraged to recognise the potentially vital role that education, housing, environment, leisure, social services, community development projects and men's development projects can play in addressing men's health, especially those in disadvantaged areas.

Recommendation 36 The expansion and increased resourcing of Men's Health Programmes, Men's Development Projects and Community Development Projects aimed at men effected by marginalisation, disadvantage and poverty, and an increased focus on improved integration of public services in disadvantaged areas, in partnership with non-governmental organisations.

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Appendix

Appendix 1 Missing Values

Figure 5.1.1	n=566; missing values=6	Table 5.1.1	n=566; missing values=6
Figure 5.1.2	n=556; missing values=16	Table 5.1.2a	n=554; missing values=18
Figure 5.1.3	n=718; missing values=54	Table 5.1.2b	n=366; missing values=45
Figure 5.2.1(i)	n=555; missing values=17	Table 5.2.2	n=559; missing values=13
Figure 5.2.1(ii)	n=547; missing values=25	Table 5.2.3	n=525; missing values=47
Figure 5.2.1(iii)	n=544; missing values=28	Table 5.2.4a	n=548; missing values=24
Figure 5.2.1(iv)	n=551; missing values=21	Table 5.2.4b	n=520; missing values=52
Figure 5.2.2a	n=558; missing values=14	Table 5.2.5a	n=560; missing values=12
Figure 5.2.2b	n=550; missing values=22	Table 5.2.5b	n=555; missing values=17
Figure 5.2.3a	n=558; missing values=14	Table 5.2.6a	n=560; missing values=12
Figure 5.2.3b	n=560; missing values=12	Table 5.2.6b	n=546; missing values=26
Figure 5.2.3c	n=555; missing values=17	Table 5.2.7	n=535; missing values=37
Figure 5.2.3d	n=560; missing values=12	Table 5.2.8	n=564; missing values=8
Figure 5.2.4a	n=562; missing values=10	Table 5.2.9	n=230; missing values=59
Figure 5.2.4b	n=546; missing values=26	Table 5.2.10	n=442; missing values=130
Figure 5.2.4c	n=543; missing values=29	Table 5.2.11	n=495; missing values=77
Figure 5.2.5a	n=559; missing values=13	Table 5.3.1	n=560; missing values=12
Figure 5.2.5b	n=547; missing values=25	Table 5.4.1	n=544; missing values=28
Figure 5.2.5c	n=549; missing values=23	Table 5.4.2	n=555; missing values=17
Figure 5.2.6a	n=561; missing values=11	Table 5.4.4	n=556; missing values=16
Figure 5.2.6b	n=180; missing values=9	Table 5.4.7	n=545; missing values=27
Figure 5.2.7a	n=558; missing values=14	Table 5.5.5	n=537; missing values=35
Figure 5.2.7b	n=560; missing values=12	Table 5.5.6	n=472; missing values=100
Figure 5.3.2	n=222; missing values=12	Table 5.6.1a	n=566; missing values=6
Figure 5.3.3	n=551; missing values=21	Table 5.6.1b	n=559; missing values=13
Figure 5.3.5	n=181; missing values=2	Table 5.6.2a	n=557; missing values=15
Figure 5.3.6	n=556; missing values=16	Table 5.6.2b	n=565; missing values=7
Figure 5.5.4	n=558; missing values=14	Table 5.6.3	n=558; missing values=14
Figure 5.9.1	n=370; missing values=54	Table 5.6.4	n=562; missing values=10
Figure 5.9.2	n=366; missing values=45	Table 5.6.5	n=556; missing values=16
Figure 5.9.3	n=350; missing values=61	Table 5.7.1a	n=556; missing values=16



>> Appendix

Figure 5.9.4 n=349; missing values=62 Table 5.7.1b n=522; missing values=50
Table 5.7.2a n=529; missing values=43
Table 5.7.2b n=527; missing values=45
Table 5.7.3 n=553; missing values=19
Table 5.7.5 n=553; missing values=19
Table 5.7.6 n=543; missing values=29
Table 5.7.7 n=556; missing values=16
Table 5.7.8 n=534; missing values=38
Table 5.7.9 n=487; missing values=85
Table 5.7.10a n=547; missing values=25
Table 5.7.10b n=513; missing values=59
Table 5.7.11 n=548; missing values=24
Table 5.7.12 n=536; missing values=36
Table 5.7.13 n=544; missing values=28
Table 5.7.14 n=540; missing values=32
Table 5.7.15 n=551; missing values=21

