

MEN'S HEALTH IN IRELAND



A REPORT FROM THE MEN'S HEALTH FORUM IN IRELAND
JANUARY 2004

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Prepared by Rachel McEvoy and Noel Richardson

A Note from the Men's Health Forum in Ireland

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: p1).

Established in 2002, the Men's Health Forum in Ireland works on an all Ireland basis to enhance the health of men. The Forum recognises the right of all men to good health regardless of age, gender, sexual orientation, disability, race, culture, religious or political affiliations.

The Men's Health Forum in Ireland aims to promote and enhance all aspects of the health and well being of men and boys. Men have:

- The right to the best possible health, irrespective of social, cultural, political or ethnic differences;
- The right to gender-specific information and education initiatives on how to keep themselves healthy;
- The right to equity of access to available, affordable and gender-sensitive services for all men;
- The right to have men's issues recognised and properly addressed, in a way that is not at the expense of women's or children's health, but seen as beneficial to all and to society as a whole;
- The right to call for greater emphasis on a partnership approach in developing future strategies or initiatives on men's health, that includes consultation between policy makers, health-care providers, statutory and voluntary groups working on behalf of men, employers and men themselves.

Men's Health Forum in Ireland Committee

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A report on Men's Health in Ireland

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CONTENTS

List of Abbreviations	2
List of Figures	3
List of Tables	4
Technical Notes	5
Introduction	6
Executive Summary	7
Chapter 1 Mortality	9
Chapter 2 Life Expectancy	21
Chapter 3 Morbidity	25
Chapter 4 Risk Behaviours	29
Chapter 5 Health Seeking Behaviour	49
Chapter 6 Conclusion and Recommendations	53
References	58
Glossary of Terms	64

LIST OF ABBREVIATIONS

BPH:	Benign Prostatic Hyperplasia
CHS:	Continuous Household Survey
CSO:	Central Statistics Office
DSR:	Directly Standardised (Mortality) Rate
EU-15:	Comparison of 15 European Countries
GHA:	Gay Health Authority
GMHP:	Gay Men's Health Project
GP:	General Practitioner
GUM:	Genito-Urinary Medicine
MHF:	Men's Health Forum, UK
MHFI:	Men's Health Forum in Ireland
MPV:	Mechanically Propelled Vehicle
NEHB:	North Eastern Health Board
NHS:	National Health Service
NI:	Northern Ireland
NISRA:	Northern Ireland Statistics and Research Agency
NMS:	Non-melanoma Skin Cancer
RoI:	Republic of Ireland
RTA:	Road Traffic Accident
SEG:	Socio-Economic Group
SEHB:	South Eastern Health Board
SOPHID:	Survey of Prevalent HIV Infections Diagnosed
STI:	Sexually Transmitted Infections
UA:	Unlinked Anonymous
VRL:	Virus Reference Laboratory

LIST OF FIGURES

- Figure 1.0** Annual Directly Standardised Mortality Rates (per 100,000 persons) on the Island of Ireland by Gender, 1989-1998.
- Figure 1.1** Annual Directly Standardised Mortality Rates (per 100,000 males) by Jurisdiction, 1989-1998.
- Figure 1.2** Death Rates from Diseases of the Circulatory System (per 100,000 population) on the Island of Ireland, 2001.
- Figure 1.3** Total Number of Suicides by Gender in the RoI and NI between 1998-2000.
- Figure 1.4** Acute Hospital Discharges by Gender in the RoI in 1998.
- Figure 1.5** Annual Directly Standardised Mortality Rates (per 100,000 persons) by Jurisdiction, 1989-1998.
- Figure 1.6** Alcohol Related Deaths, in RoI, 1990-1999.
- Figure 1.7** Age and Gender Distribution of Smokers in the RoI, 2002.
- Figure 1.8** All Contacts who presented for Treatment for Problem Drug Use in the RoI, 1997-1998.
- Figure 1.9** Age and Gender Distribution of Individuals presenting for Drug Treatment in Northern Ireland, 2001-2002.
- Figure 2.0** Headline Assault and Sexual Offence Victims by Gender in the RoI, 2001.
- Figure 2.1** Domestic Violence Complainants and Offenders by Gender in the RoI, 2001.

LIST OF TABLES

Table 1.0	Average Annual Number of Deaths by Gender and Cause on the Island of Ireland, 2001.
Table 1.1	Number of Men with Malignant Prostatic Disease, 2002.
Table 1.2	Rates of Benign Prostatic Hyperplasia/ 100,000 males aged 40 years and over showing wide variations, 2002.
Table 1.3	Number of Urologists, 2002.
Table 1.4	Life Expectancy, South and North, at Birth and at 65 years, 2002.
Table 1.5	Annual Number of Deaths and Standardised Mortality Rates due to Transport Accidents (per 100,000 population), 1989-1998.
Table 1.6	Drink and Driving Offences by Age and Gender of Persons convicted in the RoI in 2001.
Table 1.7	Annual Number of Alcohol Misuse Deaths and Directly Standardised Mortality Rates (per 100,000 persons) on the Island of Ireland, 1989-1998.
Table 1.8	Adult Drinking Patterns in the RoI, National Health and Lifestyle Surveys 1999.
Table 1.9	Conviction at all Courts by Gender and Offence Group in Northern Ireland, 1999.
Table 2.0	Prisoners in Custody by Age and Gender on the Island of Ireland, 2001.
Table 2.1	Sexually Transmitted Infections in the RoI in 2001.

TECHNICAL NOTES

When assessing North-South comparisons, it is important to consider the many factors that influence rates of mortality and morbidity; such factors may range from socio-economic and environmental factors to lifestyle factors and the provision of health and social services.

Methodological discrepancies in the recording and presentation of some data were also noted between both jurisdictions (RoI and NI). As a result, it often proved impossible to combine statistics for both the RoI and NI to produce an 'all of Ireland' result. In such instances, so as not to skew the overall presentation of data, the statistics for each jurisdiction will be presented separately and explained accordingly.

Although 'health' goes beyond 'the absence of disease or infirmity', for practical purposes the health of a population is frequently measured by health indicators derived from life expectancy, mortality and morbidity statistics (Department of Health and Children 2001). While this presents a limited picture, it is of value in describing population trends over time and making comparisons with other countries.

INTRODUCTION

On the island of Ireland, excess mortality amongst males represents a fundamental inequality in health (Balanda and Wilde 2001: p.11).

Men in Ireland die, on average, nearly 6 years younger than women do, and have higher death rates at all ages, and for all leading causes of death. Evidence of sex differences in the incidence, symptoms, and prognosis of a wide range of health problems is also well documented. There has, however, been little evidence to date that these differences are reflected in the planning and delivery of healthcare, or in wider social and economic policies (Doyal 2001).

Whilst the issue of women's health (Department of Health and Children 1997) has been the source of extensive consultation and careful strategic planning in the RoI, the same cannot be said for men's health. Although men have been identified as a target population group, for the first time, in the strategic planning of health promotion and healthcare (Department of Health and Children 2000; 2001), there appears to have been little momentum to date to act on these initiatives.

There is growing evidence that in constructing, displaying and maintaining their male identity, men engage in risk behaviours that can be seriously hazardous to their health (Courtenay 2000). Since sickness may be seen as an expression of weakness, many men may decide not to seek help, and instead to present a stoical, brave and unflinching front to the outside world.

The absence of a strategic policy on men's health is partially a result of very sparse and fragmented research into men's health in general in Ireland. The purpose of this report is to begin to redress this deficit and to draw together the principal issues and concerns relating to men's health on the island of Ireland. Hence, the report considers mortality, life expectancy, morbidity and risk behaviour trends amongst Irish men, and where possible, makes comparisons with women and with other European countries. The report also remarks upon health seeking behaviour amongst men on the island of Ireland.

EXECUTIVE SUMMARY

The following are the principal findings of this report:

- Statistics confirm that in spite of increased male life expectancy, men on the island of Ireland continue to die, on average, six years younger than women do and have higher death rates at all ages, and for all leading causes of death.
- Compared to men in the highest occupational class, men from the lower occupational classes have worse health in all years and for all the conditions which are analysed in this report.
- Sex differences in mortality figures are particularly pronounced in the case of road traffic accidents (RTAs) and suicides.
- Compared to women, men have higher levels of health damaging behaviours and risk behaviours.
- Although research is limited in Ireland, it is well documented internationally that compared to women, men have limited contact with GPs, are reluctant users of primary care services and often present late in the course of an illness.
- Although social and economic roles of men and women are changing, traditional values and attitudes towards gender remain prevalent. Boys and young men continue to be socialised to appear in control, to be strong and to take risks; thus reinforcing their exposure to illness and accidental deaths.
- Men's health is under-researched, both clinically and in terms of health promotion.

CHAPTER 1

MORTALITY



1. MORTALITY

Circulatory disorders, diabetes, alcoholism, duodenal ulcer, and lung cancer are all commoner in men, while women have significantly higher rates of depressive, eating and connective tissue disorders. Male suicide rates continue to exceed those in females throughout life, and as is universally known, women survive men by several years in almost all countries, and the gap is widening (Kraemer 2000).

...I think it's a sad thing that we have to wait until one of our friends dies before we go to the doctor (M42, Stakelum and Boland, 2001).

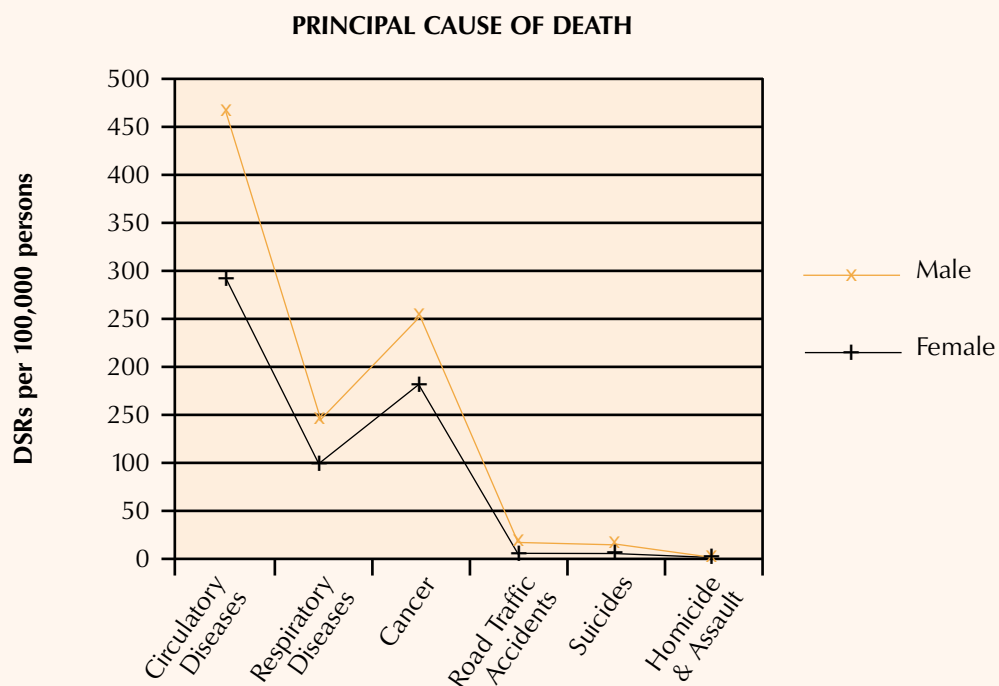
- In spite of increased male life expectancy, men continue to have higher death rates at all ages, and for all leading causes of death (Richardson 2003a). The annual directly standardised mortality rate (per 100,000) during the period 1989-1998 on the island of Ireland for men and women was 1007 and 662 respectively. This represents a 54% higher level for men, and has been described as a “*fundamental inequality in health*” (Balanda and Wilde 2001: p.11).
- In 2001 the leading causes of death among men on the island of Ireland (in order of the number of deaths) were circulatory diseases (40%), cancers (27%) and respiratory diseases (13%). Sex differences in mortality figures are particularly pronounced in the case of road traffic accidents and suicides (Table 1.0).
- O'Shea (1997) and Barry *et al.* (2001) note that clear occupational class gradients in mortality rates amongst men are present for circulatory diseases, cancers, respiratory diseases, and injuries and poisonings. According to Barry *et al.* (2001), in 1996 unskilled men were twice as likely to die as higher professional men (standardised ratio 122 versus 64), and were eight times more likely to die from an accidental cause (standardised ratio 136 versus 17). In addition to the obvious health and safety issues that need to be addressed here, there is also a need to gender men's health in the context of social class.

TABLE 1.0 AVERAGE ANNUAL NUMBER OF DEATHS, BY GENDER AND CAUSE, ON THE ISLAND OF IRELAND

Principal Causes	1990		2000		2001	
	Males	Females	Males	Females	Males	Females
Circulatory Diseases	11,098	10,323	9,170	9,266	8,903	8,840
Respiratory Diseases	3,725	3,517	3,683	4,338	2,994	3,393
Cancer	5,619	4,941	5,772	5,332	6,042	5,321
Road Traffic Accidents	485	179	359	117	387	106
Suicides	366	126	471	105	475	114
All other	3,138	3,234	3,603	3,802	3,704	4,136
Total Deaths	24,431	22,320	23,058	22,960	22,505	21,910

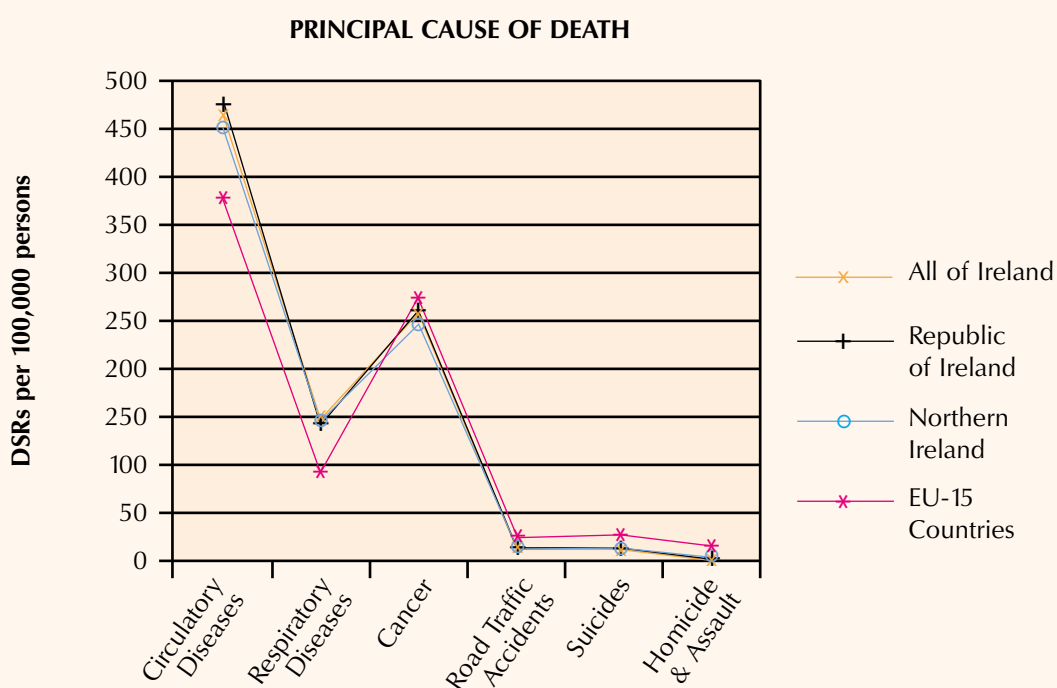
Sources: CSO(2000a), Republic of Ireland and NISRA, Northern Ireland (2002).

FIGURE 1.0 ANNUAL DIRECTLY STANDARDISED MORTALITY RATES
(PER 100,000 PERSONS) ON THE ISLAND OF IRELAND BY GENDER 1989-1998



Source: The Institute of Public Health in Ireland (2001).

FIGURE 1.1 ANNUAL DIRECTLY STANDARDISED MORTALITY RATES
(PER 100,000 MALES) BY JURISDICTION 1989-1998

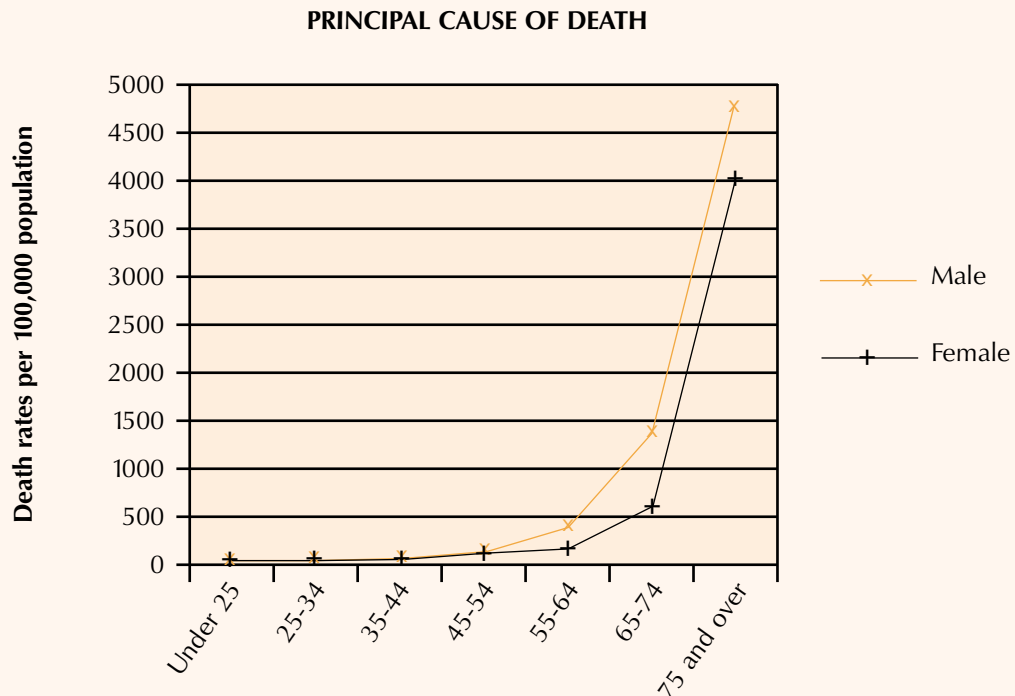


Source: The Institute of Public Health in Ireland (2001).

1.1 CIRCULATORY DISEASES

Heart disease kills more men in the Western World than any other disease... In Ireland alone, heart disease wipes out the size of a small town every year... Every man is immortal until it happens to them (Armstrong 1999: p.21).

FIGURE 1.2 DEATH RATES FROM DISEASES OF THE CIRCULATORY SYSTEM (PER 100,000 POPULATION) ON THE ISLAND OF IRELAND 2001



Sources: Central Statistics Office (2002b).

■ Key Facts

- During 1989-1998, the directly standardised mortality rate per 100,000 for circulatory diseases amongst males was 61% higher than it was for females (Balanda and Wilde 2001);
 - The mortality rate was higher for males in the RoI than in NI: Directly standardised mortality rate of 474.2/100,000 males to 452.9/100,000 males respectively (*ibid*);
 - The standardised death rate for males was significantly higher in the RoI than it was in the (combined) EU-15 countries. In France, for example, the standardised death rate per 100,000 men for ischaemic heart diseases was 78.2 compared to 261.6 in the RoI (Eurostat 2000);
 - Ischaemic heart disease is responsible for more than half of all deaths from circulatory diseases amongst men on the island of Ireland (NISRA 2002, Balanda and Wilde 2001).
- For circulatory diseases the directly standardised mortality rate in the lowest occupational class was over 120% higher than the rate in the highest occupational class (Balanda and Wilde 2001); According to O'Shea (1997), the mortality differentials among socio-economic groups arising from diseases of the circulatory system are likely to be due to variations in causal factors known to influence the risk and incidence of heart disease. Smoking behaviour, for example, is believed to be a major influencing social class differential in the risk of ischaemic heart disease.

1.2 MALIGNANT CANCERS

I've become more familiar with the dynamic of fear over time. If anything, I'm eager to convey the message that fear is far more dangerous than the cancer could ever be (Sheridan 2002a: p.7).

■ Key Facts

- Overall, men and women had similar risks of developing cancer, although men were more likely to die from it (National Cancer Registry Board 2001);
 - Estimated lifetime risks of developing malignant cancer were about 1 in 3 for both men and women. The risk of dying from malignant cancer before the age of 75 was about 1 in 8 for women, but about 1 in 6 for men (National Cancer Registry Board 2001);
 - During 1994-1998, the incidence of prostate cancer in the RoI was higher than the European average and was second after Scotland and NI (National Cancer Registry Board 2001);
 - In NI, age-standardised cancer mortality rates are almost 50% higher for men than women (Northern Ireland Cancer Registry 1996);
 - Non-melanoma skin cancer was the most frequent cancer in both sexes, with lung and related cancers second most frequent for both sexes combined. After lung cancer, prostate cancer has the second highest mortality rate among men (O'Dowd et al. 2002);
 - In 1998, the RoI ranked sixth amongst fellow EU countries in terms of standardised death rates due to cancer of the prostate (31.6 per 100,000). Sweden ranked the highest with a rate of 38.6 per 100,000 and Greece the lowest with a rate of 16.3 per 100,000 (Eurostat 2000);
 - In 1998, 28.5% of male deaths in Europe were attributed to malignant neoplasms, compared to 22% of female deaths (Eurostat 2000).
- In 2000 on the island of Ireland, deaths from cancer represented around a quarter of both male and female deaths (CSO 2002). In the RoI, overall survival from cancer was 43%, but was generally better for women. The worst survival from common cancers was for men with lung cancer, only 8% of whom were alive after five years (National Cancer Registry Board 2001).
- During 1994-1996, an average of 3,889 new cases of malignant non-melanoma skin cancer (NMS) were registered in males each year. On average, females were estimated to have a 1-in-12 chance of developing NMS by age 74, **males a 1-in-8 chance**. European-age-standardised rates were also significantly higher among males than females, by about 48%. On average, females were estimated to have a 1-in-6600 chance, **males a 1-in-1600 chance**, of dying from these cancers by age 74. As with melanoma of the skin, excessive exposure to direct sunlight is the main risk factor for non-melanoma skin cancer. Outdoor workers may be at special risk, and this may account, in part, for the higher rates of NMS among males (Walsh et al. 2001).
- The directly standardised mortality rate for cancer amongst men on the island of Ireland was over 100% higher in the lowest occupation class (Balanda and Wilde 2001). These results are similar to those found in Britain, where deaths from malignant neoplasms are highest in the lower socio-economic groups (O'Shea 1997).

- *Nature hid the prostate gland and most people seem content to leave it at that* (Bulla 2003: p.18). According to O'Dowd *et al.* (2002), very few countries collect healthcare information on non-malignant prostatic disease that could be used to help estimate a more accurate figure of the number of men with this condition. The Netherlands is the exception. Most countries, however, who took part in the study, could provide actual figures of the incidence of malignant disease (Table 1.1).
- As the percentage of people over the age of sixty five continues to rise the incidence rate of men suffering from Malignant Prostate Disease will undoubtedly continue to grow.

TABLE 1.1 NUMBER OF MEN WITH
MALIGNANT PROSTATIC DISEASE, 2002

Country and estimated male population	Actual figure or estimate	Malignant prostate disease
Denmark 5,356,845	Actual	Incidence: 1,500 per year
Hungary 4,867,283	Estimate	Incidence: Approx. 4,000-6,000 new patients annually. Mortality: 1,200 men die each year.
Ireland (RoI) 1,805,970	Actual	Incidence: 1994 - 1,068 1995 - 1,113 1996 - 1,147 1997 - 1,180 1998 - 1,244 This incidence rate is much greater for men aged 65 and over; in 1998 1022 cases (from the 1,244 total) were men aged 65 years and over compared to 222 from men aged under 65 years.
Netherlands 7,833,646	Actual	Incidence: 6,402 per year
Slovenia 956,319	Actual	Incidence: 384 new cases per year
Spain 19,126,607	Estimate	Incidence: 8,000 new cases per year
UK 29,037,778	Estimate	Incidence 1997: 21,000 per annum (19,000 England and Wales plus 2,000 Scotland) excluding Northern Ireland. Mortality 1999: 9,300 per annum (8,533 plus 760)

Source: O'Dowd *et al* 2002, Department of Community Health and General Practice, Trinity College Dublin, (2002) and the CIA World Fact Book, Populations (1999).

Note: The countries outlined in Table 1.1 were selected in order to have as broad a European involvement as possible with countries of different size, geographical spread and range of knowledge, experience and expertise. Belgium, Germany and France were also invited to join the project but declined the invitation (O'Dowd *et al.* 2002).

TABLE 1.2 RATES OF BENIGN PROSTATIC HYPERPLASIA/
100,000 MALES AGED 40 YEARS AND OVER SHOWING WIDE VARIATIONS, 2002

Country	Rates for BPH per 100,000 males	Based on:
Denmark	833	Patients treated for BPH
Ireland (RoI)	16,642	Prevalence from Scottish Study (253 per 1,000).
Netherlands	5,000	Prevalence from Krimpen Study (9-20%).
Spain	15,049	Prevalence from Andalusian Survey (18-20% of males over 50, 30% for males over 70).
UK	18,604	Prevalence from Stirling BPH study.

Source: O'Dowd et al 2002, Department of Community Health and General Practice, Trinity College, Dublin (2002).

- In a European study carried out by O'Dowd et al. (2002), findings show that there was an abundance of clinically related information for benign prostatic hyperplasia (BPH). However, there is very little patient-focused, qualitative research that looks at the morbidity of non-malignant prostatic disease and the impact it has on men's lives and the lives of their family members.

In a broader context, there is very little research that looks at specific issues in relation to men's health including their health-seeing and coping strategies and how they view health (O'Dowd et al. 2002: p.53).

Indeed, this research shows that very little work has been done to look at the psychological and social aspects of this chronic condition that may affect one in four men at some stage of their lives.

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 (Cahill 2002: p.18).

- O'Dowd et al. (2002) also noted a significant shortage of urologists or prostate disease specialists in the RoI, which suggests that Irish men could be denied access to the treatments they need (see Table 1.3). The study found that there were only twenty-three urologists in the RoI, representing a rate of 3.2 specialists per 100,000 males aged forty and over.

- Even though prostatic cancer killed 900 Irish men in 2002, there is no prostatic cancer screening on the island of Ireland. Furthermore, although 65 radical prostatectomies were carried out in 2002...

...the Department of Health and our hospital administration do not think this is value for money, and have now closed all our urology beds (except day beds) in order to balance their books (Smith 2003: p.18).

TABLE 1.3 NUMBER OF UROLOGISTS, 2002

Country	Number of Urologists	Urologists per 100,000 males aged 40 years and over
Denmark	105	8.6
Hungary	360	17.2
Republic of Ireland	23	3.2
Netherlands	283	8.1
Slovenia	31	7.2
Spain	1,633	19
UK	506	5.9

Source: O'Dowd et al 2002, Department of Community Health and General Practice, Trinity College, Dublin (2002).

- The relative contribution of cancer to overall mortality has been increasing in recent decades. For example, 2.9 deaths per 1,000 of the population was attributed to cancer in the 1950's, compared with 4.4 deaths per 1,000 in 2001 (CSO(2000a)). According to the Department of Health and Children (2001), this pattern is likely to continue in future years on account of current population trends. In addition, as our population ages it is likely that cancer morbidity will increase.

1.3 RESPIRATORY DISEASES

■ Key Facts

- In 1998, the standardised death rate (per 100,000) for respiratory diseases amongst males in the RoI was 153.2, compared to 94.4 amongst their female counterparts (Eurostat 2000);
 - Between 1989-1998, the incidence rates for males was higher in NI than the RoI: 155.5/100,000 males to 147.3/100,000 males respectively (Balanda and Wilde 2001);
 - In 1998, the standardised death rate for males was significantly higher in the RoI than it was in the (combined) EU-15 countries (Eurostat 2000);
 - Between 1989-1998, over half of all deaths from respiratory diseases on the island of Ireland were due to pneumonia, with the percentage being much higher in NI than it was in the RoI. Chronic lower respiratory disease accounted for another third of such deaths, with the percentage in the RoI being much higher than it was in NI (Balanda and Wilde 2001).
- For respiratory diseases the directly standardised mortality rate was over 200% higher in the lowest occupational class (Balanda and Wilde 2001). Homelessness, poor housing, damp housing, and household overcrowding are likely to lead to increased amounts of respiratory infection with an increasing risk of mortality (Martin *et al.* 1987, Townsend *et al.* 1988).

1.4 SUICIDE AND INTENTIONAL SELF-HARM

*The increasing suicide trend, both internationally and in Ireland, is now a major public health problem. This is particularly so for young Irish men, where there has been a four-fold increase in the suicide rate since 1990, making it the most common cause of death in young males. The rate of suicide among young males is more than **six times as high** as among young females, but women are more likely to attempt to kill themselves. Of the 368 people aged 24 and under who took their own lives between 1994 and 1997, 318 were males (Aware 1998).*

FIGURE 1.3 TOTAL NUMBER OF SUICIDES BY GENDER IN THE ROI AND NI BETWEEN 1998-2000

	Rol		NI	
	Males	Females	Males	Females
1998	421	83	95	31
1999	349	90	103	18
2000	341	72	130	33
2001	356	92	119	22

Source: National Suicide Review Group Report (2002).
Registrar General Reports 1998-2001

■ Key Facts

- In recent years, four to five times more men than women died by suicide on the island of Ireland (CSO 2002a, NISRA 2002);
- In 1998, the RoI ranked sixth amongst fellow EU countries in terms of standardised death rates amongst men due to suicide and intentional self-harm (22.8 per 100,000). Finland ranked the highest with a rate of 36.8 per 100,000 and Greece the lowest with a rate of 5.7 per 100,000 (Eurostat 2000);
- In both NI and the RoI, there were clear occupational class gradients in mortality from suicide and intentional harm (Balanda and Wilde 2001);
- Mental illness has a very important association with suicide (Foster *et al.* 1997, Kelleher *et al.* 2000);
- Identification with traditional masculinity has been linked to the act of taking one's life amongst males (Sabo 1999).

- Between 1945 and 1995 the rate of suicide in the RoI rose from 2.38 per 100,000 population to 10.69 per 100,000. The increase in suicide in recent decades, however, has been primarily a male phenomenon.

- In the preparation of the *Interim Report of the National Task Force on Suicide*, (Department of Health and Children, 1998b) it was found that suicide is the second most common cause of death among fifteen to twenty-four year old males in the RoI, and is equal to a rate of 19.5 per 100,000 population compared with 2.1 per 100,000 among fifteen to twenty-four year old women. During the same period from 1991 to 1993 young male suicide deaths increased from a position where they were as frequent as cancer deaths in 1976 to greatly exceeding cancer deaths by 1993. The overall rate of suicide among men in 1995 was 17.2 per 100,000 population compared with a rate of 4.3 among women.
- A psychological autopsy of suicides in Cork between August 1989 and January 1993 found that only 18% of young men aged fifteen to twenty four years who had died by suicide had received psychological treatment in the year before their death, even though almost 75% of this group were regarded as being mentally ill (Department of Health and Children 1998b). In the case of older people, men aged sixty-five years and over have shown a significant increase in their rate of suicide from 9.4 per 100,000 to 17.9 per 100,000 population between 1976 and 1993. In the age group sixty-five to seventy-four years there is a far greater incidence amongst men than in the seventy-five years of age plus age group.
- *An Investigation of One Hundred Suicides* (Kelleher et al. 2000) shows males who died from suicide were significantly younger than female suicides. Among those aged 15-44 years old, males outnumbered females by 4:1. After the age of forty-five years, the number of men and women is almost equal. The numbers treated for psychiatric illness by a general practitioner or psychiatrist prior to death also shows major divergence between the sexes. Over 80% of the women were known to have been medically treated, as opposed to 49% of the men. In the under twenty-nine year olds, the situation with the males was even starker.

Although the failure among clinicians to diagnose depression in men contributes to men's low treatment rates,

Men's own unwillingness to seek help contributes to the social construction of their invulnerability to depression (Courtenay 2000: p.1396).

In response to depression, men are more likely than women to rely on themselves, to withdraw socially or to try to talk themselves out of depression (Warren 1983, Chino and Funabiki 1984, O'Neill et al. 1985).

- *An Investigation of One Hundred Suicides* (Kelleher et al. 2000) also shows that marital status differed significantly for male and female suicide victims. Over 80% of men were single, separated or divorced as opposed to 46% of women. This difference remains significant after adjustment for age. Female suicides were twice as likely to be married at the time of their death (Kelleher et al. 2000).
- According to the report of the National Suicide Review Group (2001), almost half of all suicides in the RoI are by hanging (49.7%). For males, hanging accounted for more than half of all suicides with drowning and poisoning accounting for 17.7% and 14.2% respectively. Suicide by firearms is less common for males overall, but accounts for one in eight young males who died from suicide (15-24 years) and almost as many in elderly men (11.3%, over 64 year olds). Stillion notes that often males select more violent methods and, compared with females, they see surviving a suicide attempt "as yet another failure, a mark against their masculine adequacy..." (1995: p.52). Canettos' (1995) research found that traditional masculine expectations elevated the likelihood of a suicide resulting in a fatal outcome for some men.

1.5 DEATH FROM HOMICIDE/ ASSAULTS AND TRANSPORT ACCIDENTS

Male violence represents both the most celebrated and the most censured features of masculinity. It is also one of the most paradoxical. When displayed for noble, righteous, or patriotic causes, male violence is exalted as in the form of the 'warrior male' or 'epic male'. Nevertheless, because of its immense destructiveness, it clearly represents one of the greatest impediments to the physical health of men and women (Brooks 2001: p.15)

■ Key Facts

- On the island of Ireland, deaths from both homicide/assaults and transport accidents occurred more frequently amongst males (CSO 2002a, NISRA 2002);
 - In the RoI, there has been a startling increase of over 450% in reported crime over the past ten years (Cusack 2002);
 - In 2001, five times more men than women were killed on the island of Ireland due to road traffic accidents (RTAs) (National Roads Authority 2001, NISRA 2002);
 - According to Balanda and Wilde (2001), occupational class was highly correlated with deaths from homicide/assault and transport accidents. Between 1989 and 1998, the directly standardised mortality rate for homicide/assault in NI was 252% higher in the lowest occupational class than it was in the highest. In the RoI, the rate for transport accidents was 354% higher in the lowest occupational class than it was in the highest.
- The directly standardised mortality rate for homicide/assault was 514% higher in NI than it was in the RoI (Balanda and Wilde 2001). Lockhart (2003) maintains that these crimes are almost exclusively associated with terrorism and the 'Troubles'.
- In the RoI, the murder rate in 2001 showed a worrying increase, up to 52 compared to 39 the previous year. When detailed comparative data become available for 2002, they are likely to reveal that Dublin has become a more deadly city than London and that the national rate has crept closer to the EU average (O'Donnell 2003). In addition, victims were predominantly male (over 85%) and young (average age 34). Stabbing was the most common method (*ibid*).
- The 2001 Garda Síochána Crime Statistics Report shows an unexplained drop in the percentage of women murder victims:

This may be due in part to the fact that the traditionally high percentage of 'domestic' murders is fast being overtaken by the number of murders by young men of young men, often characterised by drunken aggression (Cusack 2002: p.22).

CHAPTER 2

LIFE EXPECTANCY



2. LIFE EXPECTANCY

Here in Ireland, for every seven women who are aged sixty-five years of age or over, there are five men, and amongst those who are eighty-five years of age or over, there are three women for every one man (Murphy-Lawless 2003 p.11).

**TABLE 1.4 LIFE EXPECTANCY, SOUTH AND NORTH,
AT BIRTH AND AT 65 YEARS, 2002**

Years	RoI				NI			
	At birth		At 65 years		At birth		At 65 years	
	Male	Female	Male	Female	Male	Female	Male	Female
1925 - 1927	57	58	13	13	55	56	12	13
1950 - 1952	65	67	12	13	66	69	12	14
1960 - 1962	68	72	13	14	68	72	12	14
1970 - 1972	69	74	12	15	68	74	12	15
1985 - 1987	71	77	13	16	71	77	13	17
1990 - 1992	72	78	13	17	73	78	14	18
1995 - 1997	73	79	14	17	74	79	15	18

Sources: CSO(2000a), Republic of Ireland and NISRA, Northern Ireland (2002).

- Life expectancy at birth provides one of the broadest indicators of the overall health of a population. Life expectancy at birth has increased, substantially, for Irish men and women over the past four decades, although life expectancy is still poorer for men (Table 1.4). According to Murphy-Lawless (2003), the reasons for gains for both sexes include the following:
 - Control over infectious diseases;
 - Other scientific and medical advances;
 - Improved public health measures, like sanitation;
 - Better housing conditions;
 - Better nutrition.
- According to figures shown in Table 1.4, a baby boy or girl born in 1925 in the RoI could expect, on the basis of mortality figures at that time, to live on average to about 57 years of age. By contrast, the life expectancy for people born in 1996 was on average 73.5 for boys and 79 for girls, both north and south. Hence what was once a minor difference in life expectancy has widened into a perceptible gap of 5.5 years. This gap between the sexes is subsequently resulting in a growing female-dominant population amongst those over sixty-five years of age.

- Life expectancy is broadly comparable in both north and south of the country. Female life expectancy at birth is 79 in both jurisdictions, and male life expectancy at birth is 73 in the RoI and 74 in NI. In Northern Ireland, male life expectancy has increased by three years and female life expectancy by two years over the last decade (CSO 2002b).
- Life expectancy for males at birth in the RoI is the 3rd lowest in the EU and lowest of all EU countries at age 65 (Eurostat 2000; Stakelum and Boland 2001). On average, Irish males can expect to live to 73.9 years, British men to 75 years, while Swedish men make it to 77.1 years (Eurostat 2000).
- In both the RoI and NI, projected life expectancy figures for 2000-2002 are as follows:

Males:	at birth 73.8 and at 60 years 17.9
Females:	at birth 79.5 and at 60 years 22.1

There is still, however, a notable gap between the sexes of 5.7 years at birth, and 4.2 years at sixty years. Epidemiologists and health researchers point to four broad elements that may contribute to our understanding of this difference in outcomes between the sexes:

- 1 Biological/genetic differences between men and women (Ramey, 1997; Kraemer 2001).
- 2 Material and social differences and structural inequalities (Phillipson 1995; Fahey and Murray 1994).
- 3 Cultural and behavioural differences linked to different social expectations of men and women (Skakelum and Boland 2001; Waldron 1985).
- 4 Gendered use of and access to the health services (Stakelum and Boland 2001; O'Dowd and Jewell 1998; Senior and Viveash 1998).

CHAPTER 3

MORBIDITY



3. MORBIDITY

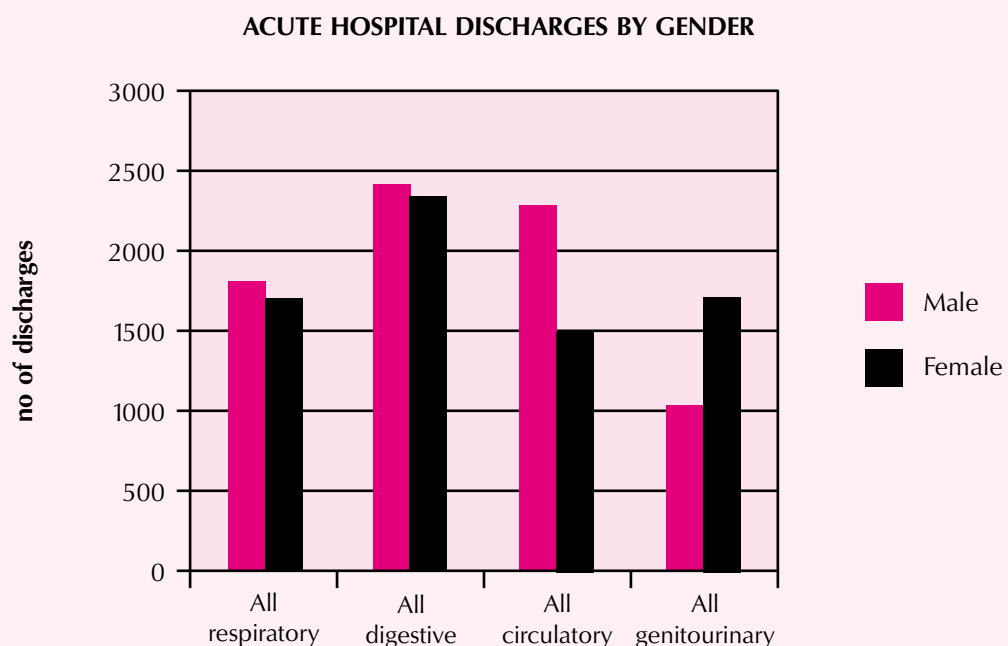
I would say I would never have ever seriously thought about, personally, how my health was... and like the thought of going to a doctor, I mean, I wouldn't have had a check-up in, (pause) actually I never had a check-up (M42, Richardson 2003d).

- It is important to remember that when comparing male and female morbidity one must also consider the different age structure of the male and female populations. Diseases which are prevalent mainly in the elderly will tend to show a female excess simply because there are more elderly females than males (Mant and Silagy 1998).
- In Northern Ireland, 33% of males reported having a long-standing illness and 24% of males reported that they had a long-standing illness that limited their activities (NISRA 2002).
- In a study by NISRA, 12% of males compared to 19% of females interviewed had consulted a GP in the previous 14 days. Those aged 45 years and above were more likely to have consulted a GP than those aged under 45 (NISRA 2002).

...health is something, well in my own case that wouldn't come into 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 (M24, Richardson 2003d).

- In 1998, males were admitted to hospitals in the RoI more often than females for all major diagnostic categories, with the notable exception of genito-urinary diseases (See Figure 1.4).

FIGURE 1.4 ACUTE HOSPITAL DISCHARGES
BY GENDER IN THE ROI 1998



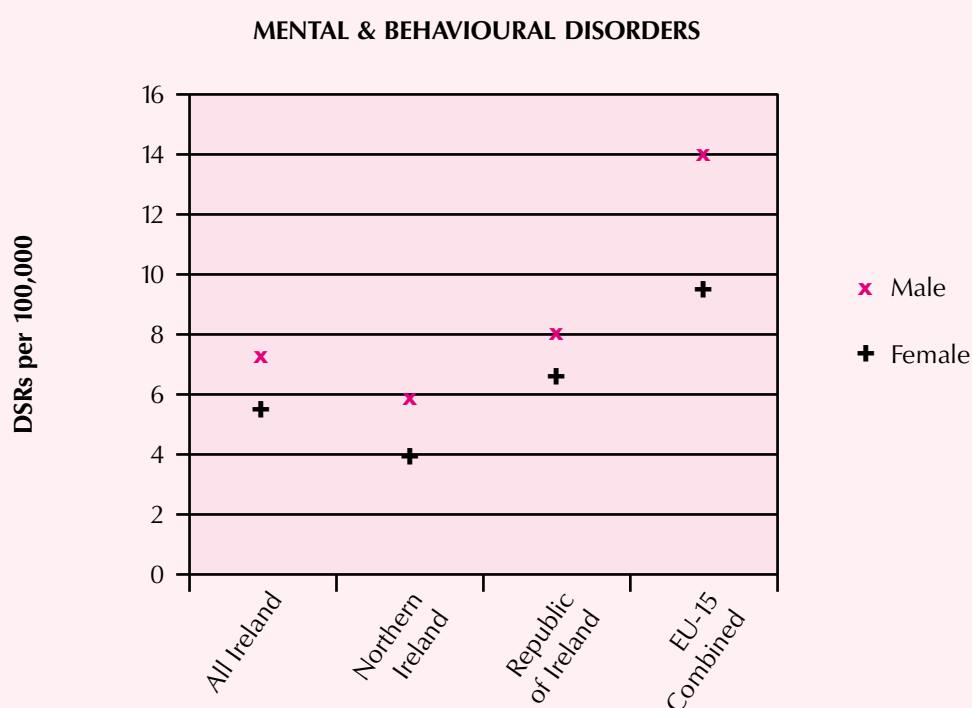
Sources: Public Health Annual Report (2002).

3.1 MENTAL AND BEHAVIOURAL DISORDERS

Denial of depression is one of the means men use to demonstrate masculinities and to avoid assignment to a lower status position in relation to women and other men (Courtenay 2000: p.1397).

...men keep their problems 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... it's that macho bit or it's some sort of weakness that you're admitting to or something like that (M47, Richardson 2003d).

FIGURE 1.5 ANNUAL DIRECTLY STANDARDISED MORTALITY RATES (PER 100,000 PERSONS), BY JURISDICTION 1989-1998



Sources: The Institute of Public Health in Ireland (2001).

■ Key Facts

- During 1989-1998, an average of 350 people died each year on the island of Ireland as a result of mental and behavioural disorders; 170 of whom were male (Balanda and Wilde 2001).
- The all Ireland annual standardised death rate was significantly higher for males than it was for females. This was true in both NI and RoI (*ibid*).
- When compared to the combined EU-15 countries the all Ireland standardised death rate for males was lower (*ibid*).

- According to Prior and Hayes (2001), the relationship between gender and mental disorder remains a highly complex and contentious issue. Claims and counter-claims abound as to which gender, male or female, is the most vulnerable to mental disorder.

- According to the Health Research Board (2001a), single males had the highest rate of psychiatric hospitalisation, at 329.7 per 100,000 population. Over half of all resident patients in health board hospitals (59%) and general hospital psychiatric units (51%) in the RoI were male.
- In comparison to England, it could be estimated that the mental health needs in Northern Ireland are potentially 21% higher for men. In Northern Ireland the prevalence of mental illness amongst men rises more steeply with age than in either England or Scotland (McWhirter 2002).
- In both NI and the RoI there were clear occupational class gradients in mortality from mental and behavioural disorders. In both jurisdictions the annual directly standardised mortality rate in the lowest occupational class was significantly (over 360%) higher than the rate in the highest occupational class (Department of Public Health 2001). In NI, potential mental health problems were lowest in the professional/managerial and the skilled manual groups, and highest in the partly skilled group (McWhirter 2002).
- According to Stakelum and Boland (2001), the male sex role stereotype demands that men be healthy, strong and self-sufficient. Often in an attempt to maintain a self-image consistent with society's expectations to be manly, men become more reluctant, not just to admit, but often recognise, their physical and mental health needs. Furthermore, men who have traditional attitudes towards masculinity are often inclined to suppress their emotions, which may partly explain the lower rate of mental health problems reported among males. However, suppressing emotions is only a short-term solution, and eventually such emotions will surface in some way or another. A common reaction among men when this happens is to act out their emotions by engaging in fast driving, hard drinking and other risk-taking behaviours.

CHAPTER 4

RISK BEHAVIOURS



4. RISK BEHAVIOURS

A man who does gender correctly... would spend much time in the world 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: p.21).

... to take risks, from a male point of view, it's seen as macho and you're seen as great... you get attention and you get praise... women actually can talk things out and get acknowledgement from friendships... with men, it's more from their actions and their deeds (M47, Richardson 2003d).

- There is growing evidence that in constructing, displaying and maintaining their male identity, men engage in risk behaviours that can be seriously hazardous to their health and be a major cause of male's higher mortality (Courtenay, 2000). It seems that there is a moral acceptability of risky behaviour among men, where injuries from high-risk activities are culturally legitimated within their social and occupational worlds (Stakelum and Boland 2001).

There is compelling evidence of quite dramatic increases in certain high-risk behaviours that are almost exclusively perpetrated by males. For example, in the RoI the number of 'joyriding' incidents (categorised as 'the unauthorised taking of mechanically propelled vehicles', to distinguish it from vehicle larceny), increased from 11,754 in 1995 to 15,964 in 2000 (Humphreys 2002: p.3). During the same period, the number of proceedings in the RoI under the 1994 Public Order Act increased from 10,209 to 37,749 (Sheridan 2002: p1).

4.1 ROAD TRAFFIC ACCIDENTS (RTAs)

... unfortunately they've got way bigger machines under them now, that have powerful engines and you know, I don't think they fully appreciate the power they have under them (M42, Richardson 2003d).

TABLE 1.5 ANNUAL NUMBER OF DEATHS AND STANDARDISED MORTALITY RATES DUE TO TRANSPORT ACCIDENTS (PER 100,000) 1989-1998

	All Ireland		Northern Ireland (NI)		Republic of Ireland (RoI)		EU-15 Countries
	Number	Rate	Number	Rate	Number	Rate	Rate
Females	161	5.9	46	5.1	115	6.2	6.1
Males	454	17.2	121	14.6	333	18.4	19.1
Persons	615	11.4	167	9.8	448	13.3	/

Source: The Institute of Public Health in Ireland (2001).

■ Key Facts

- During 1989-1998 an average of six hundred people died each year on the island of Ireland from transport accidents. The age specific mortality rates due to transport accidents clearly show a dramatic rise starting in the teenage years and continuing until the mid twenties (Balanda and Wilde 2001);
 - In the RoI, the standardised death rate in 1998 was significantly higher for males (18.4 per 100,000) than it was for females (6.2 per 100,000) (Eurostat 2000);
 - When compared to the (combined) EU-15 countries, the all Ireland rate for males was lower (Eurostat 2000);
 - In both NI and the RoI there were clear occupational class gradients in mortality from transport accidents. In both jurisdictions the mortality rate in the lowest occupational class was significantly higher than the rate in the highest occupational class (Balanda and Wilde 2001);
 - In the RoI alcohol is estimated to be associated with at least 30% of all road accidents (National Safety Council 2002).
- In the RoI, between 1993 and 1997 there were 32,351 hospital admissions due to a RTA. Two thirds of admissions were young males, and males accounted for almost 74% of RTA-related deaths. In the under sixty-five year population the peak in both deaths and in admissions is in males aged twenty to twenty-four years (Department of Public Health Medicine and Epidemiology 2001).
- In a survey of men in Donegal aged between seventeen and twenty-four years of age, 30% of respondents admitted to driving over the legal alcohol limit; 88% claimed to have seen friends driving over the legal limit; 94% thought they were 'safe' drivers and only 45% always wore a seat belt in the car (Kievits 1998). In the latest National Health and Lifestyle Surveys (Kelleher et al. 2003), 21.8% of men reported driving having drunk at least two drinks compared to 8.6% of women.

- In 2001, 6,790 persons in the RoI were convicted of drink driving offences, with 93% of those convicted being male (Garda Siochana 2001). The number and gender of persons convicted of drink driving offences is shown in Table 1.6 (Note: MPV = mechanically propelled vehicle). 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 gender practice. It is the peer group, more than the individuals within it that sustains the definition of masculinity (Richardson 2003).
- There has, however, been a marked decline in RTAs among males and females between 1990 and 2001, in both north and south of the country. In 1990 on the island of Ireland, RTAs accounted for 485 of male deaths, by 2001 this figure had fallen to 387 (20% decline) (CSO 2002b). This may be attributed to stiffer penalties being imposed for driving offences.
- In the context of speeding, the NEHB found that young men were somewhat pragmatic about the 'adrenalin buzz' versus the associated risks:

The buzz was guaranteed, whereas the injury was only something that could or might happen (Stakelum and Boland 2001: p.28).

A belief in their own invulnerability seems to be particularly prevalent among young men, and is linked to underestimating various risk behaviours, failing to adopt positive health behaviours and failing to connect long-term risks with current habits (Davies et al. 2000).

TABLE 1.6 DRINK AND DRIVING OFFENCES BY AGE AND GENDER OF PERSONS CONVICTED IN THE ROI IN 2001

Offences	Persons Convicted		17 and under 21 years		21 years and over	
	Male	Female	Male	Female	Male	Female
Driving or attempting to drive MPV while drunk or with a blood/urine/ alcohol concentration above the prescribed limit	3,404	267	173	27	3,231	240
Driving or attempting to drive MPV with breath/alcohol concentration above the prescribed limit	2,118	124	148	13	1,970	111
Being in charge of MPV while drunk or alcohol concentration above prescribed limit	154	13	10	2	144	11
Being in charge of MPV with breath/ alcohol concentration above the prescribed limit	62	2	4	0	58	2
Refusing/failing to give evidential breath sample	264	26	23	3	241	23
Refusing to provide or permit the taking of blood/urine specimen at Garda Station	272	30	18	1	254	29
Refusing to provide or permit the taking of blood/urine specimen at the hospital	10	1	0	0	10	1
Refusing to provide a preliminary specimen of breath	38	5	1	0	37	5

Source: Garda Siochana, Year 2001 Crime Statistics.

4.2 ALCOHOL ABUSE

Alcohol is widely used in society but the heaviest users are young men. It is a great social lubricant that is associated with fun, enjoyment, and good life. It has a darker side, which is often hidden from the general practitioner; particularly as adult males are absent from the doctor's consulting room anyway (Smail and Rollnick 1998: p.129).

TABLE 1.7 ANNUAL NUMBER OF ALCOHOL MISUSE DEATHS AND DIRECTLY STANDARDISED MORTALITY RATES (PER 100,000) 1989-1998

	All Ireland		Northern Ireland (NI)		Republic of Ireland (RoI)		EU-15 Countries
	Number	Rate	Number	Rate	Number	Rate	Rate
Females	24	1.1	9	1.2	15	1	1.1
Males	50	2.3	19	2.8	31	2.1	4.9
All	74	1.7	28	2	46	1.5	1.5

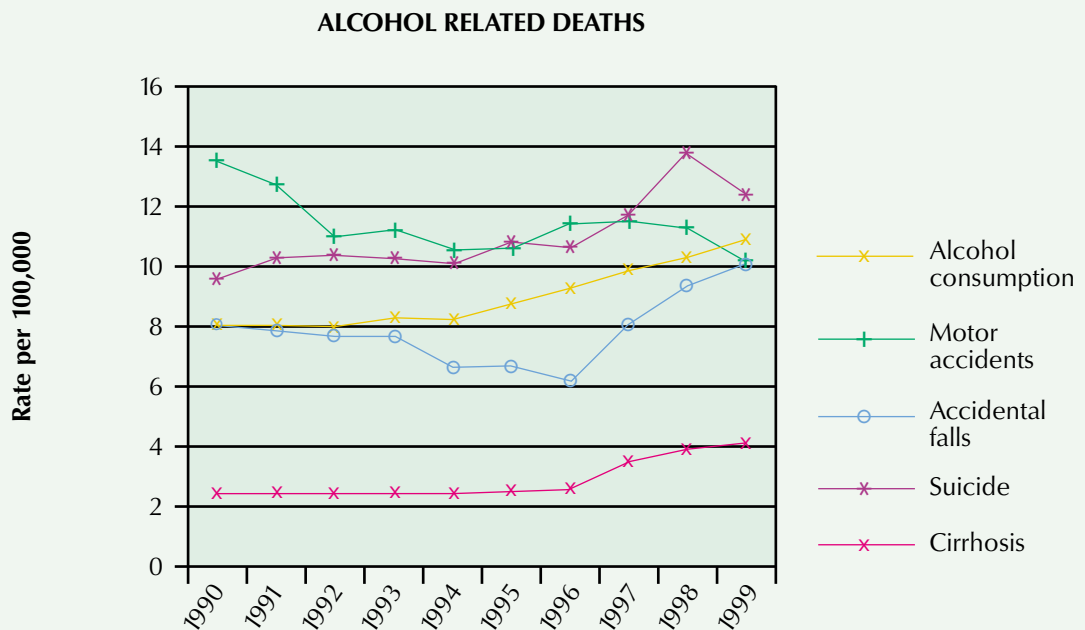
Source: The Institute of Public Health in Ireland (2001).

■ Key Facts

- During the last decade the increase in alcohol consumption mirrors the increases in cancers relating to alcohol and in particular alcohol poisoning and alcohol dependency (Strategic Task Force on Alcohol 2002);
- Between 1989-1998, the all Ireland annual standardised mortality rate was significantly higher for males than it was for females (Balanda and Wilde 2001);
- Men drink about three times as much alcohol as women do, have a much higher prevalence of binge drinking than women and experience greater adverse consequences from drinking (Ramstedt and Hope, 2003);
- In both NI and RoI there were clear occupational class gradients in mortality from alcohol abuse (including alcoholic psychosis). The annual standardised mortality rate in the lowest occupational class was significantly (over 280%) higher than the rate in the highest occupational class (*ibid*);
- In the RoI alcohol is estimated to be associated with at least 30% of all road accidents and 40% of all fatal accidents (National Safety Council 2002).

- In the last decade, the RoI has seen many changes that have influenced the context and nature of drinking and increased alcohol related harm. Against the backdrop of the fastest growing economy in Europe, the RoI has had the highest increase in alcohol consumption among EU countries. Between 1989 and 1999, alcohol consumption per capita in the RoI increased by 41% while ten of the EU Member States showed a decrease and three other countries showed a modest increase during the same period. Ireland's consumption continued to increase in 2000 and ranked second after Luxembourg for alcohol consumption with a rate of 11 litres of pure alcohol per head of population. The EU average for 2000 was 9.1 litres of pure alcohol per capita (Strategic Task Force on Alcohol 2002).

FIGURE 1.6 ALCOHOL RELATED DEATHS IN ROI, 1990-1999



- There have been parallel increases over the past two decades 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 (Strategic Taskforce on Alcohol 2002). 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, Pernanen and Rehm 2001).
- According to the latest National Health and Lifestyle Surveys (Kelleher *et al.* 2003) in the ROI, the level of binge drinking (which is defined as six drinks or more in a session) is rising each year. Statistics show heavy drinking among men has increased from 35% to 41% over the past four years; compared to women, which has risen from 12% to 16% (Andrew 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) highlight that alcohol use is in fact symbolic of being male, and is part of the male sex role and of being manly.
- In NI, the most worrying figures, in terms of alcohol misuse, relate to the prevalence of drinking above sensible limits and drinking at dangerous levels, which increased for both men and women. For example, in 1988 15% of men drank above sensible or at dangerous levels; this figure rose to 28% in 2000/01 (McWhirter 2002).
- For both men and women in NI, the proportion drinking over the sensible limits decreased with age. Men aged 16-24 were almost three times as likely to drink above the sensible limits (37%) as those aged 65-74 (14%) (NISRA 2001).

- According to the Northern Ireland Health and Social Well-being Survey (DHSSPS, 2001) there is no significant difference in the prevalence of respondents drinking above sensible weekly limits between manual and non-manual SEGs. In fact, respondents who were non-smokers and non-drinkers were more than twice as likely to be from an unskilled manual socio-economic group (SEG) background (46%) than a professional/managerial SEG background (19%).
- Alcohol abuse is a significant risk factor in suicide and compounds the other factors which lead to suicide. There has been a sharp increase in male suicides, especially among the 15-29 age groups, and overall it is the biggest cause of death for men aged 15-35 years.
- Alcoholic disorders continue to be a main cause of admissions to psychiatric hospitals especially for males. In 1999, out of all psychiatric hospitals in the RoI, alcoholic disorders accounted for 26% of male admissions and 11% of female admissions (Daly and Walsh 1999). Research in a RoI general hospital reported that 30% of all male patients (compared to 8% of female patients) were identified as having underlying alcohol abuse or dependency problems, many of which were not detected by the admitting medical team. The study highlights the deficiencies and the under recording of alcohol related problems in the medical setting (Strategic Task Force on Alcohol 2002).

The challenge provided by male problem drinking is not just a clinical one. Because drinking is so much part of the social fabric of our culture and subcultures, general practitioners cannot avoid the social context by simply treating the problem as a clinical one... A non-confrontational approach, based on a good rapport and supported by a clear understanding of the effects of heavy drinking, will produce better results than simply telling the patients that they should do something about the problem (Smail and Rollnick 1998: p143-144).

- At a time of growing concern in Ireland with regard to the strong links between alcohol advertising and sport, 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 and the nurturing of this 'drink culture' (Richardson 2003a).

TABLE 1.8 ADULT DRINKING PATTERNS IN THE ROI,
NATIONAL HEALTH AND LIFESTYLE SURVEYS 1999

	18-24 yrs	25-34 yrs	35-44 yrs	45-54 yrs	55-64	65+ yrs
High risk drinking per session*						
Male	51.5	46.8	30.3	24.5	23.4	9.1
Female	61.3	44	26.1	13.8	10.3	11.1
Over recommended weekly upper limits**						
Male	35.5	29.9	24.7	22.7	31.4	16.2
Female	34.8	20	12.6	16.1	13.2	21.2
Driven a car after consuming 2 or more drinks in the last year***						
Male	16.8	30.1	36.1	31.9	25.5	10.1
Female	6.4	12.8	16.7	11.2	7.4	2.7
As a result of someone else's drinking, in the last year						
Verbally abused						
Male	20.3	10	6.3	5.1	6.5	1.7
Female	17.6	11	6.9	6.7	4.7	1
Family/marital difficulties						
Male	6.7	6.5	5.8	5.5	4.9	1.2
Female	11.2	11.3	9.5	7.2	5.9	2.4
Passenger with drunk driver						
Male	16.7	10.3	3.8	3.4	5.2	2.5
Female	13.6	6.6	3.4	3	3.4	1.9
Financial trouble						
Male	6.5	4.3	2.9	3.2	4.5	1.2
Female	4.7	4.2	3.3	3.2	3.1	0.7
Hit/assaulted						
Male	10	3.8	1.2	1.9	1.6	1
Female	3.2	2.7	1.5	1.5	0.9	0.3

*High risk drinking (70 grams or higher of pure alcohol for males; 50 grams for females)

**Weekly upper limits (14 standard drinks for females; 21 standard drinks for males)

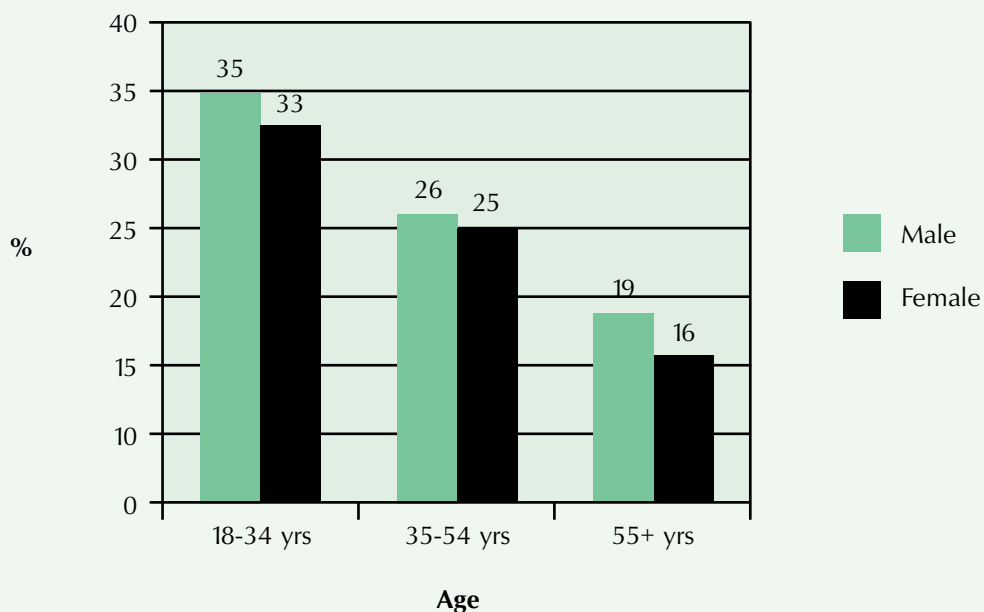
***based on those who drive

4.3 SMOKING

Men smoke themselves into an early grave. About 11 men die every day in Ireland due to smoking, compared to 6.8 female smoking-related fatalities a day (Armstrong 1999).

- The latest National Health and Lifestyle Surveys in RoI (Kelleher *et al.* 2003) highlight that people are smoking less than they were four years ago. The study found that more than 31% of the RoI population were smoking in 1998, but by 2002, the number of smokers had dropped by 4% to 27%. Minister for Health, Michael Martin, believes that “*This pattern may be indicative of the success of the anti-tobacco campaign*” (2003, p.8).

FIGURE 1.7 AGE AND GENDER DISTRIBUTION OF SMOKERS IN THE ROI (2002)



Source: The National Health and Lifestyle Surveys (Kelleher *et al.* 2003).

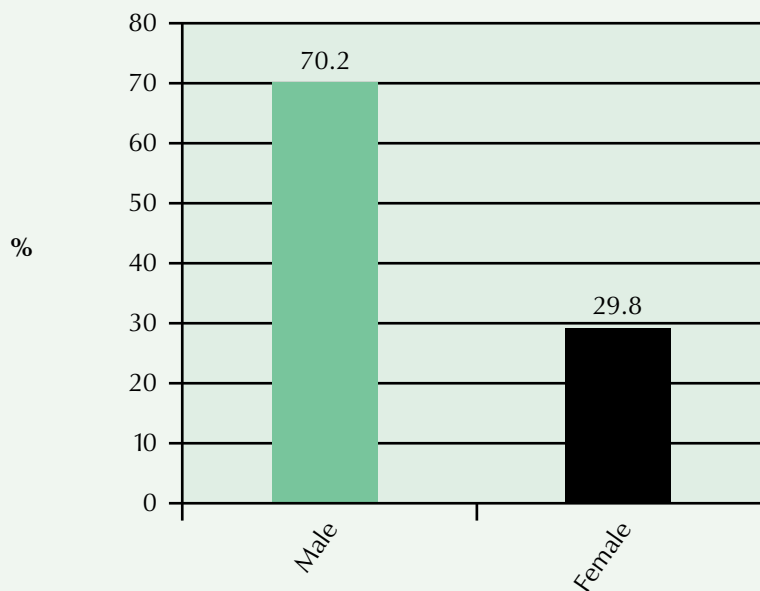
- According to the National Health and Lifestyle Surveys findings (Kelleher *et al.* 2003), the prevalence of smoking is slightly higher among males (28%) than females (26%). Marked age gradients continue to exist among both men and women, with highest smoking rates among younger people.
- The rates of current smoking increase with age, and by age 15-17 both boys and girls of all social classes are exceeding the national targets for those aged 15+. Although boys are starting to smoke at an earlier age, by age 15-17, the smoking rates for girls exceed those for boys (Kelleher *et al.* 1999). According to the latest National Health and Lifestyle Surveys in the RoI, however, the number of 15-17 year old males smoking is increasing (Keane 2003). Although, overall the trend is consistently downwards (Kelleher *et al.* 2003).

- The proportion of people in NI aged 16 and over who smoke has dropped in recent years - from 33% in 1984 to 27% in 2000/01 (Continuous Household Survey 2001). Whilst the decrease has been marked among men (39% in 1984, 26% in 2000/01), the prevalence amongst women has changed little (29% in 1984, 28% in 2000/01) (McWhirter 2002). In addition, men between the ages of 16-24 are almost twice as likely to smoke cigarettes (32%) as men aged 75 or above (19%) (NISRA 2001).
- Connell (2000) stresses that the mass marketing of nicotine and alcohol provides key examples of the collective dimension of masculinity, and does so at two levels. There is the 'boardroom masculinity' of the corporate executives who drive these industries, and the cultural imagery of 'he-man masculinity', which is frequently used to sell these products (Richardson 2003a). A recent report on the impact of alcohol advertising on teenagers in Ireland, found predominantly positive beliefs among older teenagers towards alcohol, and these beliefs related in particular to "*affective enhancement and social facilitation*" (Department of Health and Children 2002: p.36). Connell (2000) suggests that the advertising used in these industries frequently addresses anxieties that are most acute in adolescence, and attempts to connect tobacco and alcohol use with prominent displays of masculinity. These include clear connotation of sexual freedom and sexual prowess, and the achievement of optimum performance in elite sport (Richardson 2003).

4.4 DRUG MISUSE

Many young people experiment with drugs. Most use them on an occasional basis and do not develop significant problems. For others the 'buzz' they get from the drugs can prove an effective way of getting temporary relief from personal and social pain and draws them back again and again for more and more. What began as casual drug use can soon spiral out of control: at the beginning the person takes the drug to feel good; later on they need it just to feel ok (Merchants Quay Ireland 2003).

FIGURE 1.8 ALL CONTACTS WHO PRESENTED FOR TREATMENT
FOR PROBLEM DRUG USE IN ROI, 1997 & 1998



Source: Drug Misuse Research Division, Health Research Board (2002).

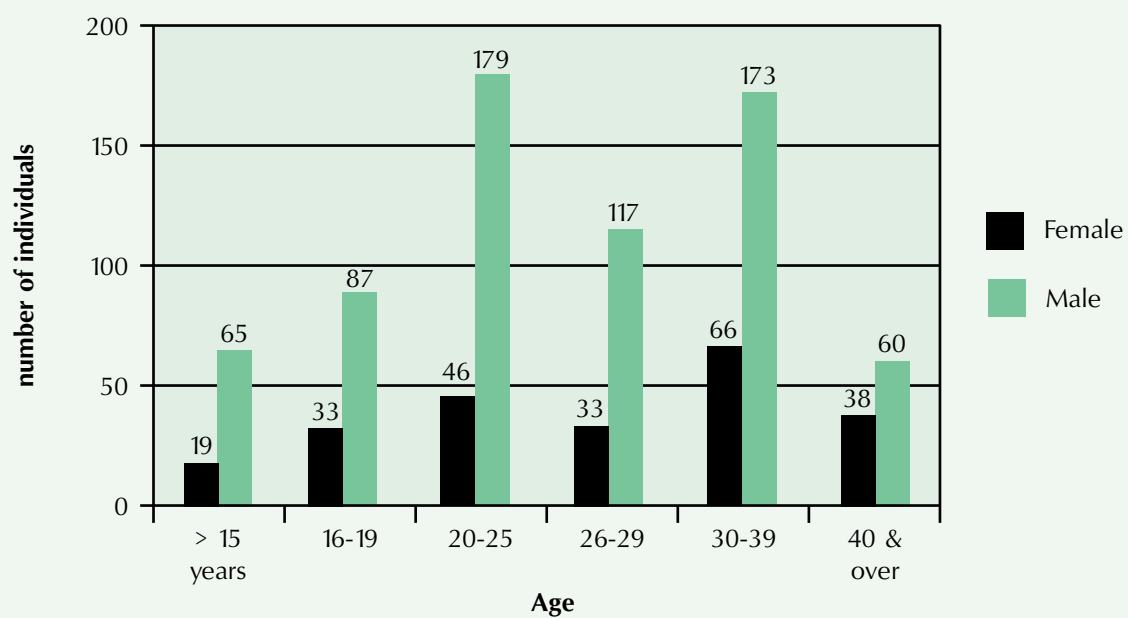
- Figure 1.8 clearly reinforces the findings of the UK Health Authority i.e. “Men are less likely than women to see drug-taking as a health risk” (1992: p.37). Statistics from Merchants Quay Ireland (2003) show men outstripping female users 2:1, with three times as many men reporting to services for drug users.

- According to the National Health and Lifestyle Surveys (Kelleher et al, 2003), a clear gender difference emerged in relation to drug misuse:
 - 12% of men, compared to 7% of women, reported smoking cannabis in the past twelve months. Interestingly, cannabis use is notably higher among people educated to third level (Keane 2003b);
 - Lifetime use of marijuana or cannabis among adults has increased by 4.2% in men (compared with 3.2% in women) over the last 4 years (*ibid*);
 - Since 1998, cocaine usage has also increased from 1.8% to 3% in men and from 0.6% in women to 1.9% (*ibid*);
 - The rate of ecstasy used by men is also higher than the rate amongst women (1.5% higher) (*ibid*).
- In NI during the twelve-month period ending 31st March 2002, information relating to 969 individuals presenting to drug misuse agencies was received. Almost three-quarters of users presenting were male, just over two-fifths of users were in their twenties whilst more than a fifth were aged under twenty (see Figure 1.9). This gender ratio of around three males to one female is similar to the typical distribution found in the UK over recent years. There was also considerable variation between males and females in the main drugs used. Nearly two-fifths (39%) of males reported cannabis as their main drug misuse (almost double the proportion of females). Heroin misuse amongst males (24%) was also higher than the corresponding figures for females (14%) (Department of Health, Social Services and Public Safety 2002).
- Research clearly shows that drug misuse and addiction is primarily a male problem:

Although addiction does not discriminate against women, it does seem to be a disease that is closely associated with men (Rosenfield 1989: p.332).

Brooks (2001) also notes that although the aetiology of substance abuse is a complicated matter that requires consideration of genetic as well as environmental factors, there can be little doubt that the social construction of masculinity plays a significant role.

FIGURE 1.9 AGE AND GENDER DISTRIBUTION OF INDIVIDUALS PRESENTING FOR DRUG TREATMENT IN NORTHERN IRELAND: 2001-2002



Source: Department of Health, Social Services and Public Safety (2002).

4.5 CRIME, RAPE, SEXUAL ASSAULT AND VIOLENCE

The motivation for all male violence is related to males attempting to reinforce and render incontestable their heterosexual masculinity (Hong 2002: p.16).

It is possible that the pursuit of status - perhaps through involvement in the drug trade - and the desire to establish a reputation for toughness have contributed to the development of a code of violence in some of our urban areas (O'Donnell 2003).

TABLE 1.9 CONVICTION AT ALL COURTS BY
GENDER AND OFFENCE GROUP IN NORTHERN IRELAND, 1999

Gender	Male	Female
Violence against the person	1,551	148
Sexual offences	89	1
Burglary	689	14
Robbery	127	2
Theft	1,625	370
Fraud and Forgery	372	104
Criminal damage	865	66
Offences against the State	171	7
Other offences	899	44

Source: Northern Ireland Annual Abstract of Statistics (2002).

- In NI, the total number of convictions for males was around eight times the corresponding female rate (Table 1.9). Similar trends are also reported for the RoI (Garda Siochana 1999). Men's fascination and respect for violence is often tied up with proving their manhood which, in part, explains their greater risk of being perpetrators or victims of homicide than females (Stillon 1995, Staples 1995, Reed 1991).
- According to the Irish Prison Service Report, (CSO, 2002b) the number of male prisoners in custody in the RoI was around forty times the corresponding female rate (see Table 2.0).

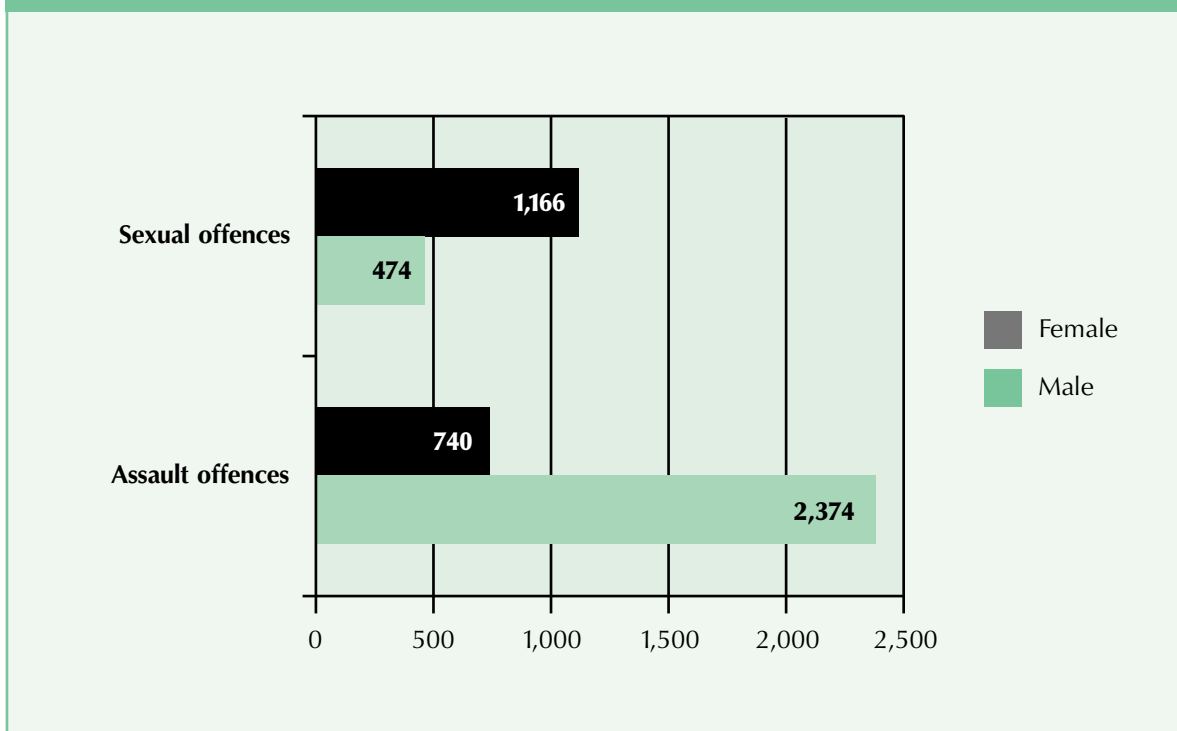
TABLE 2.0 PRISONERS IN CUSTODY BY
AGE AND GENDER ON THE ISLAND OF IRELAND 2001

Age	Male	Female
15-16	20	5
17-20	438	8
21-24	572	21
25-29	573	14
30-39	575	9
40-49	246	4
50+	215	5

Source: Central Statistics Office (2002b).

- The number of adult prisoners (21 years of age +) in custody on the island of Ireland was significantly higher for males than females (forty-five times higher). In 2001, there were 2,714 male adult prisoners in custody and only 53 female adult prisoners (Statistical Yearbook of Ireland 2002; Northern Ireland Annual Abstract of Statistics 2002).

FIGURE 2.0 HEADLINE ASSAULT AND SEXUAL OFFENCE VICTIMS
BY GENDER IN THE ROI 2001



Source: Garda Síochána Year 2001 Crime Statistics.

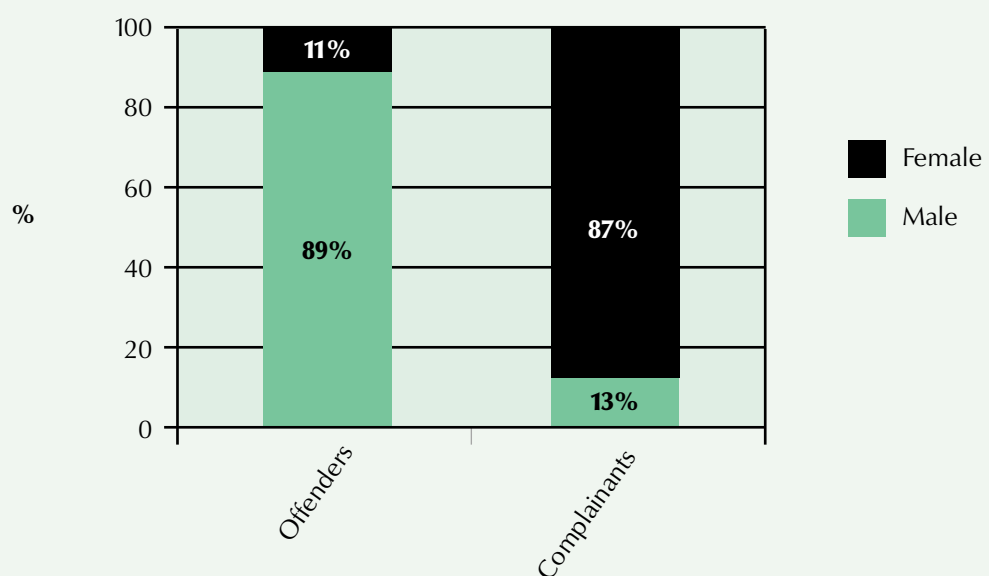
The perpetrator is usually male but the patient is usually female. At the core is the need of one gender to control the other. Doctors (and perhaps authors) turn a blind eye to it, fearing the opening of a can of worms or perhaps offending women by mentioning it (Bradley 1998: p.241).

If a man hits a woman it's assault. If a woman hits a man it's funny. This is the common view of violence in a relationship. Cases are biased in favour of females as they are seen as the 'weaker sex'. Yet males can be physically and mentally battered by their partner too (The Male Link 2000).

It isn't right for women and it isn't right for men. For women the political and legal changes and social conscious raising has travelled many miles in recent years and still has more to go. For men the journey has been a slower one. In many ways the suitcases haven't even been packed yet (Anonymous 2003).

- In the ROI there were 9,983 incidents of domestic violence recorded in 2001, which represents a decrease of 8% when compared with the corresponding figure for the previous year. Figure 2.1 shows the gender of domestic violence complainants and offenders in 2001. Although the offenders were predominantly male some 11% of offenders were females. Complainants were predominantly female. Male complainants accounted for 13% of the total, a decrease of 3 percentage points over the previous year.

FIGURE 2.1 DOMESTIC VIOLENCE COMPLAINANTS AND OFFENDERS BY GENDER IN THE ROI 2001



Source: Garda Siochana Year 2001 Crime Statistics.

- According to McKeown (2002), the biggest difference between men and women in the area of domestic violence is that women end up more seriously hurt, both physically and psychologically, and are more likely to require and seek outside help. Although there is a very significant difference, it does not imply that men are unaffected by domestic violence. The general reluctance of male victims to seek outside help also needs to be taken into account.

4.6 SEXUALLY TRANSMITTED INFECTIONS AND HIV

You don't want to use them [condoms]... in my experience with the girl's consent, you won't... like if you find out they're on the pill (M20, Richardson 2003d).

A lot of girls would say they're on the pill... just tell the guy I'm on the pill and its okay (M19, Richardson 2003d).

An influx of foreign hookers, a spate of gay saunas, and the more cosmopolitan nature of Irish society are all contributing to the growth of sexual diseases (McDonald 2003: p.48).

- In Quarter 2 (Q2) 2001, 2,330 cases of STIs were notified in Ireland, compared to 2,145 during the same quarter in 2000, representing a 13.75% increase in STI notifications (National Disease Surveillance Centre, 2002a).
Table 2.1 represents the number of male and female cases for each of the notifiable STIs. Sabo (2000 in Richardson 2003c) 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, multiple partners, with minimal emphasis on intimacy or emotional attachment, is deemed not just to be acceptable, but also to bestow greater masculinity (Brooks 2001 in Richardson 2003c).
- Sex between men was decriminalised in the RoI in 1993. In 1998, the Virus Reference Laboratory (VRL) confirmed 124 new HIV infections, diagnosed in the RoI, where the route of transmission was known (the route for another 12 was not known). The incidence of HIV infection through sex between men has remained at about 45 cases per year between 1992 and 1999 (National AIDS Strategy Committee 2000: p.13).

**TABLE 2.1 SEXUALLY TRANSMITTED INFECTIONS
IN THE ROI 2001**

STI	Male	Female	Unknown	Total
Ano-Genital Warts	518	507	-	1,025
Candidiasis	44	238	-	282
Chancroid	0	0	-	0
Chlamydia Trachomatis	167	212	-	379
Genital Herpes Simplex	29	44	-	73
Gonorrhoea	84	16	-	100
Granuloma Inguinale	0	0	-	0
Infectious Hepatitis B	6	4	-	10
Lymphogranuloma Venereum	0	0	-	0
Molluscum Contagiosum	21	17	-	38
Non-Specific Urethritis	339	82	-	421
Pediculosis Pubis	20	8	2	30
Syphilis	66	5	-	71
Trichomoniasis	5	6	-	11
Total	1,299	1,139	2	2,440

- The Surveillance Sub-Committee of the National AIDS Strategy Committee concluded that *“transitions among homosexuals have continued to rise at a steady rate”* (2000: p.20). In the first six months of 2000 there were at least 32 new diagnoses of HIV infection acquired during sex between men.
- In total, to June 2000, the VRL had made 350 diagnoses of HIV in men, acquired through sex with another man, of whom at least 120 have died (HIV/AIDS statistics 6/2000, Department of Health and Children). This suggests there are at least 410 homosexually active men living with diagnosed HIV infection in the RoI (Carroll *et al.* 2002).
- In Belfast, the Unlinked Anonymous (UA) survey between 1992-1995 tested 531 blood samples from homosexually active men attending a GUM clinic, of whom sixteen had HIV (3.0%), of which only two knew of their infection. This picture remained identical over the following four year period from 1996 to 1999 inclusive (Carroll *et al.* 2002). The UA survey tested 559 samples, of which seventeen were positive and three previously diagnosed (Carroll *et al.* 2002). This suggests only a small proportion of prevalent HIV infections in homosexually active men in NI are diagnosed. The Survey of Prevalent HIV Infections Diagnosed (SOPHID) estimated there were 58 homosexually active men living with diagnosed HIV infection in mid-1999.
- The ‘official’ invisibility of gay men has inevitably meant that the impact of HIV infection on gay men in Ireland was for many years played down or denied. However, in 1988, a third of gay men knew someone with HIV (GHA 1989). By 1992, this had risen to 66% (Gay Men’s Health Project (GMHP) 1992).

CHAPTER 5

HEALTH SEEKING BEHAVIOUR



5. HEALTH SEEKING BEHAVIOUR

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: p.1813)

It's actually acknowledging and accepting the problem, that's where the big bottle neck is... it's the whole denial and fear and 'oh I'll be alright, this thing will pass off and sure I'll be okay in a months time', it's that whole blockage, that is where I think the crux of the problem lies (M42, Richardson 2003d).

- Although research is limited in Ireland, it is well documented internationally that compared to women, men have limited contacts with physicians and healthcare services in general (Roter and Hall 1997; Courtenay 1998; The Lancet 2001; Richardson 2003c). Hence it is hardly surprising to learn that for almost every condition common to both sexes, the outcome for men tends to be poorer.
- In terms of accessing 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). It has been estimated that 40% of male consultations are at the prompting of a female (Denyer 1998). Little wonder then that eight out of ten men admit to waiting too long before going to see their doctor.
- According to Stakelum and Boland, the main reasons for men being reactive, rather than proactive, in the maintenance and promotion of their own health are rooted in the following four areas:
 - Lack of awareness as to when they should attend for screening;
 - Linked to this is the absence of a preventative healthcare ethos in the current delivery of general practice;
 - Men believe that, unlike women, they are not socialised into the health culture from an early age, and are therefore less likely to develop the confidence to seek preventative help;
 - Finally, men are less likely to interpret their symptoms as arising from physical symptoms, which may be a form of denial bound up in what men regularly referred to as the 'macho principle' (2001: p.23).
- In addition, Stakelum and Boland (2001) found that there was very little evidence of self-directed preventative health amongst men. Any health screening that did occur was superimposed on men due to previous illness, school medicals, or pre-employment checks, rather than being actively sought by the men themselves. For adolescent males it was the school medical, or a pre-college medical that was their last experience of preventative health checking.
- Late presentation can result in poorer health outcomes, and explains why men, despite being half as likely as women to develop malignant melanoma, are twice as likely to die (Banks 2001).

- The 1997 Northern Ireland Health and Social Well-being Survey (O'Reilly and Browne 2001) indicated that 66% of men and 82% of women had consulted their GP in the previous year. Consultation rates for women were higher than those for men and were fairly constant throughout the age range.
- Continuous Household Survey (CHS) data for consultations with the NHS GP in the 14 days before the interview were 12% for men and 19% for women (16% overall) (McWhirter 2002).
- In a study relating to the health status, attitudes and behavioural patterns of middle aged men in a General Practice in an urban area of Dublin (O'Keeffe 2000), the results show very little differences between the attitudes and behaviours of the men who attended the well-man clinic and those who did not. The men did recognise the importance of health maintaining behaviours yet in practice the health status was poor as indicated in the results from the screening in the well-man clinic. The majority of the men had visited the GP within the last year.

The results of this study not only indicate the need for health promotion initiatives but also indicate that a GP service which is acceptable to the community and is well utilised has a key role to play in the prevention of cardiovascular disease (O'Keeffe 2000: p.10).

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS



6. CONCLUSION

Men learn to conceal vulnerability, to be stoic and independent, and may turn to unhealthy behaviours and indeed risk behaviours that are culturally defined as masculine to 'prove' their masculinity to themselves and others. Self-care practices on the other hand have become culturally defined as 'feminine' (Richardson, 2003c).

The statistics outlined in this report demonstrate that men's health on the island of Ireland is in critical need of attention:

- The risk of dying from malignant cancer before the age of 75 was about 1 in 8 for women, but about 1 in 6 for men (National Cancer Registry of Ireland 2001);
- One in every 273 men will develop testicular cancer; some needlessly die from it each year because of failure to detect it in time (Armstrong 2001);
- Even though prostatic cancer killed 900 Irish men in 2002, there is no prostatic cancer screening (Smith 2003);
- In 2001, four times more men than women died by suicide (CSO 2000a, NISRA 2002);
- For every seven women who are aged 65 years or over, there are five men and amongst those who are 85 years of age or over, there are three women for every one man (Murphy-Lawless 2003);
- Statistics show that heavy drinking among men has increased from 35% to 41% over the last four years (Andrew 2003);
- In 2001, 6,790 persons in the RoI were convicted of drink driving offences, some 93% of those convicted were male (Garda Siochana 2001).

Data presented in section four of this report makes it clear that men engage in risk behaviours and lifestyle habits that are detrimental to their health. According to Griffiths (1996), however, it is not just the impact of lifestyles and biology but society's expectations of men that also need to be addressed. Such expectations have created an environment in which men are less able than women to recognise physical and emotional distress and to seek help.

Research further indicates that men are reluctant users of primary care services, make little use of preventative services and often present late in the course of an illness. "Men often believe that their role is to 'tough out' illness for as long as possible rather than admit to what feels like a weakness" (MHF (UK) 2002:8); a belief that is reinforced by cultural and institutional values:

It is society's expectations regarding the stereotypical male role, which exerts the biggest cost on men's ability to seek and obtain timely healthcare (Stakelum and Boland 2001:20).

The Men's Health Forum UK maintains that in order to work effectively with men, policy makers and practitioners must "improve their understanding of male gender roles and seek to develop and deliver services that are aimed at men as they are and not as some might wish them to be" (2002:3).

Compared to countries like Australia, USA and the United Kingdom, Ireland lags far behind in terms of being proactive in the area of men's health (Richardson 2003b). In Australia for example, during the 1990's men's health emerged as a vibrant issue at both a policy and service delivery level, resulting in two national men's health conferences, a draft national policy, as well as the development of taskforces, advisory groups and policy and strategy documents within several Australian states (Richardson 2003c).

It was not until very recently that men have been identified as a target population for the strategic planning of healthcare in the RoI (Department of Health and Children 2000, 2001). However, as Richardson (2003b) notes, there still remains a fundamental lack of understanding and clarity about what is meant by 'men's health' in Ireland, which is at least in part a function of very sparse and fragmented research in men's health in general.

"The major gap in existing research in Ireland is on the relationship between gender as a dynamic construct and men's health, and the role of masculinities in actively constructing behaviours and attitudes, that ultimately impact on health. New research in these areas is called for" (Richardson 2003c: p55).

It is envisaged that the information contained throughout this report will, to some degree, act as a launching pad for further research into men's health.

6.1 RECOMMENDATIONS

To impact upon the issue of men's health, the Men's Health Forum in Ireland recommends:

■ The Establishment of an Advisory Group for Men's Health on the island of Ireland:

The Forum recommends the establishment of a multi-sectoral Advisory Group for Men's Health by Spring 2004. It is important that the Advisory Group would liaise closely with gatekeepers and stakeholders who are engaged in the area of men's health at statutory, community and voluntary levels.

The Group's main role would be to provide terms of reference in relation to men's health and monitor and assess progress made both north and south of the country; thus ensuring that male health issues are constantly kept in focus. The Group's work would also aim to develop and strengthen understanding and awareness about men's health in both jurisdictions.

■ Research and Data Collection:

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. To understand what it is 'to be a man' in Ireland is an important and necessary step if we are to appreciate how men on this island actively construct behaviours and attitudes that ultimately determine their health status.

It is vital that research increasingly takes '*sex differences*' into account. Where the population analysed includes men and women, the findings should be broken down by sex. This is as important as findings stratified by age, social class or ethnicity. A more critical appraisal of such sex differences (ie. a '*gendered*' approach to health) is called for in the future.

The collection of data within each jurisdiction also needs to be strengthened, and differences in data collection protocols and procedures reduced, so that north-south data can be combined and compared in a more meaningful way.

The Forum also calls for the establishment of an all Ireland Men's Health Database by Autumn 2004. The aim would be to create greater awareness around men's health by providing up-to-date statistics, trends and alliances in men's health on the island of Ireland. It is envisaged that the information contained within this report will lay the foundations for such a Database.

■ Policy Development:

At a practical level, there is a need to develop a national policy for men's health relevant to all men on the island of Ireland, similar to that adopted for women in 1995 in the RoI. The development of a national policy would emanate from extensive consultations throughout both NI and the RoI. It is also increasingly important that men (who can speak about their experiences and needs as men) are brought into the process of policy and practice development. It should also be noted that the establishment of a working group for men's health in the RoI was planned for **early 2002**, (Department of Health and Children 2001) but has yet to be delivered.

■ **Increased Training and Awareness:**

Research clearly indicates that men and women engage in health differently, hence, training should be provided for health professionals and service providers on men's health issues and on working with men as a specific sub-group. Training is particularly needed on how to identify men's health needs at the local level and how to design and deliver effective services for men.

There is an urgent need for more health promotion initiatives that are specifically targeted at men rather than based on the traditional population-wide approach. The Forum recommends targeting and promoting one particular men's health issue annually for the next five years (2004-2009). For example, year one may be given to increasing awareness around prostate cancer, year two to mental illness, year three to suicide and self-harm etc.

In addition, men's health advocates must be encouraged at every level in order to lobby and campaign for improvements to men's health policy and services and to act as men's 'champions' for 'ordinary men'.

■ **Resources:**

The Forum calls for an urgent review of resources (i.e. funding, health programmes and initiatives, training, time and research) specifically allocated to men's health.

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GLOSSARY OF TERMS

Directly Standardised Mortality Rate:

In order to compare the mortality experiences of two populations (the Republic of Ireland (RoI) and Northern Ireland (NI)), directly standardised mortality rate ratios are frequently used. These are ratios of directly standardised rates, expressed as a percentage, where the denominator serves the base for comparison. 1994 population estimates corresponding to the mid-point of the study period (1989-1998) were taken as denominators for mortality rates (Balandia and Wilde 2001).

Standardised Death Rate:

Comparison of the general (total) mortality rates in Member States of the EU is affected by the differences of age structure of the populations. In a relatively 'old population' there will be more deaths than in a 'young population' because mortality is higher in higher age groups. For comparisons the age effect can be offset by the use of a standard reference population. The standardised death rate is thus an adjusted crude rate that enables comparisons to be made between countries and between two sexes. However one should not recalculate absolute numbers from the given standardised death rates. The standard reference population is the 'standard European population', i.e. structured by age in the 'region of Europe' as defined by the World Health Organisation (Eurostat 2000).