mentalking

Men Talking

A Study of Men s Health in the North Eastern Health Board.

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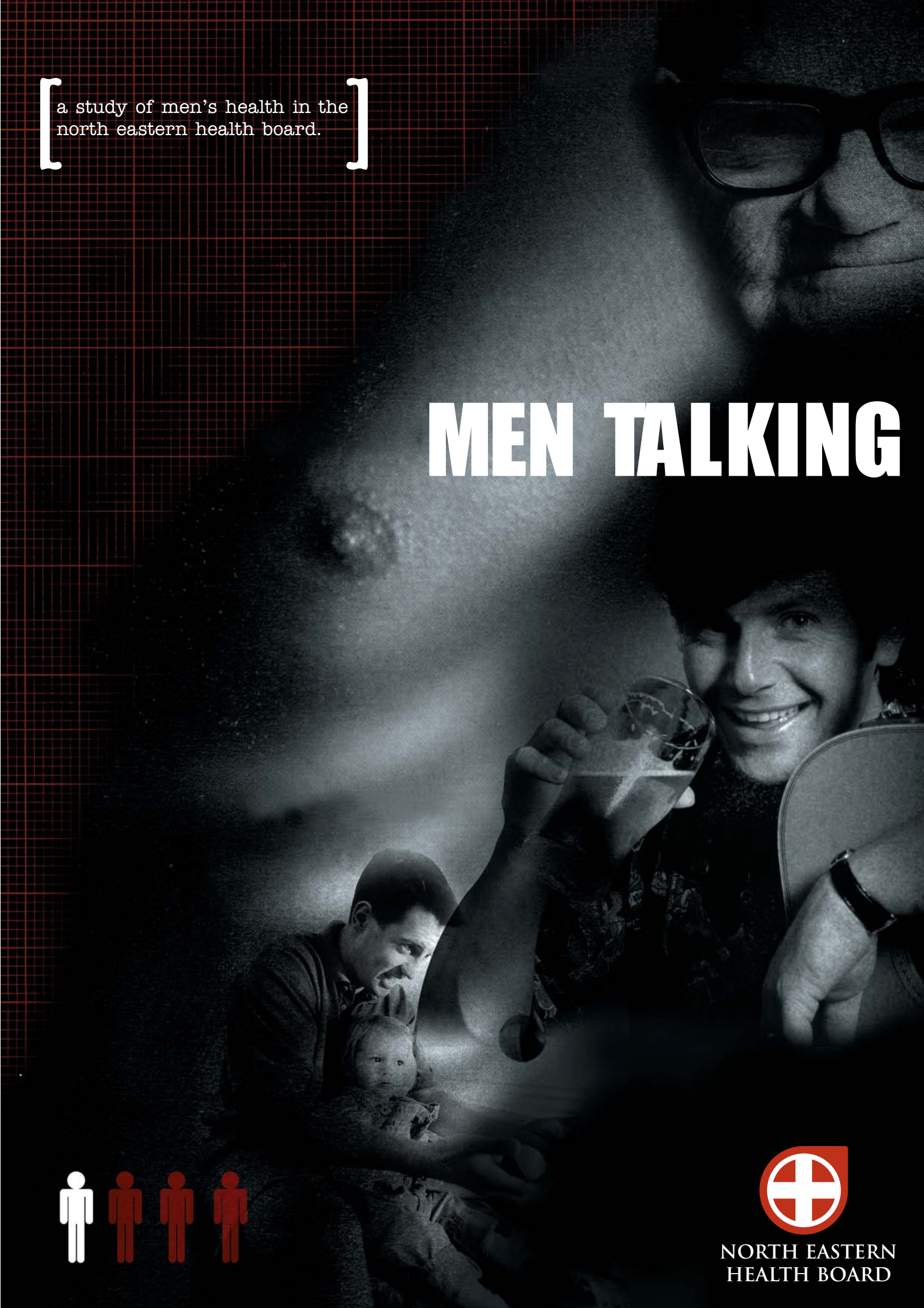
MEN TALKING



NORTH EASTERN HEALTH BOARD

"... I think it's a sad thing that we have to wait until one of our friends dies before we go to the doctor."

male 41 years

Introduction

Improving the health status of men is a priority for the North Eastern Health Board. Reliable baseline information is already available on Men's Health from the Board's Health Status report and from the National Lifestyle Survey. Significant improvements in Men's Health will, however, only be achieved through consultation and through working in partnership with men, men's groups and other statutory and voluntary agencies who have a responsibility for men's health.

In undertaking this research on Men's Health, the main focus of the North Eastern Health Board was:

1. To engage in consultation with men in the North Eastern Health Board region, so as to explore their health beliefs, attitudes and, perceptions. Submissions were also sought from the public

2. To gain insights into the health seeking process adopted by men in times of illness

3. To explore men's views and experiences on current health service provision in the North Eastern Health Board region

4. To identify men's suggestions for improvement and changes for the future

5. To elicit men's reaction to suggestions or new ideas.

"Ah sure it will be alright tomorrow…
then it will be alright in a week or two,
you keep pushing it down and you keep going,
you blot it out." male 48 years

This is the first time that health-specific views of men from the North Eastern Health Board have been sought and reflects the Board's commitment to consultation and partnership. The views of men obtained in the course of this research will reshape the services, taking into account men's needs, and will assist in the development of a strategy for men's health in the region.

I would like to thank all involved in this important research, particularly the men who gave of their time while participating in the process. I would also like to thank the key researchers, Ms Anne Stakelum and Ms Jennie Boland. To Dr Declan Bedford, for overseeing the public consultation process, and to Ms Ita Hegarty, for the co-ordination and editing of the final report.

Dr Rosaleen Corcoran
Director of Public Health & Planning

The data generated from the qualitative research process serves to increase our insight into the area of men's health. It does not assume 'representativeness' and the authors acknowledge that the results presented here cannot be considered as typical of the views and experiences of all men in the NEHB.

"There is a very fine difference between making a man sensitive and making him a sissy, that's the problem."

male 19 years

mentalking

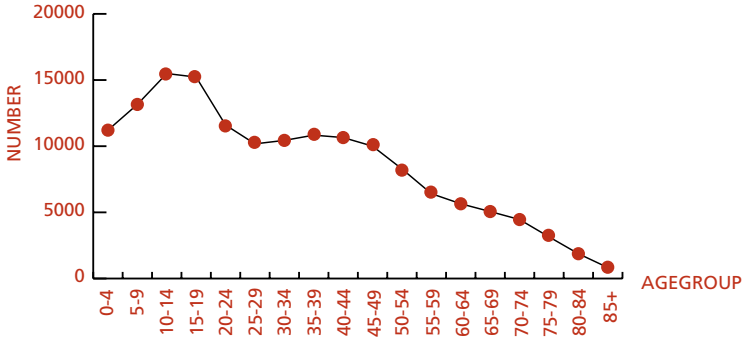
Contents

A Review of the Statistics on Men s Health in the NEHB

Population

Data from the 1996 Census showed that there were 144,243 males resident in the NEHB region. Figure 1 outlines the number of males in 5-year age groups.

FIGURE 1. THE NUMBER OF MALES IN THE NEHB REGION (CENSUS '96)



Of those aged 15 years and over:

- 56.6% were married
- 38.2% single
- 2.8% widowed &
- 2.4% separated or divorced

Life Expectancy

Currently, life expectancy for males in Ireland is 73.0 years.

- This is 5.6 years less than that of females.
- Life expectancy for males at age 40 in Ireland is the 4th lowest in the European Union (EU) and lowest of all the EU countries at age 65.
- Life expectancy for males at age 65 in Ireland is 13.7 years. This compares to the EU average of 15.0 for males and 18.8 for women.

MORTALITY

Mortality analysis - an important indicator of health status - looks at causes of death and trends in males resident in the NEHB region (The last year for which complete data are available is 1999). The mortality pattern for males in the NEHB region is similar to the national profile, with the majority of death caused by diseases of the circulatory system (43%), cancers (23%), respiratory diseases (14%) and injury and poisoning (7%).

- A total of 1,393 males, resident in the NEHB region, died in 1999.
- This compares with 1,502 in 1980.
- There has been a steady decrease in mortality over the years as demonstrated in Figure 2, which shows a continuing drop in male mortality. This is similar to falling rates in males and females nationally.

FIGURE 2. STANDARDISED DEATH RATES FOR ALL CAUSE OF MORTALITY FOR NEHB MALES 1980-99 - FIVE YEAR MOVING AVERAGES

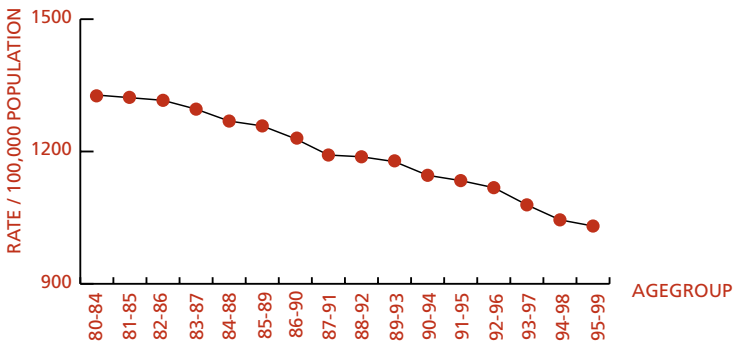
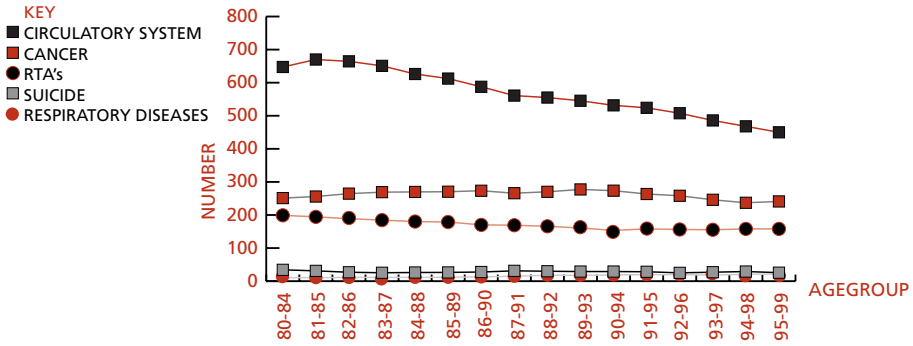


Figure 3 illustrates the main causes of mortality in males resident in the NEHB from 1980 to 1999. This figure confirms the pattern of diseases of the circulatory system, cancers and diseases of the respiratory system, as the main causes of death in males. It is worth noting the drop over time in the death rate from diseases of the circulatory system.

FIGURE 3. STANDARDISED DEATH RATES FOR NEHB MALES 1980-99
- FIVE YEAR MOVING AVERAGES



Over the five-year period, from 1995 to 1999 inclusive, 6,933 males resident in the NEHB region died (see Table 1, Appendix 2 for details of these figures and those outlined below). This rate is not significantly higher or lower than the national rate, although it is higher than the rate for females resident in the region.

- Circulatory diseases accounted for 43% of all the deaths in males, with cancer accounting for 23%. Deaths from ischaemic heart disease accounted for 63% of the deaths from circulatory diseases.

- For most causes of mortality, only a minority of deaths occur in those aged less than 65 years of age. However, at least 80% of deaths in males from injury and poisonings, motor vehicle accidents, suicide, and self-inflicted injury occur in those aged less than 65 years.

- Over the period 1995-1999, males resident in the NEHB region have statistically significant higher mortality rates than the national rate for males, in respect of injuries and poisonings (for all deaths and deaths in those aged less than 65 years) and motor vehicle accidents (for all deaths and deaths in those aged less than 65 years).

- Conversely, over the period 1995-1999, males aged 65 years and less in the NEHB region, have a statistically significant lower mortality rate than the national rate for males in respect of deaths from cancer.

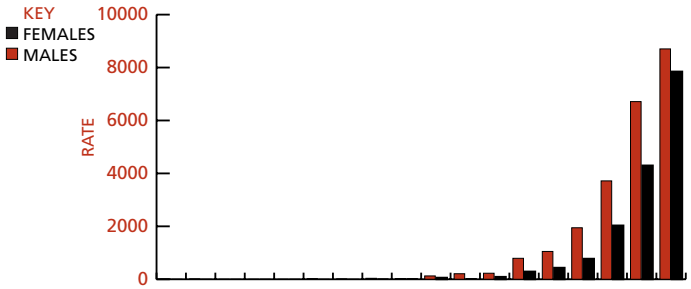
Circulatory Disease

Approximately 600 men living in the NEHB region die each year as result of circulatory diseases.

As illustrated in Figure 4, from the age of 25 years upwards, the rates are higher for males than for females.

Of the males that die as a result of circulatory diseases, approximately 250 (42%) die as a result of acute myocardial infarction (heart attack).

FIGURE 4. THE RATE/100,000 OF POPULATION OF DEATHS FROM CIRCULATORY DISEASES BY SEX FOR NEHB RESIDENTS IN 1999



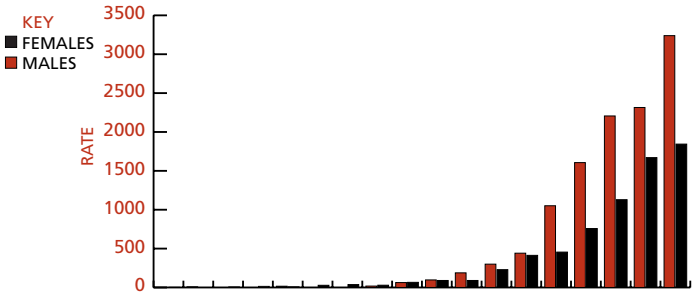
Cancer

Approximately 325 men living in the NEHB region die each year as a result of cancer.

Males, as illustrated in Figure 5, have higher death rates than females at ages above 45, whilst females have higher rates at ages between 25 and 44. Of the deaths resulting from cancer:

- Cancer of the lung is the commonest cause of death, with an average of 76 deaths in males resident in the region each year over the period 1995-99.
- Cancer of the prostate resulted in an average of 41 deaths in males each year and
- Cancer of the colon resulted in an average of 31 deaths

FIGURE 5. THE RATE/100,000 OF POPULATION OF DEATHS FROM CANCER BY SEX FOR NEHB RESIDENTS IN 1999



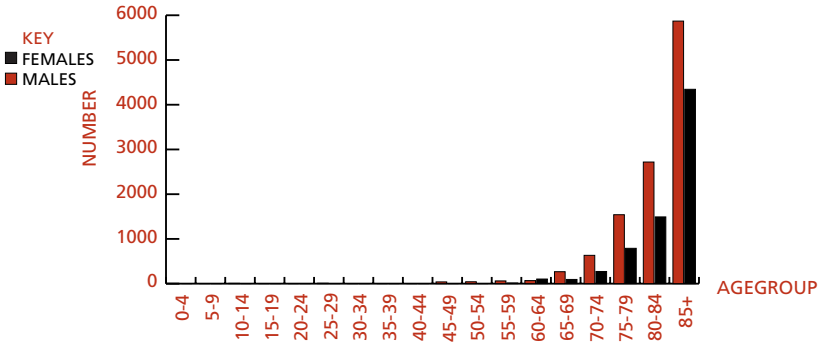
Respiratory Diseases

Approximately 200 men die each year in the NEHB region as a result of respiratory diseases.

Figure 6 outlines the death rate per 1,000 of the population by 5-year age groups from respiratory diseases (chronic bronchitis and emphysema) for residents of the NEHB region.

Males have higher death rates than females at almost all ages.

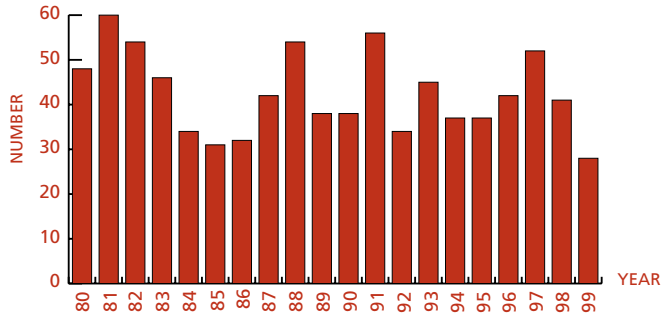
FIGURE 6. THE RATE/1000 OF POPULATION OF DEATHS FROM RESPIRATORY DISEASES BY SEX FOR NEHB RESIDENTS IN 1999



Road Traffic

A total of 410 males from the NEHB region died as a result of road traffic accidents (RTAs) from 1980 to 1999.

Figure 7. The number of males in the NEHB region who died as a result of RTAs from 1980 to 1999



As can be seen from Figure 7, there has been little decrease in the number of deaths in males from the region over the 20-year period 1980 to 1999.

Males resident in the region have a statistically significant higher mortality rate than the national rate in respect of deaths from RTAs. RTAs often involve young males, and this is reflected in a high level of premature mortality. One measure of premature mortality is the number of "years of potential life lost". Table 1 outlines the number of years of potential life lost by males as a result of RTAs from 1990 to 1999. As can be seen from the table, the NEHB has a higher rate than the rest of the country for each year, for years of potential life lost, due to RTAs.

Table 1: Years of potential life lost as a result of RTA's for male residents of NEHB and the rest of Ireland

	NEHB Region		Rest of Ireland	
	No.	Rate/ 100,000 Pop.	No.	Rate/ 100,000 Pop.
1990	1451	955	11225	701
1991	2148	1413	10082	630
1992	1155	738	9499	594
1993	1830	1203	10015	626
1994	1403	974	9419	567
1995	1662	1154	10506	633
1996	1645	1142	10656	642
1997	2146	1490	9817	591
1998	1456	1011	11144	671
1999	1022	710	9795	590

Suicide

An average of 33 males commit suicide each year in the NEHB region.

Suicide has become a more significant problem in recent years. Figure 8 outlines the number of suicides in the NEHB region from 1980 to 1999. There has been a noticeable rise in the number of suicides in males over the period.

FIGURE 8. THE NUMBER OF SUICIDES IN THE NEHB REGION FROM 1980 TO 1999

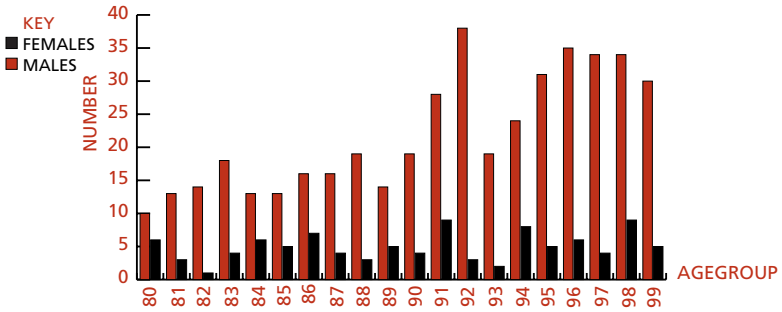
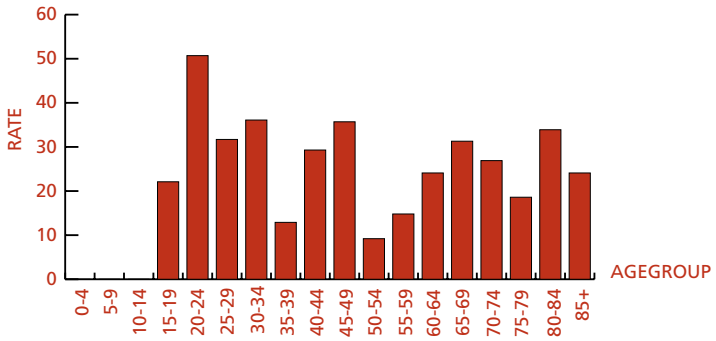


Figure 9 outlines the average yearly rate of suicide per 100,000 population by five-year age group in males, for the period 1995-99. As can be seen in the figure, the rates are highest in young men. The high rates in young men have been a feature of the rising incidence of suicide in Ireland in recent years.

FIGURE 9. THE AVERAGE YEARLY DEATH RATE/100,000 POPULATION OF DEATHS FROM SUICIDE IN MALES IN THE NEHB 1995-99



Morbidity

Morbidity, or the level of ill health that the population experiences, is difficult to quantify. Information systems are not yet sufficiently developed to allow a comprehensive analysis of the burden of ill health in the population. However, useful information is available from a number of sources including the National Cancer Registry and the Hospital Inpatient Enquiry System (HIPE).

Cancer Incidence

The risk of getting cancer is age-related, as illustrated in Figure 10, with a rise in incidence as age increases, up to a threshold (over 75s) where cancer incidence starts to fall off. The incidence is higher for females from the age to 25 until age 54, but is higher for men thereafter.

Figure 10. Male & Female deaths per 100,000 population for all cancers

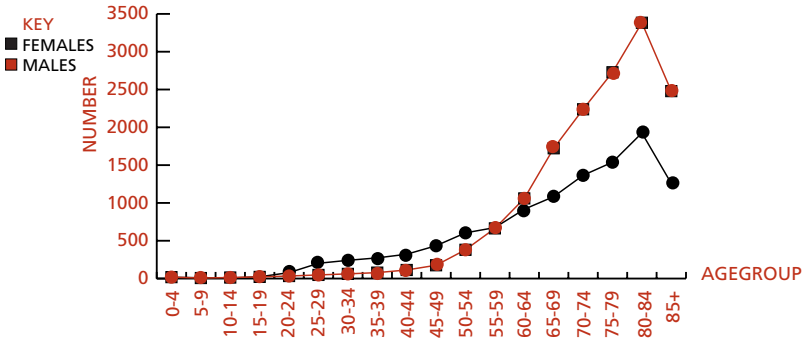


Table 2 outlines the average number of cancers per year and the age standardised incidence rates for "all cancers", for the more commonly occurring cancers in males in the NEHB region, for the years 1994-97 inclusive. As can be seen in the table, there was an average of 210 cancers in males each year over the 4-year period. The incidence of cancer in males in the NEHB region is similar to that nationally, with none of the standardised rates in respect of "all cancers", or of any of the specific cancers, being either significantly higher or lower than the national average.

Table 2. The average number of cancers per year and the age standardised incidence rates for "all cancers" and selected cancers in males in the NEHB region for the years 1994 -97 inclusive

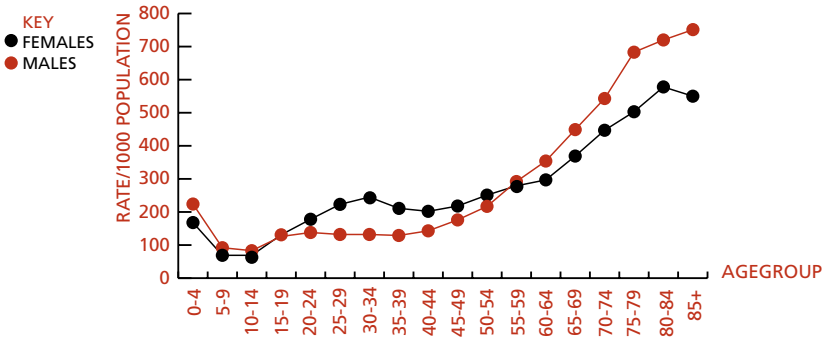
	Yearly Average No.	Rate / 100,000
"All Cancers"	210	623
Prostate	91	65
Lung	73	55
Colon	47	34
Stomach	27	20
Bladder	26	20
Rectum	25	19
Pancreas	14	10

Utilisation of Acute Hospitals

The Hospital Inpatient Enquiry system (HIPE) collects data on all patients who encounter the acute hospital services, either as an inpatient or as a day case. It does not deal with those attending Accident and Emergency units or outpatient departments. Data are collated at the time of discharge.

Data for 1999 show that there were 33,138 admissions to the acute hospital service, as either day patients or inpatients, by males in 1999. Figure 11 outlines the male and female rate of episodes of care per thousand population in 5-year age groups. Males initially have greater contact with acute hospital services in the first 15 years, probably because they are more prone to injuries at this stage. From 15 to 59 years females have a higher rate of hospital attendance than males but thereafter, males encountered the hospital services more than females.

FIGURE 11. AGEGROUPS OF HOSPITAL PATIENTS, RATE/1000 POPULATION



There were 3,782 different diagnoses made for males throughout 1999. Admissions due to diseases of the digestive system (16.8%), circulatory diseases (12.5%) and injury and poisoning (12.2%) are the commonest reason for admission. However, circulatory diseases (22.0%) account for the greater number of bed days occupied (See Table 2, Appendix 2 for details).

Lifestyle

Two baseline surveys of health-related behaviours among adults and school going young people were carried out across the Republic of Ireland in 1998. The key objective of the surveys was to provide reliable baseline data for a nationally representative cross-section of the Irish population, which would inform the Department of Health & Children and the Health Boards, future policy and programme planning in the area of health promotion. The work was commissioned by the Health Promotion Unit in the Department of Health & Children, and was carried out in the Department of Health Promotion, National University of Ireland, Galway. Two reports have been produced to date, one dealing with the national results, and the other dealing with the regional results. The data below are abstracted from these reports.

Smoking

Smoking rates in the NEHB region were quite similar to the national profile. Overall, 30% of adult NEHB male residents smoke as against 32% of adult males nationally. Children's smoking rates were also ascertained for those aged between 9 and 17 years. In the NEHB region, 25% of boys aged between 9 and 17 years reported being current smokers, as against 21% for boys nationally.

Alcohol

The recommended sensible weekly limit for alcohol consumption is 21 units for males. In the NEHB region 31.1% of males consumed more than the recommended weekly limit, as against the national picture of 27.0% of males. Seventeen percent of NEHB male respondents said that they would drive after having consumed two or more alcoholic drinks. This compares to 31% nationally for males.

Children aged 11 to 17 inclusive, were asked about their drinking habits, and 39% of boys in the NEHB region reported that they had had a drink in the last month, 35% had been drunk at least once, and 8% that they had been drunk on at least 10 occasions.

Using self-reported height and weight, the body mass index (BMI) was calculated and used to categorise respondents as underweight, normal weight, overweight and obese. In the NEHB region, 13.0% of males (12.0% nationally) and 8% (9.0% nationally) of females were classified as obese. Table 3 outlines BMI category by gender and age for NEHB and national respondents.

Table 3. BMI category by gender and age for NEHB and nationally

Gender	NEHB Region			Rest of Ireland		
	Normal %	Overweight %	Obese %	Normal %	Overweight %	Obese %
Male	53	34	13	49	40	11
Female	69	23	8	66	25	9
Age						
18-34	76	20	4	70	24	6
35-54	57	31	12	51	37	12
55+	49	35	16	50	37	13

A significantly higher percentage of females (19%) than males (6%) were on a weight reducing diet. Table 4 outlines the percentages consuming different foodstuffs. As seen in the table, just under half of the males in the NEHB region eat the daily recommended amount of cereals, breads, potatoes, fruit, vegetables, and just over half, of meat poultry or fish. Furthermore, 16% eat fried foods on more than 4 occasions a week and consume butter daily, indicating the likelihood of a diet too high in saturated fats.

Table 4. Percentage consumption of foodstuffs for males, for NEHB and Ireland

Foodstuff	NEHB %	Ireland %
6+ servings/daily of cereals, breads & potatoes*	48	44
4+ servings/daily of fruit and vegetables*	58	52
Up to 2 servings/daily of meat, fish & poultry*	54	56
Fried food more than 4 times a week	16	17
Percentage consuming butter daily	57	63

* *Recommended Daily Allowance*

Exercise

Regular exercise has been shown to benefit one's health, and 20 minutes of exercise on most days of the week is recommended. The evidence suggests that males in the NEHB region, as with elsewhere in Ireland, do not take enough exercise. Thirty-one percent of males resident in the NEHB region take no exercise at all, as compared to 22% nationally. Table 5 outlines the percentage of respondents engaging in various types of exercise.

Table 5. Percentage of males engaging in different levels of exercise

Activity	NEHB %	Ireland %
Mild physical exercise for at least 20 minutes most days of the week	21	24
moderate physical exercise for at least 20 minutes 3 days of the week	25	26
Percentage engaging in strenuous physical exercises for at least 20 minutes 3 days of the week	13	13

Use of Seatbelts

Respondents were also asked about their wearing of seatbelts in the front seat of a car. In the NEHB region, 59% of males wore a seatbelt in the front seat of a car, as against the national picture of 51% for males.

Of the children who were asked how often they use a seatbelt when in a car, only 32% of boys in the NEHB region reported always wearing a seatbelt. In addition, when asked how often they wear a helmet when riding a bicycle, only 7% of boys reported always doing so.

Themes

1. Masculinity and its impact on Mens Health - Masculinity Uncanned
2. Men s Conceptions of Health & Illness - Boys Don t Cry ?
3. Men s Health and Illness Behaviour - The Peril of the Stiff Upper Lip
4. Risk Behaviour As a Component of Men s Health - Give Em Hell
5. Men s Emotional Health and Well-being - Suffering in Silence

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Theme 1

Masculinity & its impact on Men s Health

"Nobody wants to be left out... everybody wants to be one of the lads."

FAS worker, 18 years

company: North Eastern Health Board
reference: Men Talking
theme: Masculinity and its Impact on Men's Health

Masculinity Uncanned

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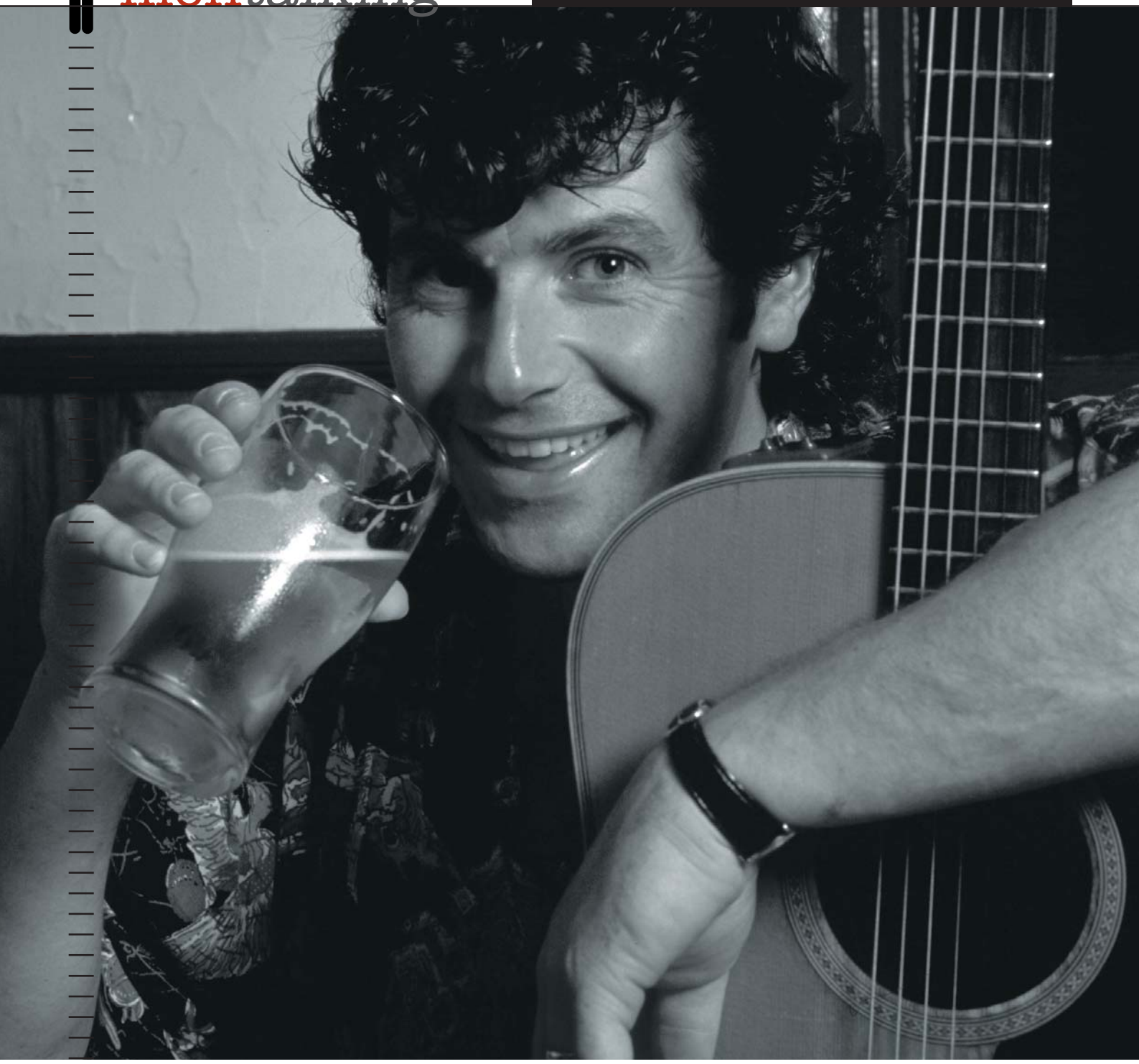


"It's a natural thing - hormones."

middle aged male

"...You have this thing in your head... you have to be big and strong and you can't be seen to be weak."

male 30 years

details:

This theme illustrates the strongest finding of the report - that masculinity rules men's decision-making processes and behaviours, and has far reaching implications for men's health and well-being.

"As a child you are conditioned.
When you fall down and hurt your knee,
what I call the 'cut knee syndrome', big boys don't cry only girls cry.
And it is through this that we are conditioned all the way up."

It would appear from the men in this study, that gender socialisation influences the extent to which boys adopt masculine behaviour, which in turn, impacts on their susceptibility to illness and accidental deaths.

"You have to get out there, get a load of pints down you and get out and play football and cop yourself on, but that's not reality at all. It's the way we are brought up... not to express it, and if you bottle it up, then that is what happens."

middle aged male

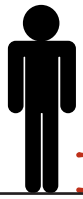
'A give'em hell' approach to life can lead to hard drinking and fast driving, which accounts for about half of all male adolescent deaths.

"Nobody wants to be left out... everybody wants to be one of the lads."

FAS worker, 18 years

"It also could be a form of escapism from something, that you can have the freedom to drive faster and show off and that, but really they might be carrying some problems."

male 26 years



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details:

The need to be the 'Big Daddy,' and to avoid the semblances of feminine dependency, may account for men's reluctance to seek timely help.

"It's conditioning, he might cry to himself but he doesn't like to make it open. He's supposed to be the head of the family and hold the whole thing together."

male 44 years

"All these little aches and pains...
ah sure you say to yourself 'I will be alright'.
You have to keep on going."

male 45 years

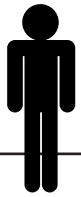
details:

These manifestations of male behaviour are inextricably tied to an outer web of sex roles and gender expectations, which inadvertently result in men themselves reconstructing the myth of masculinity.

Although men recognised, and repeatedly identified this process, it seems they are powerless to change it. They are immersed in socially and historically constructed webs of manhood that they find impossible to change.

“We’re born like that. It’s in our genes.”

farmer 19 years



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Theme 2

Men s Health & Illness Behaviour

“Get up and work.
By God you have to work.”

retired male 73 years

company: North Eastern Health Board
reference: Men Talking
theme: Men's Conceptions of Health & Illness

This theme explores the common orientations men use to conceptualise health and illness, and to a lesser extent disability. This study, like an earlier study by Mc Cluskey (1989), identified four broad orientations to health as conceptualised by men:

1. Performance orientation: the ability to work and carry out normal roles and tasks
2. Fitness orientation: experience of being active and physically fit
3. Feeling - state orientation: a general feeling of well-being
4. Symptom - free orientation: the absence of symptoms or illness

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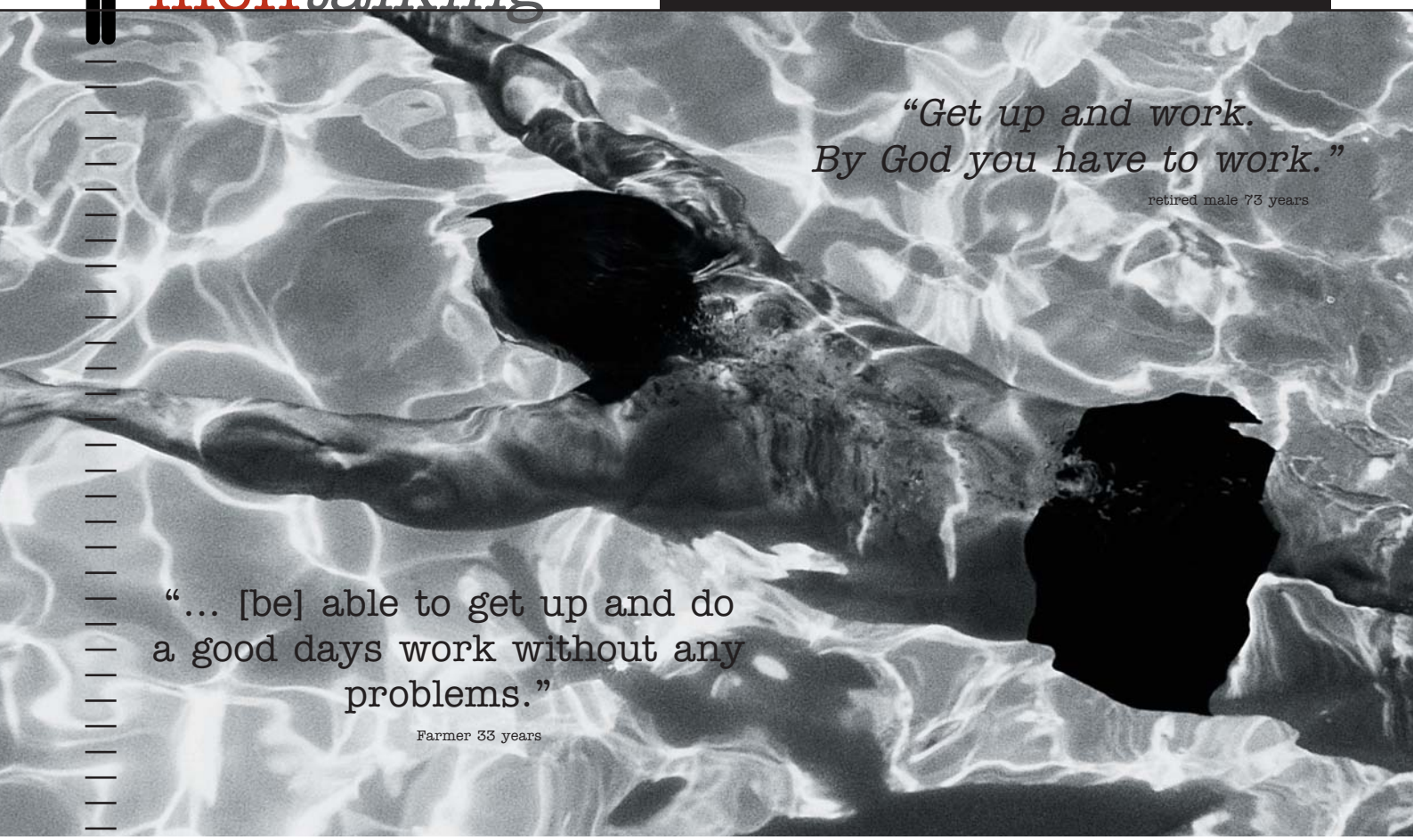

"Get up and work. By God you have to work."

retired male 73 years

"... [be] able to get up and do a good days work without any problems."

Farmer 33 years

"Being able to do light exercise, if it is light exercise that you need, if you're sports minded... well to go out and do something a bit heavier."

disabled male

"If they are the right weight and things, and a level of exercise they can do, like not overweight I suppose."

adolescent male

Boys Don t Cry ?

details:

1. Performance Orientation: The ability to work & carry out normal roles & tasks

Of great importance for the men in this study was the ability to 'get up and work', reflecting the high ranking given to a performance orientation to health. This was true of all men involved, even those with a disability. It would appear that being able to work and being healthy, are still mutually bound up in the male psyche.

2. Fitness Orientation: Experience of being fit & active

The second most common orientation emerging from discussion was a fitness orientation, with men defining health in terms of being fit, active and energetic.

In addition, younger men also defined being fit in terms of being the proper weight, and more specifically, not being overweight. This emphasis suggests that at least there is awareness among younger men of the link between weight and health.

3. Feeling State Orientation: General feeling of well being

The third most common orientation to emerge, was a feeling-state orientation, which represents a somewhat holistic notion of health and well-being and recognises the link between emotional health and physical well-being. Its ranking, in third place, would suggest the lower priority given by men to emotional health issues vis-à-vis physical health.

4. Symptom Free Orientation: The absence of symptoms or illness

This orientation was the least frequently mentioned, which might reinforce the notion that symptoms are only worth considering when they interfere with men's ability to work. While a symptom-free orientation emerged for Mc Cluskey (1989) as the most important orientation, for men in this study it was ranked least important.

While men recognise the multidimensional nature of health, there is still a strong tendency to equate health with physical well-being. The ability to work is still the defining health benchmark for many men. Emotional health, in contrast, is still given far less priority.

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Theme 3

Men s Conceptions of Health & Illness Behaviour

“Men need a mother figure the longest day they live”

company: North Eastern Health Board
reference: Men Talking
theme: Men's Health & Illness Behaviour

This theme explores preventative health strategies employed by men at different stages of the life cycle and looks at the sequence of help-seeking behaviour adopted by men from the onset of symptoms until the professional is reached. It also addresses men's experiences of the health services, with a view to making them more responsive to men's needs in the future.

mentalking

details:

1. Preventative Health in Men: Sickness prevention not health promotion

Little evidence of self-directed preventative health behaviour emerged from this study. Any health screening that did occur, was superimposed on men due to previous illness, school medicals, or pre-employment checks. Screening does not appear to have been actively sought by the men themselves.

"I had let my blood pressure get too far and eventually it ended up I had angina problems... I probably should have kept it checked but I do it now."

male 42 years

"The last check up I had [before coming to this college] was the school medical, that was about 10 years ago and I didn't go since."

adolescent male

Indeed, for many it was the 'the fright' of impending serious illness, experienced either directly or vicariously, that motivated them to seek help in the first instance, and it is this fear of becoming seriously ill that ensures that they now attend their doctor for regular check ups.

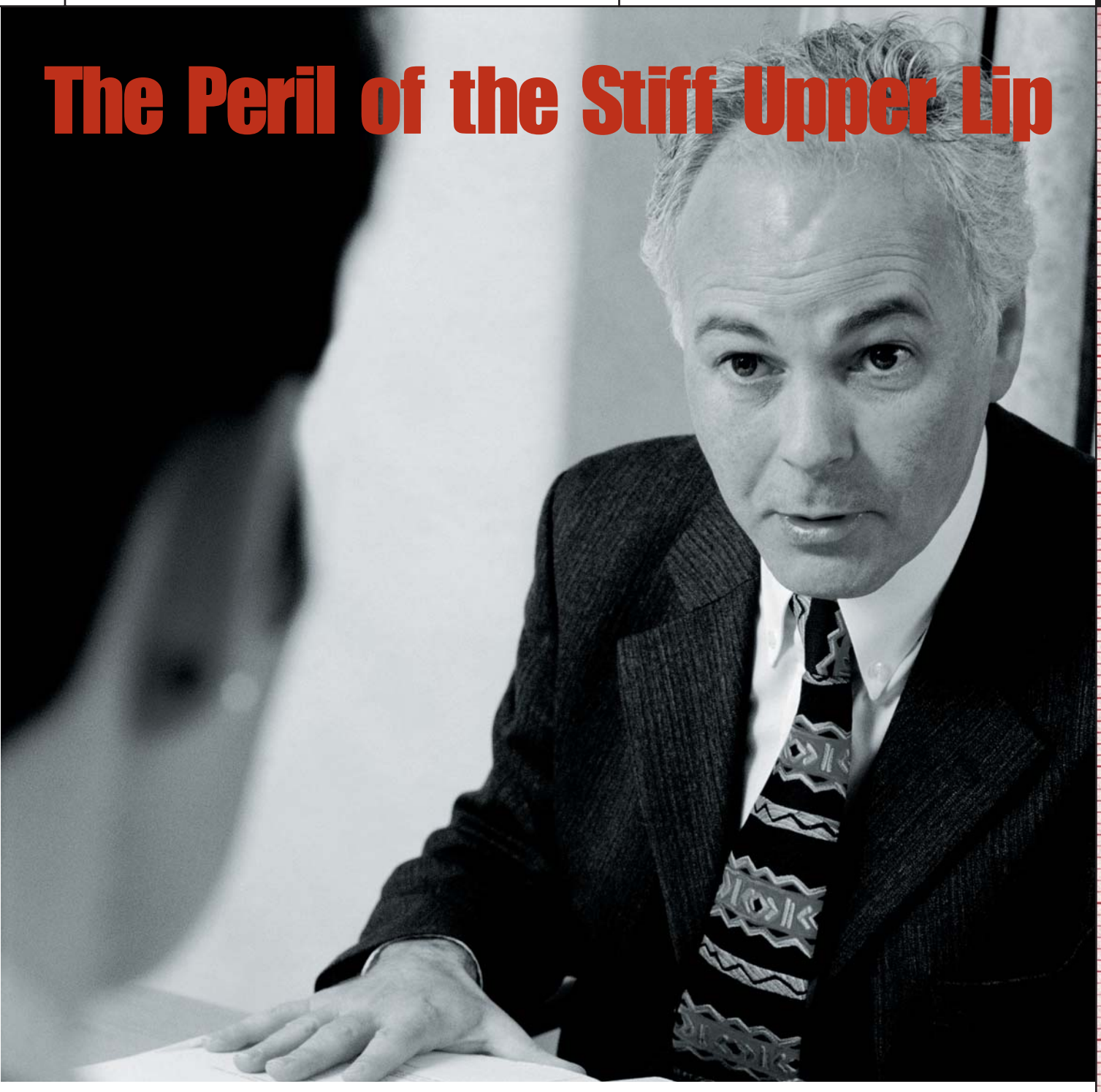
"I went 26 years without ever going to the doctor, and I never needed to thank God. I just became conscious when a friend of mine died, that I did go... and I do go every six months, but only the fear of God was put into me I would not go."

male 42 years

*"Unless I had a reason to go, I certainly wouldn't go for a check up,
It's not like you get the motor car serviced or anything like that."*

rural bachelor 62 years

The Peril of the Stiff Upper Lip



2. Barriers to Preventative Health Care: Men s Views

Men feel that there are four main reasons underlying the fact that they are reactive, rather than proactive, in the maintenance and promotion of their own health:

(a) Lack of awareness on their own part, as to when they should attend for screening...

"I don't know whether it is only a macho thing I think the responsibility of being a male if you are in a family situation you tend to prioritise these things. Your responsibility is to put bread and butter on the table and running off to the doctor... well there won't be bread and butter on the table... I think that has a lot to do with it."

male 45 years

"I know a fella who went in (to have his cholesterol checked) and he said you are too young... you need not bother with that."

male 27 years

(b) The absence of a preventative health ethos in the current delivery of general practice...

"Then a lot of surgeries would have been clinics for women... well woman clinics... but there are only very few doctors that would have a man's clinic so as to make us aware of our health."

male 37 years

(c) 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...

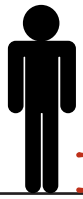
(d) Finally, men are less likely to interpret their symptoms as arising from physical symptoms, which may be a form of denial bound up in what men regularly referred to as the 'macho principle.'

"It boils down to women... because there is a lot more happening to them in adolescence... there is a lot more happening for a girl than there would be for a boy, and I think it starts there, and maybe even before that girls are taught to take care of themselves and boys aren't and that goes on into adolescence"

male 37 years

"Well I had a leaking valve... I was not able to walk from the workshop to the lift and I had to take a break... I just put it off. When I would get into the car, I had to wait a few minutes after walking before I could start, and than I lost the power in one of me arms and I used to have to start the car with the other hand, but I left it and I did not go to anyone."

males 55 years



mentalking

details:

3. Illness Behaviour: From Symptoms to Help

In addition to preventative health, the study was also interested in looking at how men behave in times of illness. There was a particular interest in the exploration of barriers to timely help-seeking, as well as the lay referral system that men used in times of ill health.

It emerged that barriers to help-seeking clustered around sociocultural barriers and institutional barriers.

"You would hope that you would die real quick and not have to go into hospital, O Jesus no I mean a man doesn't like to have to go into hospital...
anyway a man doesn't like to attended to on a sick bed anyway..."

retired male 81 years

details:

4. Sociocultural Barriers

Sociocultural barriers refer to the way males, through their up-bringing, place a high priority on work and providing for others, and a low priority on self-care. In addition, it refers to the macho principle, which equates illness with weakness.

Men were afraid of losing control and of being considered weak, but were also afraid that their symptoms might harbour something more sinister

"What you don't know won't bother you, right, so I don't want to know it. So fear would come into it big time, because you are conscious of all that, you are afraid of your life to go for tests and things like that..."

male traveller 37 years

"I had a friend who had testicular cancer and I found it strange that he allowed the growth to become the size of probably...a peach, now that is not something that happened overnight and he lost his testicles as a result..."

male 47 years

"If you hadn't the wee bit of flexibility, it would be hard to get a GP after 6pm [in this town]"

male 40 years

details:

Institutional barriers, on the other hand, refer to the perception by men that current health services are not male-friendly. These mainly related to inflexible surgery times, the feminisation of doctors' waiting rooms and protracted waiting times.

"If you wanted to go to a doctor you would be loosing half a day... there is queuing in a lot of doctors around the town...."

male 45 years

While institutional barriers are important and will need to be addressed in the future, most of the dialogue suggested that the real barrier to help seeking was rooted at the sociocultural level. It is society's expectations regarding the stereotypical male role, which exerts the biggest cost on men's ability to seek and obtain timely health care.

"It's always women's magazines that's in them, but then it's always women that are there full stop, so I suppose why should they have men's magazines"

male farmer 30 years

5. Lay Referral and Lay Intervention

While men were slow to seek professional help, they did make use of a very specific lay referral system, which was restricted, in the main, to close female confidants, mothers, wives, and sisters.

"I would not be the best in crowds or talking to other men. I can't explain it I just speak to a woman better, don't ask me why, maybe it is a macho thing you just don't talk about your feelings."

41 year old separated father

"Yes because my wife hassles me to go to the doctor, or to get something checked out. She would know if something was wrong more than I'd know" male 37 years

"Well I often went out with a problem ...and I might be in the company of men I'd never tell it to them but if I was in the company of a woman I'd probably come out and tell it...it must go back to the mother son relationship, it must be that the males won't talk about their problems amongst themselves but they would to a female"

69 year old male bachelor

Fathers, in contrast, were rarely mentioned as a source of support in times of illness. It appears that fathers and sons are locked together in a 'collusion of masculinity' which prevents either one from comforting the other in times of illness. This is something that is carried with them right throughout their adult lives until wives start to perform the role of a kind of surrogate mother.

"If I was sick or feeling down in the dumps [as a child] it would be the mammy we would go to ... ah sure the dad had this macho image that you were a weakling or something, no you went to the mother for a little hug." retired male 71 years

"I think doctors are too quick in reaching for the pill bottle to prescribe pills rather than giving you a good examination... they are far too quick to reach for the prescription pads"

44 year old male

6. Men s Experience of the Health Services

In the main, the three services men had most contact with were GPs, the acute hospital sector and social workers.

details:

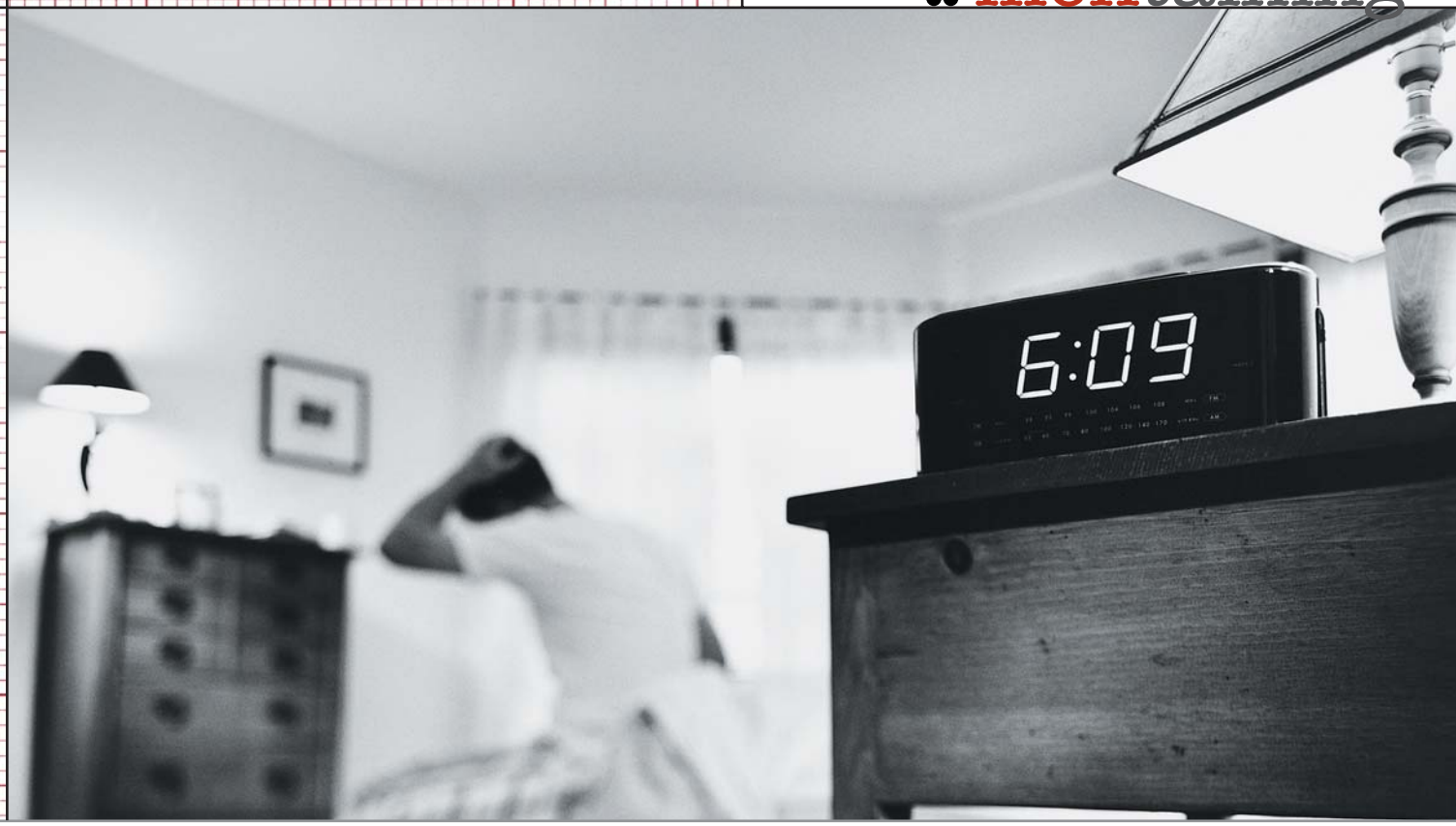
- GPs

Older men, and men who had built up a good rapport with their GPs (often because of an on going illness), were most satisfied with their doctor. Younger and middle-aged men, in contrast, often spoke about the rushed nature of the medical encounter, -'the supermarket' approach to general practice and the tendency of doctors to medicate and not listen.

Men in the study who were victims of domestic violence had mixed views regarding their GPs' ability to help them in their hour of need. In general, it varied from 'ignorance' on the part of the GP, to a recognition that GPs are not equipped to deal with what, for many, is a new social phenomenon.

"I went to the doctor I was busted, I was split by a door and he just threw his hands and he says 'well what can I do'...what do you want me to do, what can I do."

48 year old male victim of domestic violence



- Acute Hospital Sector

Some men, particularly older men, did spend some time in the acute hospital sector. Almost without exception, these men were very satisfied with the care they received. While this is a welcome finding, it should not give way to complacency, as low levels of expectation can often yield disproportionately high levels of satisfaction. Given the enormous fear men expressed at having to be admitted to hospital, the fact that they survived the ordeal for many, may have been enough reward.

When complaints regarding the hospital sector did emerge, they revolved around what men described as, the female bias that surrounded doctor-patient communication. This was particularly true for separated fathers, who felt demeaned by a system that seems to reinforce the societal notion that mothers are always 'the better carers.'

This plight of the separated father was not just confined to the acute hospital services, but it arose with some GPs, with the educational system, the legal system, the social welfare system, and in particular, with social work departments within the NEHB region.

- Social Workers

Difficulty with social workers was confined to two categories of men, who by virtue of their circumstances had a lot of exposure to this service. These were (a) men who were victims of domestic violence and (b) separated fathers, striving for custody of their children.

Men were particularly critical of what they perceived as the female bias that permeates current social work. They felt that, at best, they were not listened to and at worst, their stories were not taken seriously. The mother's story, they felt, was always held in higher esteem.

This gender bias, it was suggested, is often not intentional on the part of the social workers, but rather is a by-product of the occupational socialisation of social workers.

Men felt that social workers are mainly female, their client base is also predominantly female, and contact by men, when it does occur, is often secondary following initial interaction with the mother.

"They are finding it very difficult to listen to you, they won't believe you. They find it difficult to believe that women can do these things... they just find it impossible to believe that."

45 year old victim of domestic violence

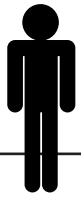
Conclusion

The findings that constitute this theme suggest that the stereotypical role of men, which equates 'self-control' and 'denial' with manhood, and views sickness as a form of weakness, may in fact, be injurious to men's health. The male sex role stereotype demands that men be healthy, strong, and self-reliant. Society in turn, via cultural and institutional mores, reinforces this image.

Male patients and health service providers, it seems, are locked together unwittingly in perpetuating male gender myths based on sexual differences and societal expectations. Men's health is thus, inextricably tied up in the image of the perfect man, with illness being perceived as a loss of masculinity. As Sabo and Gordon (1995) put it 'consonant with the tenets of sex role theory, researchers recognised that masculinity as a inner psychic process was inextricably tied to an outer web of sex roles and gender expectations.'

"I wanted to stay overnight in the 'parents' room' it said it on the door, but the nurse told me it was the mothers room... right enough she said I could stay in the games room for children... in the games room at 6.30am there would be kids in. It was not a suitable place to put anybody"

middle aged separated male parent



mentalking

Theme 4

Risk Behaviour as a Component of Men s Health

“It’s more the fact that you might get caught more than killing someone, I think”

adolescent farmer

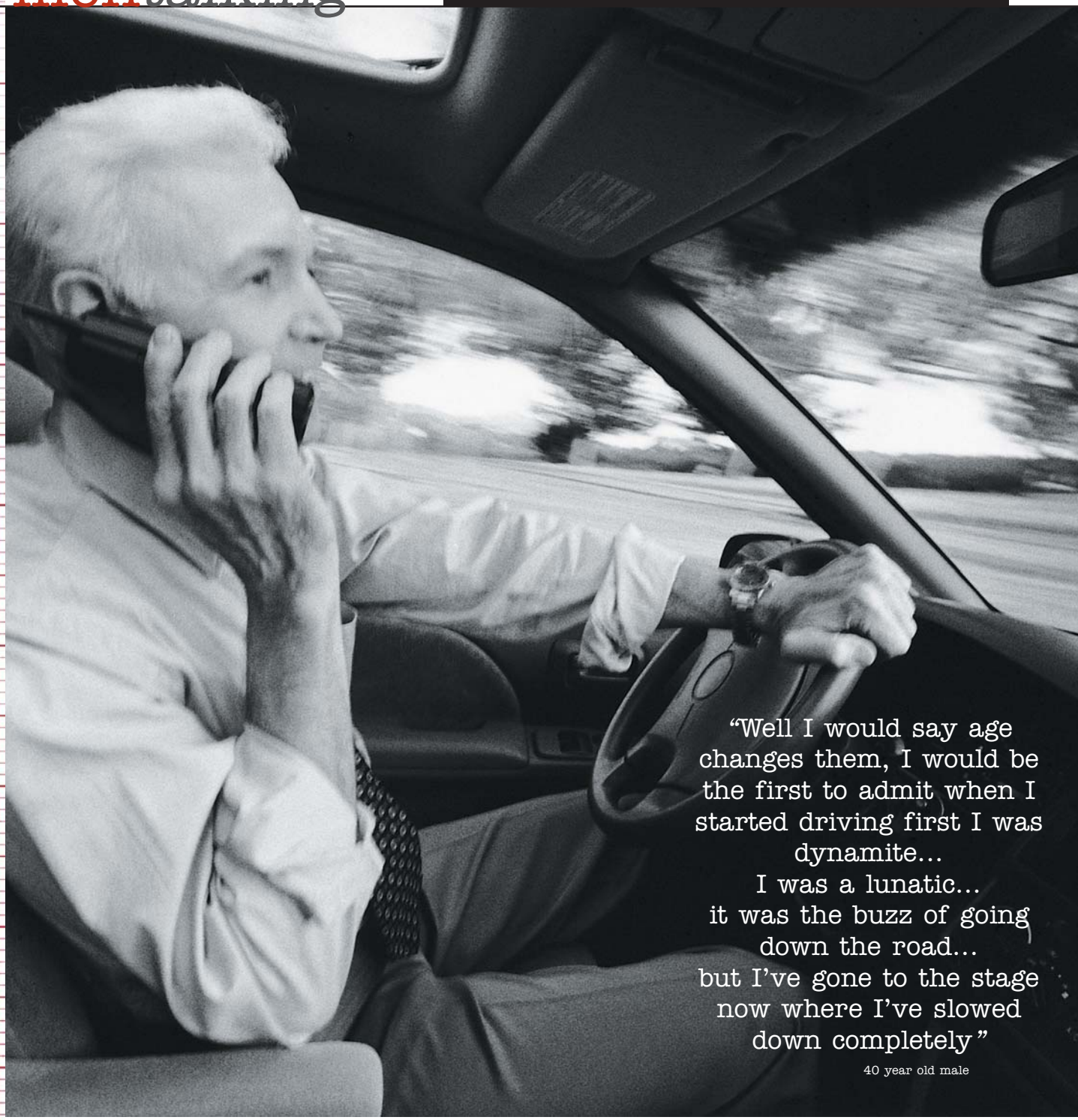
company: North Eastern Health Board
reference: Men Talking
theme: Risk Behaviour as a Component of Men's Health

Recurrent statistics suggest that risk-taking behaviour in relation to speeding and to drinking and driving, is an endemic problem both nationally and in the NEHB region in particular, we chose, therefore, to look specifically, at these issues.

While differences emerged across these categories, there were several common themes. For men it would seem that there is an age gradient to risk taking - the older one gets the less likely one is to admit risk-taking, particularly so with speeding.

The greatest motivator to risk reduction, it seems, is not health promotion, but legislation.

men*talking*



"Well I would say age changes them, I would be the first to admit when I started driving first I was dynamite...
I was a lunatic...
it was the buzz of going down the road...
but I've gone to the stage now where I've slowed down completely"

40 year old male

"I don't smoke, it's the only social life I have. I wouldn't get a taxi to it.
I would if I was going to a wedding...but I wouldn't get a taxi if I was going to the local pub...I'd chance it"

rural bachelor 62 years

Give em Hell

"Once you think about it, well after you do it you say Jesus I shouldn't have done that,

...but at the time you just hop in and floor it"

adolescent farmer

details:

'Being caught by the guards' or severe sanctioning by the Gardaì, in this instance, appeared to be the single biggest barrier to risk-taking in men of all ages. Similar to health-seeking behaviour, as discussed earlier, it would appear that coercion, rather than self-preservation, is still the greatest motivator to reducing risk-taking behaviour in males. Having children also emerged as a barrier, though this was confined to older men.

1. Driving & the Young Male: Risk Enjoyment

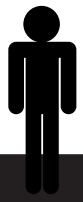
For young men in particular, it would appear that they accept the risks associated with speeding, either because they enjoy them or because they believe, intuitively or calculatively, that on balance, the expected benefits of what they referred to 'as the adrenaline buzz' outweigh the possible costs. For some young men, it was not the fact that they thought they were invincible, rather it was simply the immediate guaranteed benefit they got from the 'buzz,' which far outweighed the possible cost of injury to themselves or to others. The buzz was guaranteed, whereas the injury was only something that could, or might happen.

*"My son, he is 17yrs and I was forever trying to say to him look slow down ...
an on the spot fine of £50 and that fella has not gone too fast since"*

51 year old male bachelor

"I used to speed on the road, but then they got strict, I got caught for speeding"

71 year old male



men*talking*

"Since the law got tight,
I have got economical
with the drink"

71 years old rural bachelor

2. Drinking & Driving

While a definite age gradient seemed to exist in relation to speeding, the same cannot be said in relation to drinking and driving.

While men do not routinely drink and drive, in all groups, there were men who admitted to, at least occasionally, driving while under the influence. In the main, this was something that was spontaneous rather than premeditated. However, it is a risk that is still being taken by men, particularly men in rural areas.

"Men maybe take their frustrations out on their cars. They put the pedal down and they say right, you know that could be one way of doing it."

male 39 years

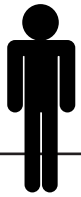
3. Barriers to Drinking & Driving

As with speeding, the biggest barrier to drinking and driving was fear of being prosecuted. It was this fear, more than any other factor, that was at the core of the risk analysis undertaken by men with regard to their decision to drink and drive

"It is only because you would be stopped by the guards. It is not actually realising not to drink and drive, it is the guards and that...it is"

69 year old male bachelor

If both speeding, and drinking and driving, are to be curtailed on Irish roads, it would seem that, in addition to educational campaigns, punitive legislative measures must also be applied and enforced.



mentalking

Theme 5

Men s Emotional Health & Well Being

"...I waited until he was asleep...
I got a piece of paper and started to write a note,
but my child coughed and that is what stopped me"

male separated father 41 years

company: North Eastern Health Board
reference: Men Talking
theme: Men's Emotional Health & Well Being in Focus

This theme explores issues underpinning men's emotional health, paying particular attention to lay perceptions of causality of suicide, as defined by the men themselves. In addition, it looks at the emotional consequences that ensue when fatherhood is denied.

men*talking*

Suffering in Silence

"Like you take the young fellow who is let go from his job or something and he has a young family and he has to keep a family running, all that and he has to keep a family going.

Depression is getting him down and he can't keep the family. There is no other way out for him."

FÁS worker 18 years

"Yes that's it... the conditioning we had in this country. Parents even knocking their kids when they were very young. You are silly, you are a fool, you know... pushing them as well.
Now somebody says that suicide was a serious form of self-criticism, but I think it is criticism from other people that is causing it. They are under pressure to do well at school and then they come to 23 or 24 and they can't get a job and they say what was all that for...
there is nothing to live for."

male 48 years

"Men are no longer as important in society as they were. Women have become as equal to them and sometimes better breadwinners than men. They have assumed more power and they have more powers within the house and within society. I may be using the wrong words here but they have become more emancipated and less reliant on men and men I think feel useless, unnecessary.

Unnecessary in the domestic and in the greater life situation"

male 55 years

details:

It is explicit in the data, that pressure is the main factor that compounds men in a cycle of emotional deadlock. On closer analysis, it is revealed that this pressure comes both from the men themselves and from societal expectations placed on them to succeed and to fulfil the role of provider.

1 The Burden of Masculinity & Men s Emotional Health

When a man loses his status in the public domain of work, he is not equipped to deal with the loss of self. Men's emotional health has not been sufficiently nurtured to allow men to value themselves outside the context of work. Failure in this domain can, the men believed, lead to emotional, and often physical suicide.

Traditionally, men have defined their lives, their identities, the very essence of their masculinity in terms of work, and have prided themselves on the work that only they could do.

With more and more women sharing the role of provider, men no longer have work as a yardstick with which to measure their own unique self-worth. In the face of diminishing traditional yardsticks, and the corresponding lack of newer evolving yardsticks, men's very sense of self-worth is called into question. With very serious consequences.

Some men suggested that suicide, as opposed to being viewed as a selfish act, could be viewed as a very selfless act. While men may wish to send out warning signals, they are prohibited from doing so due to an in-built belief that they have no right to ask others to rescue them from a plight that is, they believe, of their own making.

Men also know that admission of some failure can, in reality, lead to more failure, loss of promotion, loss of face among peers and family - so they 'tough it out' in silence. If they succeed well and good, if not well, they save their family by removing themselves as 'the burden'.

"You see with Daddy being out working Mammy in most cases is at home, and they get to know each other better, and there is a better bond, a better relationship with Mammy from birth."

2. Fatherhood - A Role Under Challenge

Undoubtedly, a coalescence of male and female gender roles has taken place in our society in recent years. Yet, there is strong evidence that men continue to prioritise work, even above their roles as fathers.

"It's a priority. Your biggest priority is to keep the money coming in. Sure none of us could afford to sit in and in most cases the mother is at home minding them when they are babies. The father is out you know making a living like."

male 47 years

"Well it is not the sort of chatty thing I suppose. There are a few fathers out there that can do it, but if it's you sitting there in front of him, and it's how are you getting on at the football or something, you are not really getting into feeling at all"

male 22 years

Many men conceded to being frequently absent in their children's lives as they grew up. As a result, the men claim their children have a stronger emotional bond with their mothers - a point all too often made during the course of this study.

Many men acknowledged that they, as fathers, have a difficulty in talking to their sons about emotive subjects. Most wanted to change and to be more involved in their children's lives, but inflexible working hours and the emphasis on work, remain constant barriers to active fatherhood.

Not only have these men been deprived of their own fathers through work commitments, but they too are deprived of being fathers themselves.

"Work is very rigid, ...
we are not allowed to be more maternal...
I'd love to be at home, I'd love to go down with the wee pram to the school and pick up my child. I'd love to be at home, I'd love what I heard in America or Canada, a teacher told me one time, where they work four years, and they put 15% of their wages away for the one year to be off...
we need more of that here"

separated father 41 years

"The gross inequality of it. Fairness in parenting, that to me goes right down into the soul of you, it's so damaging, it affects your whole well being, you can't develop your own relationship, you can't go on, it affects then the relationship you have with another person.
You can't get going because you're so attached to that baby, you were there for its birth..."

male 69 years

The women's movement did more than question the role of women, it reinforced the notion that women had rights to what was the traditional male role. Nothing tells men they have rights to what was the traditional female role, the right to stay at home full-time, or indeed part-time, while his wife or partner supports him. Despite the desire to be more 'maternal', sociocultural norms continue to trap men into current stereotypical fatherhood roles.

The denial of fatherhood was particularly acute among fathers who were victims of domestic violence, or who were in the process of striving for custody of their children. Repeatedly, these fathers spoke, often emotionally, of the great pain they have experienced, and continue to experience, as a direct result of being separated from their children.

*"...I waited until he was asleep...
I got a piece of paper and started to write a note,
but my child coughed and that's what stopped me"*

male separated father 41 years

It was only within this group of men, that suicide attempts were openly discussed.

The legitimacy of motherhood is never in doubt, yet men, it is claimed, have to fight their case through the judicial system to gain equal rights to access.

In addition, barring orders and Lone Parent Allowances are, according to these men, much more readily accessible to women. In their opinion, the latter in particular, is given as a matter of course to women, while men have a more difficult time in proving their entitlement.

"I think one of the problems in any separation in Ireland is the whole issue of custody and the whole issue of fathers involvement in their separated children, their children from their separated marriages. It is entirely and utterly very bad and unbalanced, absolutely to the detriment of the whole relationship. I fundamentally believe that you can still have a family relationship and be separated."

male 45 years

"Men should be able to get single parent allowance or deserted allowances... you know but they are not."

separated middle aged father

5. Conclusion

The burden of masculinity, in particular, the link between self-worth and work, re-emerge as core determinants of men's emotional well-being. In addition, like women, men experience emotional rejection when they separate. Unlike women, however, it would appear men are much more likely to be involuntarily deprived of their children, thus experiencing a double dose of emotional rejection.

If we ignore some of the issues raised in this section of the report, particularly those pertaining to the denial of fatherhood, men will be wasted and upcoming generations will be provided with another distorted version of love. If, on the other hand, we listen to these men, we will contribute in no small way to improving the health of these and other men in our society, well into the future.

mentalking

Theme 6

Promoting Change

If someone rang up our help line and they feel they need to see a doctor because they have a disease, an STD and ask can you recommend anyone, at the moment you have to ...say well go to Dublin.
It would be better to have one locally, so I can recommend this doctor to you. If that doesn't suit you would have someone in Drogheda, Newry or Dundalk...he would not just have to be stationed in Dundalk as long as he was gay friendly and discreet.

gay male 34 years

The Way Forward - Men s Views

company: North Eastern Health Board
reference: Men Talking
theme: The Way Forward - Men's Views

The findings so far would suggest that concepts of health and illness, help-seeking behaviour, and risk-taking in men, are inextricably bound up in the *'rules of manhood'* and notions of 'masculinity,' which seem to inhibit men's ability to act on body distress signals or emotional cues.

In the course of the discussions, the researchers were also interested in exploring the role that the school or workplace plays in either, perpetuating or challenging, the *'rules of manhood'*. Of particular interest was the exploration of men's sources of information on health and their experience of health promoting initiatives, from early childhood to manhood.

mentalking

1 Schools & a Male Health Agenda

For older men in this study, their schooling experience reinforced the notion that personal health and human biology were 'taboo' subjects, hence sowing seeds of denial at an early age. For adolescent males, the lack of consistent emphasis placed on life skills and physical education, reinforced the notion that school is still about getting a job

"Like it would be grand, like the first week, but after that she would tell you to take out your books and study. At the start of the year, it would be personal development, but after a month, it would be just a study class."

adolescent male

Difficulties with regard to life skills-type programmes, stemmed from the unstructured nature of the curriculum and the lack of training provided to the teachers. Often, what started out as a life skills programme, ended up as a 'free class'.

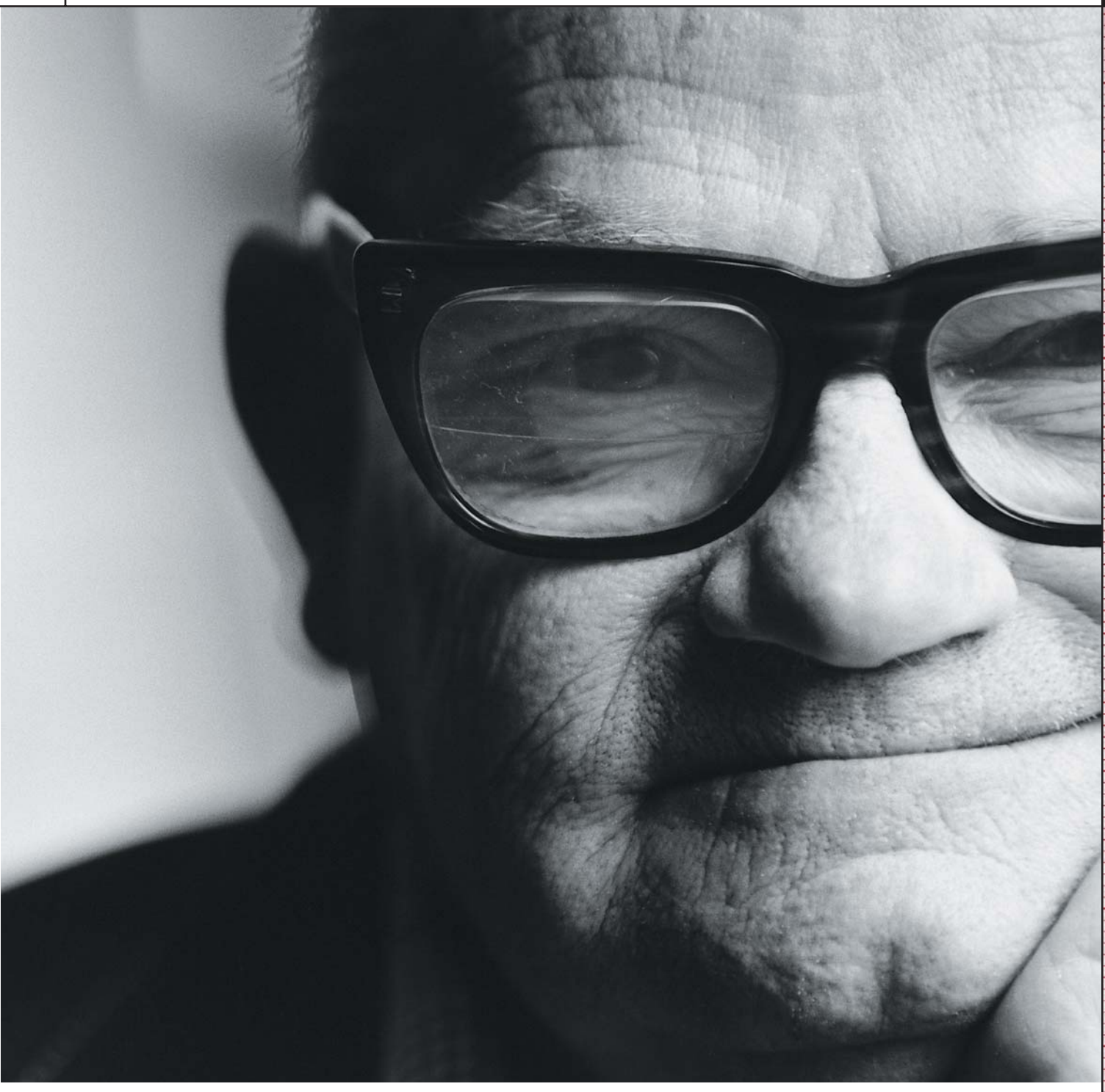
The same erratic pattern emerged when the issue of time allotted by schools to physical education was probed. In this instance, primary schools across all age groups, offered little or no structured physical education programme to pupils. It was only in secondary school that a specific time was allotted in the curriculum to sporting activities. There was, however, wide variation across the secondary schools of those involved in the discussions, with some schools allocating up to 2 hours a week, while others were allocated only 20 minutes.

All men were adamant that, in the future, one of the first initiatives aimed at *'deconstructing masculinity'* should include the creation of a health-promoting ethos right through out the schooling cycle. Adolescents stressed the need for sport, fitness, and physical education programmes to be taken seriously by schools, and the need for equity across all schools with regard to time allotted to sporting activities. The need for teachers, qualified to teach the various subjects was also emphasised. Some suggested that the emphasis should not just be on fitness, but should also include theory about health-related issues. As one adolescent put it...

"it should be a real subject - not an option."

In addition to practical initiatives, schools, as agents of socialisation, also have a role to play in delivering messages to young men, aimed at encouraging an understanding of the fact that 'they don't have to be responsible for everything...they need to be told that it is ok to cry.'

Initiatives which focus explicitly on male emotional issues, need to be developed if we are serious about tackling men's health.



"I know there are places that put all their staff through a yearly check up but the health boards never do it, they put you through a medical before you commence but then never throughout your work..."

40 years NEHB worker

2. The Work Place & the Male Health Agenda

The workplace also has a role to play in promoting and monitoring men's health. This is particularly so, given the fact that this is where men spend considerable portions of their time and invest much of their energy.

Currently, it would seem that men's experience of health promotion in the workplace, is varied at best, and non-existent at worst. For many the emphasis it seems, is on health and safety issues - not health promotion. It was felt that this is the case, primarily because the former is governed by legislation, while the latter is not.

Even in occupations governed by Health and Safety Legislation, it would appear that there are inadequate monitoring and policing systems in place to ensure that employers do adhere to this legislation. This was an issue raised, in particular, by young farmers who feel that, as an occupational group, they are most vulnerable.

For other occupational groups, the fact that men were screened on entry to the workforce, but never screened thereafter, was also an issue. This practice, they believe, suggests that employers are interested only in healthy workers, yet want no responsibility in monitoring the effect that the working environment might be having on their workers.

For other men, while there was a good occupational health structure in place, and health promoting initiatives such as, anti-smoking policies and promotion of the 'Happy Heart Week', the efforts, it was felt, were not reaching men. This was primarily because such initiatives were not preceeded by a wide scale national men's health initiative, specifically targeted at men. Generic approaches, it would appear, speak only to the converted. Suggestions made by men with regard to how a male health agenda could be established in the future revolved around the following:

- The Year Of Men: A National Men's Health Campaign
  At a general level men felt that initiatives like 'Health screening in the work place', 'Mobile health clinics', 'Well Men clinics', while good ideas in their own right, need to be preceeded and reinforced by a national men's health campaign.

- Developing Male Specific Health Promotion Initiatives
  In addition, there is a need to develop male specific health promotion initiatives, which highlight health risks associated with different stages of the life cycle. Role models from sport and the world of entertainment could prove useful messengers in this regard.

- Targeting Men Where They Meet
  It was also suggested that men need to be targeted where they meet. In addition to the workplace, sporting fixtures were deemed ideal venues for delivering messages on men's health. Organisations like the GAA, local gun clubs, men's toilets, and locker rooms, were regularly mooted as ideal venues.

Large profile events, with a strong male viewership, like snooker, Euro 2000, and golfing championships, could all be used to reinforce messages delivered at national level.

If someone rang up our help line and they feel they need to see a doctor because they have a disease, an STD and ask can you recommend anyone, at the moment you have to...say well go to Dublin. It would be better to have one locally, so I can recommend this doctor to you. If that doesn't suit you would have someone in Drogheda, Newry or Dundalk...he would not just have to be stationed in Dundalk as long as he was gay friendly and discreet.

gay male 34 years

3. From the General to the Specific

Men are not a homogeneous group, and while the above recommendations, relevant to men in general were raised in all groups, men with specific needs also raised issues that they believed should to be tackled in the future, so as to improve their health and social gain.

Six groups of men were identified as being particularly vulnerable. These related to 1) male travellers, 2) gay men, 3) male victims of domestic violence 4) male farmers, 5) rural bachelors, 6) disabled men.

a. Male Travellers

High illiteracy levels among this cohort of males, coupled with the lowest life expectancy of all men, pose a challenge for both health promotion professionals and public health advocates. Initiatives, such as the use of male peer educators drawn from the Travelling community, need to be considered. These could help, not only to deliver health promotion messages, but also advise in the development and design of health promotion initiatives that are sensitive to the particular needs of the male traveller.

b. Gay Men

Gay men's health needs in the NEHB region, also seem to have been overlooked. While social discrimination is something that must be tackled at a societal level, there are some pragmatic issues at health board level that also need to be considered. In addition to suggestions regarding the inclusion of gay and lesbian health issues in current sex education programmes, gay men also highlighted the need to consider the following:

- The establishment of a series 'Gay friendly doctors' within the NEHB region
- The Establishment of a Sexually Transmitted Disease Service (STD) service in the NEHB region

At the time when the research was conducted there was no STD service in the NEHB region. This gap in service provision is one that gay men felt should be closed in the future. While some gay men felt that they would continue to go Dublin to avail of STD services, there was a general consensus that all gay men should be given the option of availing of such a service locally.

- Establishment of links between the Outcomers' Centre and Psychiatric and Counselling services in NEHB

Currently, the Outcomers Centre provides a drop in social centre for gay men and lesbian women in the NEHB region. In addition to offering a safe meeting place for gay men, the centre also runs a confidential helpline, offering what they describe as 'informal counselling' on a voluntary basis. These men felt that in the future, they could greatly improve the quality of the current service if the were given proper training in the art of telephone counselling, plus the option of referring gay men in crisis for professional advice.

- Establishment of links between the Health Promotion Unit in the NEHB and the Outcomers' Centre

Gay men also suggested that the Outcomers Centre is an ideal venue for targeting gay health promotion initiatives. The Outcomers Centre offers a safe environment, with a captive audience, which is currently not being exploited.

- Outreach system between GP surgeries and The Outcomers' Centre

Finally, it was suggested that GP surgeries, and indeed other health venues, could be used to reach out to young men and their families in need of support as they come to terms with their own or their son's sexuality. This, they stressed, should be discreet but effective, and could be done by means of small leaflets or discreet business cards strategically located in surgeries and health centres.

c. Male Victims of Domestic Violence: Need for Male Refuges and Other Supports

menTalking

While the marginalisation of gay men has been recognised for some time, little is known about the needs of men who are victims of domestic violence. These groups of men, in the main, suffer in silence, ostracised by a society that still refuses to accept that women too can be perpetrators of violence. In the course of this study, men spoke openly about their lives as victims, recalling painful periods of personal hurt and humiliation that must be considered in future policy development.

In addition to removing the female bias which, according to this group of men, is still endemic in institutions like the health care system, the social welfare system, and the legal profession, these men also felt that they have practical needs that currently are not being addressed. In particular, they highlighted the need for male refuges. For many, being denied access to their own homes means taking refuge in...

> "cars, 'outhouses', and 'their mother's house"

While these men are vulnerable, in need of help, support and a safe place their stories go unheard. In addition to male refuges, they also suggested that initiatives such as AMEN, the national support group for male victims of domestic violence, be supported so that they can reach a wider cohort of men than is currently the case.

d. Male Farmers

From a health promotion perspective, farmers, as an occupational group, are particularly difficult to reach. This is not least because they work long unstructured hours, but also because they often work in isolation, away from support structures like occupational health services, newsletters, or even notice boards, which are often used in other occupational setting to delivers health messages.

To counteract this information 'gap,' farmers in the discussions suggested innovative ways that health promotion messages might be relayed to this sector of the male population. These included:

- Use of large billboards with health promotion messages at marts
- Introduction of health promotion campaigns at regionally based farming fairs, for example, Moynalty Thrashing, rather than confining them, as is the current practice, to larger national venues.
- Newspapers like the Farmers Journal could do a series on men's health issues.

One of the suggestions in this regard was to begin with financial stresses and their impact on men's health, rather than an overt series on men's health. This strategy, they felt, would engage farmers, and therefore make the series more effective.

- Programmes like 'Ear to the Ground', which are very popular among farmers across the age spectrum, could also be used as a medium for delivering health messages to farmers. The impact of such an initiative would be all the more powerful if it were run in conjunction with a national campaign on men's health.
- Finally, while young farmers in agricultural colleges stressed issues such as better sport amenities in rural environments, the directors of these colleges (who were contacted prior to the setting up the focus groups) stressed the need for better links between these colleges and Health Promotion Departments. These directors would like to see more health awareness programmes run in tandem with the current Health and Safety syllabus.

e. Rural Bachelors: Adding Years to Life and Life to Years

This group of men also pose new challenges, in that they are often geographically disparate and not amenable to intrusion from health professionals. Given the experience of this group of men, recounted in the focus groups, it would appear that there are ways and means of overcoming these socio-structural barriers. These include:

- Supporting and extending existing organisations such as Age and Opportunity, particularly in rural environments. According to the bachelor men who participated in this study, this initiative has indeed added 'years to their lives.'

- Using men currently involved in Age and Opportunity to act as 'scouts' for the recruitment of other rural bachelors. In addition, some suggested the local public health nurse might be useful in this regard.

- Using the Anglo-Celt or similar provincial papers to advertise upcoming events sponsored by Age and Opportunity.

- Develop training workshops for older men where they can learn or develop skills, and within this context, to later introduce health topics. This is a similar type of approach to that adopted by the North Leitrim Men's Group in the North Western Health Board (NWHB), who recruited rural bachelor men using the assistance of FÁS. This Project was both skills-based and health-promoting and included three modules
  i) Enterprise - organic vegetable growing as a means of self-motivation,
  ii) Community Project - to help break social isolation and create team work and
  iii) Development of social skills and health awareness.
  Similar projects, based on this pioneering work could be established within the NEHB.

"They're a disgrace...most of them like, you go to Drogheda just take the place where I live...I wouldn't think any of them are wheelchair friendly...I know with my own GP, he had a portable ramp that he brings out, but he has steps up to his surgery...so I have to ring in advance and say...when I come will you have the ramp out...This is his new premises before this he was upstairs...he used to actually see me in a broom cupboard that is as true as I am sitting here."

disabled man

f. Disabled Men

While undoubtedly, there have been substantial changes in terms of service delivery for disabled person in the last 50 years, this group of men did stress some areas that need to be continually highlighted.

- The first related to the recurrent high rates of unemployment among this cohort of males. While resource centres have been established in the recent past, with a view to training people for the labour market, inadequate transport services in rural areas continue to pose a problem for the uptake of these training initiatives.

- In addition, while the report on the Commission of the Status of People with Disabilities (1996), was instrumental in ensuring that all public buildings and car parks, and so on, were accessible to people with disabilities, problems still remain. Health services, at least according to the men in this study, could do better. Currently, some of the older GP surgeries are not accessible, as they are either held upstairs in premises without a lift, or they are located at street level where access is often impeded by steps.

mentalking

Theme 7

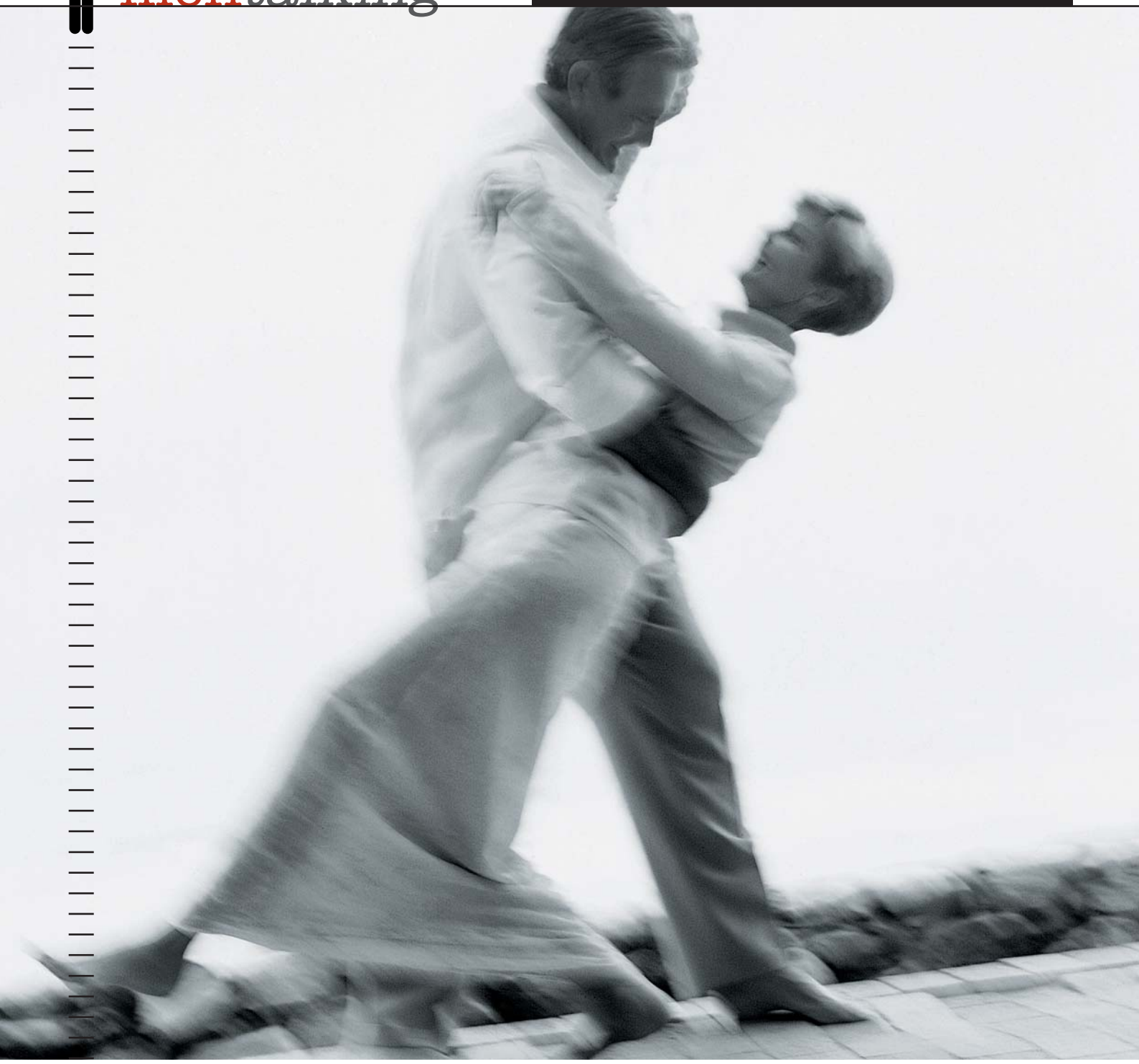
Implications

For Further Research & Development

company: North Eastern Health Board
reference: Men Talking
theme: Implications for Further Research & Development

men*talking*

In addition to the recommendations stated explicitly by men themselves in the course of the research, there are other recommendations worth considering, if the issue of men's health is to be taken seriously in the future.



1. National Discussion Document on Men s Health

At a practical level, this involves developing a national policy for Men's Health, similar to that adopted for women in 1995 (Department of Health 1995).

2. Academic Research: Development of Men s Health Studies

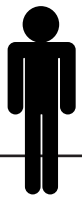
The study of how gender relations influence men's health and illness is in an early stage of development. The burning question now is, how can we continue to mobilise a broad spectrum of social scientists, medical researchers, and public health advocates, along with men themselves to think about, or as it were, 'to do masculinity differently'? Health, as this study seems to suggest, is one of the most clear-cut areas in which the damaging impact of traditional masculinity is evident. Part of the mission of men's health studies, therefore, will be to carefully research these linkages and to discuss them with professional audiences and the general public.

3. Structural Changes

In addition to changes at the sociocultural level, some structural changes also need to be considered. These include:

- Defeminisation of doctors' surgeries.

- Development of health promotion initiatives at the level of general practice, specially tailored to meet the changing health needs of men across the life cycle. The following groups might be considered: adolescents and young single men, young men with families, middle-aged men with families and men facing unemployment or retirement. To support these initiatives, Bozett and Forester (1989) suggest a place for a men's health nurse practitioner, arguing that 'as once had been the case for women, the total health care needs are not being met'. Others, like Farrell (1993), go so far as to suggest the need to establish an Office for Men's Health. Such a position would involve the appointment of a men's health co-ordinator, who would ensure that men's health issues are constantly kept in focus.



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Theme 8

Discussion & Conclusion

company: North Eastern Health Board
reference: Men Talking
theme: Discussion & Conclusion

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Shaping a New Consensus on Men s Health & Well Being

Men's health has been the focus of much media, academic and medical attention of late. Why now, is the issue coming to the fore? The answer may well lie in Susan Sontag's suggestion decades ago, that illness is a metaphor. If this is so, it is likely that our sudden preoccupation with the health and well-being of men, is less to do with the diseases in men's bodies, than with the unease about their wider position in society.

The roles of men and women are in a state of flux. While men acknowledge, and to a great extent accept, the changing role of women, the findings reveal that men are having difficulty letting go of traditional male roles. This is not surprising, in light of the way in which men have been socialised to think about themselves and the extent to which our social institutions perpetuate the myth of masculinity.

It is no longer sufficient to tell men they need to be more open about their feelings - when the dominant discourse still informs them that they need to be macho and deal with their own problems. The 'rules of manhood', which prop up the myth of the invulnerable man, must be changed.

While personal change is necessary, we must also challenge current political, economic, and ideological structures in order to prevent the fading away of the subjective gains and insights forged within (Lorber, 1994.) Personal changes need to be rooted in structural changes and buoyed by new male-friendly institutional realities.

National health campaigns raising men's awareness, while worthwhile, must be reinforced with a concerted effort by governments, academic departments, and health research bodies challenging current masculine ideologies. Initiatives in this regard must include the linking of descriptive epidemiology to more analytical studies such as the current study.

It is no longer sufficient to describe patterns of illness. We also need models of understanding, which allow us to explore the socio-cultural meanings attached to illness. It is at this level that real change to Men's Health will occur in the future.

References

Clare, A. (2000) *Masculinity in Crisis.* Chatto and Windus. London

Friel, S. and Kelleher, C. (1999) *SLÁN* -Survey of Lifestyle, Attitudes and Nutrition. Department of Health Promotion, National University of Ireland, Galway.

Mant , D. and Silagy. C. (1998) 'The epidemiology of men's health' in *Men's Health* (eds.,) O'Dowd, T and D. Jewel, Oxford General Practice Series 41.

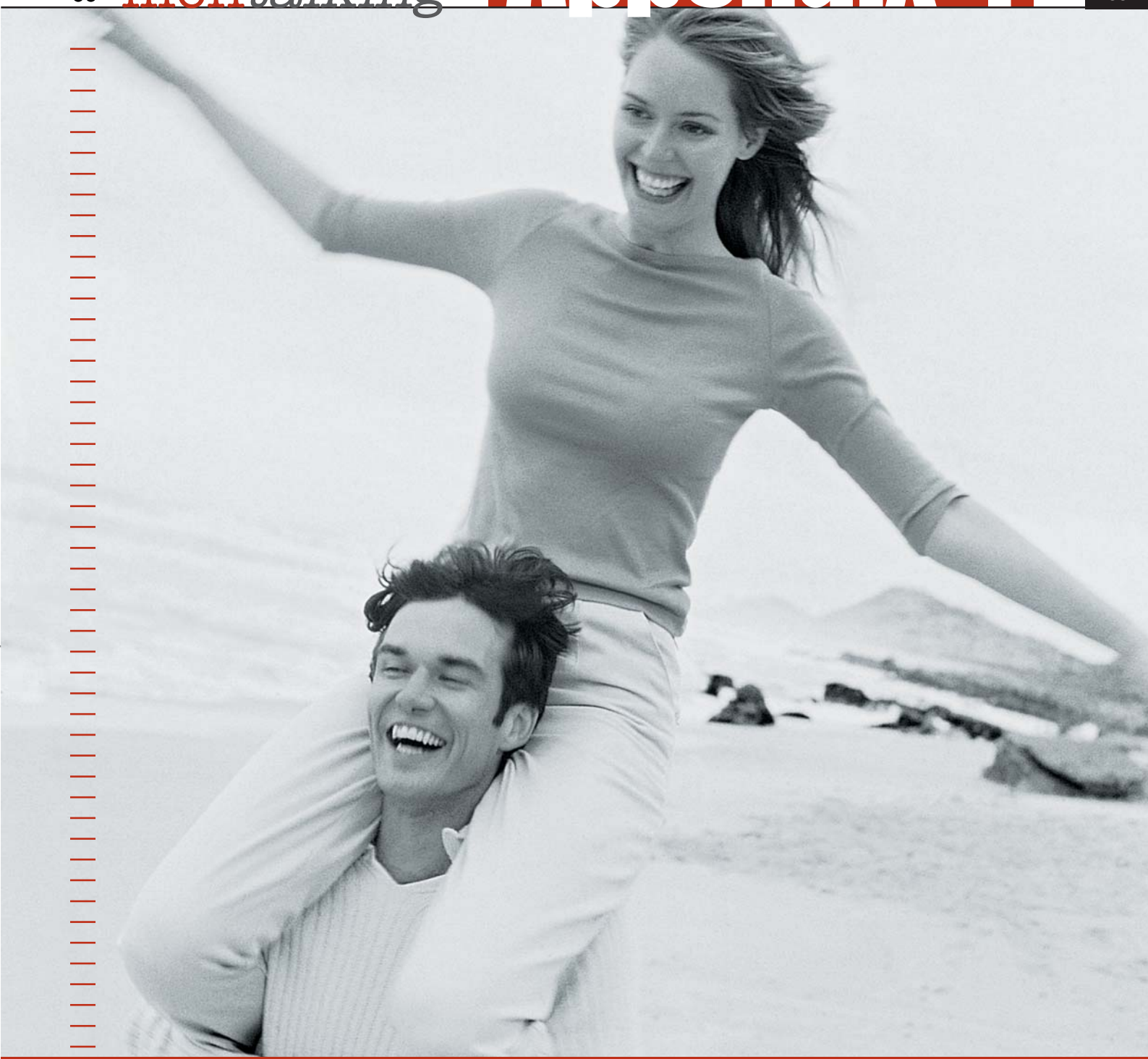
O'Dowd, T. and D. Jewell (1998) (eds.,) *Men's Health*, Oxford General Practice Series 41.

Staples, R. (1995) "Health among Afro- American Males' In : Sabo, D. Gordon DF, (eds.) *Men's Health and illness: Gender, power and the body.* Sage London.

Stillon, J. (1995) 'Premature Deaths among Males: Extending the Bottom Line on Men's Health' In : Sabo, D. Gordon DF, (eds.) *Men's Health and illness: Gender, power and the body.* Sage London.

Wilson ,A. (1998).'Getting Help' in Men's Health (eds.,) O'Dowd,T. and D. Jewell (1998) *Men's Health,* Oxford General Practice Series 41.

Appendix 1



Appendix 1 Research Process & Techniques

Study Aims and Objectives

- To engage in consultation with men in the NEHB region so as to explore their health beliefs, attitudes and perceptions
- To gain insights into the help seeking process adopted by men in times of illness
- To explore men's views and experiences on current health service provision in the NEHB region
- To identify men's suggestions for improvement or changes in the future
- To elicit their reaction to suggestions or new ideas
- With this information, to assist in the development of a Strategy on Men's Health in the NEHB region.

Method

As the purpose of the research in this instance was to explore diversity rather than establish any degree of 'representativeness', purposive or systematic non-probabilistic sampling was the method chosen. Using this method, informants were selected because they enabled exploration of issues relating to men's health across the life cycle.

Sampling

Initially it was intended to recruit men from different occupational groupings, having an equal mix of manual, semi-skilled, and professional males. Recruiting 'elites' or professional men in this instance proved very difficult to achieve, a difficulty that is not unique to this study which has been well-documented in previous studies (Dexter, 1959); Gorden, 1981; and Marshall & Rossman, 1989). Despite this difficulty, the researchers were successful in recruiting a diverse range of men, employed and unemployed, from the lower to middle income groups. These included retired men, gay men, separated men, farmers of different age groups, rural bachelor men, male travellers, F¡S workers, disabled men and men who are victims of domestic violence. In total, 16 focus groups were held, involving 127 men, ranging in age from 15 to 83 years. Recruitment was done with the assistance of 'gatekeepers' of local organisations. In addition, occupational health departments were used to gain access to the corporate sector. On occasion posters explaining the aim of the research project were delivered to interested parties as a means of further encouragement. With the exceptions of one occasion, discussions took place away from the occupational setting, at a date, time, and venue that suited the men.

While most of the men expressed some reservation about attending the discussions, all later expressed delight at being given the opportunity to speak. Without exception, this was the first occasion that any of the men had attended a group discussion where the focus was their health.

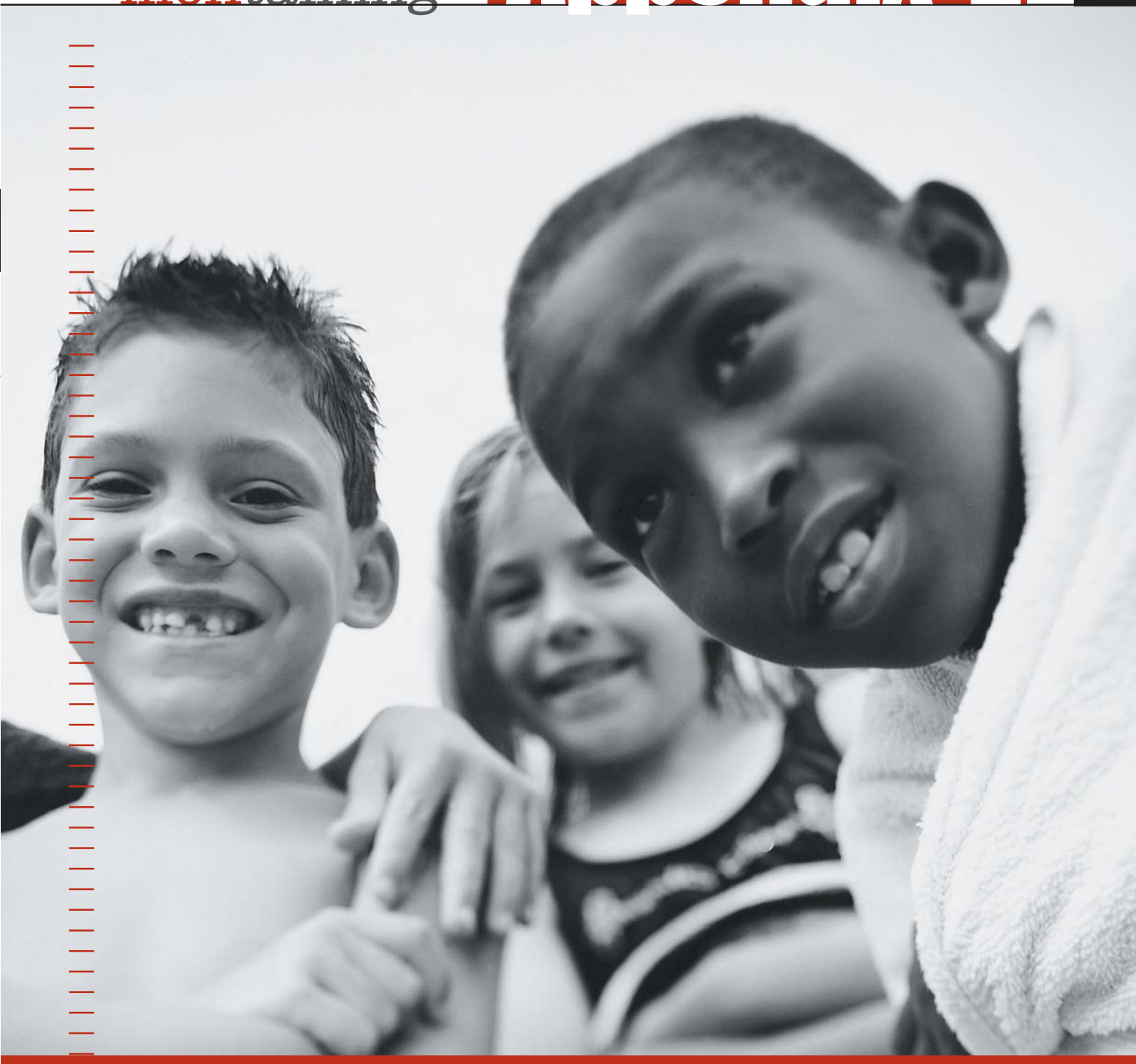
In keeping with the consultative nature of the research process, submissions were also sought from the public. Issues that arose at this level were later probed in greater depth with respondents during the focus group discussions. It is anticipated that the findings from this study along with the submissions will be considered as part of an evolving strategic plan on men's health in the NEHB region.

Data Collection & Analysis

Focus group discussions lasted approximately 2 hours and were guided by means of a topic guide. On occasion, a brief presentation outlining male health statistics was used to prompt discussion. All discussions were audiotaped with the men's permission, and later transcribed verbatim. Analysis was carried out using NUD*IST 4 (a software package for narrative data analysis).

In order to inject rigour and reduce the possibility of researcher bias, another researcher was commissioned to assist at the analysis stage of the project. Discussions between the two researchers at this stage occurred regularly to ensure that there was consistency in the coding and in the development of themes as they emerged from the data.

Appendix 2



Appendix 2

Table 1: NEHB mortality profile for males, 1995-1999

Cause of death	Sex	All Deaths. 95 - 99	SDR, All Deaths	Deaths <65 95 - 99	%Deaths <65	SDR <65
All Cause Mortality	M	6933	1031	1706	25	294
Circulatory Diseases	M	2992	450	552	18	103
All Ischaemic Heart Disease: ICD 410-414	M	1892	282	407	22	77
Cerebrovascular Disease: ICD 430-438	M	445	67	51	12	9
Respiratory Diseases	M	1030	158	87	8	16
Chronic Obstructive Pulmony Disease: ICD 490-496	M	534	79	41	8	8
Injuries and Poisonings	M	515	⇑ 69	413	80	⇑ 60
Motor Vehicle Accidents: ICD E810-E819	M	200	⇑ 26	176	88	⇑ 25
Suicide & Self-Inflicted Injury: ICD E950-E959	M	164	22	143	87	21
All Cancers	M	1626	241	409	25	⇓ 75
Cancer of the Oesophagus: ICD 150	M	69	10	21	30	4
Cancer of the Stomach: ICD 151	M	114	17	30	26	6
Cancer of the Colon: ICD 153	M	157	23	38	24	7
Cancer of the Rectum: ICD 154	M	54	8	15	28	3
Cancer of the Pancreas: ICD 157	M	85	13	19	22	3
Cancer of the Trachea/Bronchus/Lung: ICD 162	M	381	56	82	22	16
Lymphatic and Haematopoietic Cancer: ICD 200-208	M	137	21	47	34	8
Cancer of the Bladder: ICD 188	M	36	5	3	8	1
Cancer of the Prostate: ICD 185	M	204	30	12	6	2

SDR - Standard Death Rate

⇑ Significantly Higher than the National Average

⇓ Significantly Lower than the National Average

Appendix 2

Table 2: The Principal diagnosis of males, resident in the NEHB region, discharged from acute hospital in 1999

	Admissions *		Bed Days	
	No.	%	No.	%
Infectious & Parasitic Disease (001-139)	817	2.5	3208	2.4
Malignant Neoplasm (140-209)	1839	5.7	14384	10.9
Benign Neoplasm (210-239)	786	2.4	761	0.6
Endocrine / Nutritional Metabolic Diseases & Immunity Disorders (240-279)	895	2.8	3007	2.3
Diseases of Blood / Blood Forming Organs (280-289)	441	1.4	1348	1.0
Mental Disorders (290-319)	212	0.7	918	0.7
Disease of the Nervous System and Sense Organs (320-389)	1431	4.5	5680	4.3
Disease of the Circulatory System (390-459)	4024	12.5	28895	22.0
Disease of the Respiratory System (460-519)	2769	8.6	16118	12.3
Disease of the Digestive System (520-579)	5390	16.8	13472	10.2
Disease of the Genitourinary System (580-629)	1781	5.5	6430	4.9
Disease of the Skin and Sub Cutaneus Tissue (680-709)	1318	4.1	2698	2.1
Disease of the Musculoskeletal System / Connective Tissues (710-739)	1211	3.8	6270	4.8
Congenial Anomalies (740-759)	410	1.3	1199	0.9
Conditions Originating in the Perinatal Period (760-779)	326	1.0	2830	2.2
Symptoms / Signs & Ill Defined Conditions (780-799)	2818	8.8	6647	5.0
Injury & Poisoning (800-999)	3924	12.2	15635	11.9
Others (v01-v82)	1743	5.4	2017	1.5
Total	32135	100.0	131517	100.0

* Includes admissions as in patients or as day cases

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Notes