

National Men's Health Policy **2008 - 2013**

*WORKING WITH MEN IN IRELAND TO ACHIEVE
OPTIMUM HEALTH & WELLBEING*



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Department of Health and Children
Hawkins House
Hawkins Street
Dublin 2
Tel: +353 (0)1 635 4000
Fax: +353 (0)1 635 4001
E-mail: dohc@health.gov.ie
Web: www.dohc.gov.ie

Published by The Stationery Office, Dublin

ISBN 0-7557-7621-6

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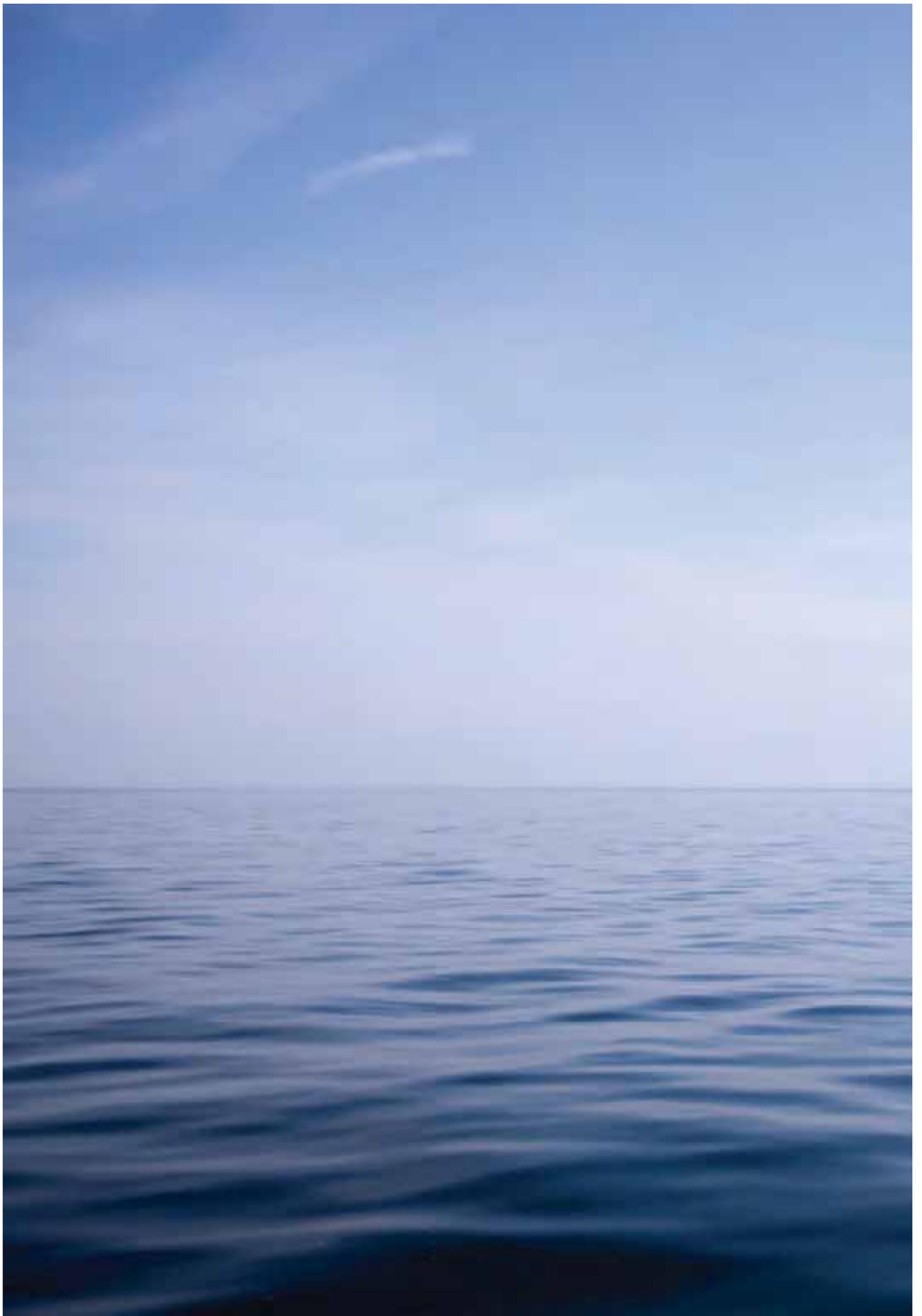
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Foreword

The publication of this National Men's Health Policy is a significant and important step in promoting optimum health and well being for all men in Ireland. The case for an increased focus on men's health is compelling. Men die, on average, almost five years younger than women do and have higher death rates at all ages, and for all leading causes of death. The burden of ill-health and premature mortality is borne, in particular by men from the lower socio-economic groups. There has been a disturbing increase in suicide rates among men in recent years, with suicide among young men being particularly high. Despite traditionally being to the forefront of health service policy and provision, men have tended to be more reticent in terms of advocating or speaking out about their own health.

This policy has been developed following an extensive research and consultation process. The need for a specific policy focus on men's health was identified in the National Health Strategy in 2001. This prompted the Department of Health and Children to fund a three-year men's health research project, the findings of which, *Getting Inside Men's Health* were launched at the first National Conference on men's health, which took place in Wexford in December 2004. An inter-Departmental and multi-sectoral Steering Group was appointed to oversee the development of the policy. Under the terms of reference of the Steering Group, an extensive and nationwide consultation process was undertaken with

all relevant stakeholders. The findings from this consultation process, together with an extensive review of the evidence underpinning the issues raised, were then translated into concrete policy recommendations and actions. These recommendations and actions address a broad range of men's health issues and have implications in terms of gender-mainstreaming men's health across a number of government departments. It should be stressed that targeting men's health can impact not just on men's lives, but can have positive spin-offs on the lives of women and children.

This policy will appeal to a wide audience – policy makers, service providers, health and allied health professionals, and to those who work with men in the community and voluntary sectors. The policy provides a clear blueprint and an unequivocal evidence base for tackling men's health in the years ahead.

Noel Richardson PhD (Author)

Paula Carroll PhD (Author)

Abbreviations

CRC	colorectal cancer
CVD	cardiovascular disease
GMS	General Medical Services
HSA	Health and Safety Authority
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
IDG	Inter-Departmental Group
IoTI	Institutes of Technology Ireland
ISC	Irish Sports Council
IUA	Irish Universities Association
LDTF	Local Drugs Task Force
OMCYA	Office of the Minister for Children and Youth Affairs
SEG	socio-economic group
SPHE	Social, Personal and Health Education

Executive Summary

Impetus for policy development

In recent years, there has been a growing awareness, and indeed concern, about the burden of ill-health experienced by men in Ireland.^[1, 2] Male life expectancy is almost 5 years lower than female life expectancy^[3] and men in Ireland have higher death rates for most of the leading causes of death across the lifespan^[4-6]. The burden of ill-health and mortality is borne, in particular, by men from the lower socio-economic groups (SEG 5 and 6). These men are up to 6 times more likely to die from the leading causes of death than men from SEG 1.^[68] Young men (aged 18-35 years) are also a high-risk group – they are almost 4 times more likely to die earlier than their female counterparts^[8] and currently have the second highest rate of suicide among the 30 OECD Member States^[9].

The profile of men's health has been raised internationally in recent years through a number of key mechanisms. These include the hosting of the first World Congress on Men's Health in 2001, the launch of the International Society for Men's Health (ISMH), the commencement of an international Men's Health Week, the launch of the European Men's Health Forum (EMHF) and the introduction of three academic journals devoted to men's health (*International Journal of Men's Health*, *Journal of Men's Health and Gender* and *American Journal of Men's Health*).

The upsurge of interest and activity around men's health at international level has also been mirrored in Ireland. In 2001, men were identified for the first time in the National Health Strategy, *Quality and Fairness*^[55], as a separate population group for the strategic planning of healthcare. Specifically, Action 15 of the National Health Strategy called for the development of 'a policy for men's health and health promotion', which is the first call of its kind internationally. This significant step has enabled men's health in Ireland to be greatly strengthened in recent years by research, advocacy work and a variety of grassroots projects in both the statutory and community/voluntary sectors. The Health Service Executive (HSE) has funded research initiatives into men's health^[1, 2], has developed a number of regional strategies on men's health^[36-38] and has funded a range of community development-related projects for men's health throughout the country. Other statutory and voluntary bodies have also supported research and initiatives on men's health, both locally and nationally.^[2, 39-42, 122]

All these initiatives have generated a considerable momentum in the area of men's health in Ireland and this momentum, from grassroots to statutory levels, has been a key factor in the development of this National Men's Health Policy 2008 – 2013.

Vision for men's health in Ireland

A number of key theoretical and philosophical principles have been adopted in developing this policy, each of which is discussed below.

Adopting a gender-mainstreaming approach

This policy adopts a gendered approach to men's health and recognises gender in the context of culturally defined masculine or feminine traits that are deemed to be socially appropriate to the sexes.^[43] A 'gender-mainstreaming'^[33] approach recognises that gender equality is best achieved through the integration of the health concerns of men and women in the development, implementation and evaluation of policies, both within and beyond health. Building on the Equal Status Acts 2000 to 2004, this policy endorses the approach taken by Health Canada's *Gender-based Analysis Policy*^[34] and the Equal Opportunities Commission's *Gender Equality Duty Code of Practice*^[35] in England and Wales, and adapts these policies as potential frameworks from which to develop a gender-mainstreaming approach to men's health in Ireland, across all Government departments, in the future.

Adopting a social determinants approach

This policy adopts a social determinants^[48] approach to defining men's health. It recognises that social and economic factors, including poverty, are key determinants of the health status of men.^[7] The policy aligns itself with existing strategies^[49, 50] that target the reduction of poverty in Ireland and that seek to tackle health inequalities by working in partnership with National Anti-Poverty Networks and the Community Development Programme. By recognising diversity within men, this policy acknowledges the right of all men in Ireland to the best possible health, irrespective of social, cultural, political or ethnic differences.

Adopting a community development approach

In recognition of the fact that one's community, defined by geography, culture or social stratification, is a valuable resource for health, this policy seeks to harness social capital among communities of men through a community development approach. By adopting this approach to men's health and positioning this policy within the wider social inclusion policy of Government^[49, 50], all communities of men in Ireland may be supported to achieve optimum health and well-being.

Adopting a health promotion, preventative approach

In the context of supporting health behaviour change and reducing premature mortality among men in Ireland, this policy calls for a gendered approach to the implementation and evaluation of health promotion policy in Ireland.^[57] It centres on three core areas – settings (e.g. workplace), populations (e.g. young men) and topics (e.g. smoking cessation) – whereby lifestyle modification is targeted via key settings and topics through a life stage approach.^[304]

Adopting an intersectoral and interdepartmental approach

Under the aegis of the Advisory Health Forum, this policy seeks to promote men's health in synergy with other policies and services within and beyond the health sector. Such an approach calls for the strengthening of alliances and partnerships with the community and voluntary sectors, as well as with the statutory sector in areas such as education, employment, environment and social affairs.

Tackling men's health from a strengths perspective

This policy endorses a positive and holistic approach to men's health – one that addresses the underlying causal factors that can be attributed to men's poorer health outcomes and that creates health-enhancing environments for boys and men. While it is imperative not to overlook the 'problems', it is equally important to build on the many strengths of men in Ireland and to challenge men to take increased responsibility for their own health. This policy does not seek to make men dependent on the healthcare system, but rather to facilitate them in looking after themselves and in their use of appropriate services for better health and quality of life.

Supporting men to become more active agents and advocates for their own health

This policy sets out a range of initiatives, in the statutory, community and voluntary sectors, designed to support men in becoming better advocates for their own health.

Research and consultation

A multi-level approach, centred around research and an extensive consultation process, was adopted for the development of this policy and its implementation, set out in the Action Plan in Part III of this policy document.^[60] A research project was conducted with more than 600 men over a 3-year period (2002-2004) to explore specific health issues. The findings of this research^[1] were launched at the first National Conference on Men's Health, held in Wexford in December 2004, attended by over 150 delegates. The outcomes from this conference were also documented and used to inform this policy. An extensive consultation was then conducted over an 11-month period during 2005, involving 500 stakeholders from a diverse range of organisations to individual men. The consultation comprised three distinct phases (6 men's health days, organised into workshops; 7 focus groups; and a call for submissions from the public and 94 targeted invitations). In addition, an extensive review of both the national and international literature on men's health was conducted to establish the efficacy of translating the issues raised into policy recommendations. Other issues that emerged from the wider literature were also considered for inclusion in this policy.

Key Policy Areas

Strengthening public policy on men's health

The successful implementation of this policy needs to take account of the factors that have impeded men's health reaching policy agendas in the past. It is important that the structures underpinning the policy are developed in accordance with best practice in relation to policy development^[60] and that they reflect the wider theoretical and philosophical framework that underpins this policy. In order to ensure that the targets set out in the men's health policy can be achieved, the necessary structures and resources will need to be put in place, together with appropriate re-orientation and integration of existing services.

This policy identifies the need to broaden and expand the research base on men's health in Ireland. A crucial first step in this regard is the development of a National Men's Health Research Framework and Network within the context of the existing National Population Health Research Framework. In order to facilitate this, it is proposed that a Centre for Research and Development in Men's Health be established, to be run on an initial pilot basis for 3-5 years. It is proposed that the Centre would be based in an academic institution (the housing costs to be borne by the institution) and that external funding would be sought for two research posts and a 'start-up' research budget. Once established, the proposed Centre would actively compete for research funding from existing sources in which research funds are disseminated, including the National Population Health Research Framework. It is imperative that the Centre would develop close working links with local HSE and community/voluntary agencies.

Promoting and marketing men's health

There is a need to devise promotional and marketing strategies and programmes for men's health that both challenge and support traditional notions of masculinity – in other words, developing health messages that appeal to men by *challenging* them to take greater responsibility for their own health so that they will be able to fulfil their traditional *support* role as provider, protector, husband and father. This policy endorses the recommendations from previous national health strategies^[55, 118, 120] on the need for good quality and accessible health information, and highlights in particular the need for more creative and gender-competent ways of making appropriate and 'male-friendly' health information available and accessible to men.

Public health policies across a number of areas have been developed at a population level to address the harmful health and risk behaviours in which many men engage.^[57, 95, 131-140] While such policies are welcomed, there is a need to ensure that their implementation takes account of the gendered nature of health behaviour. Therefore, any health promotion programme developed to support men to adopt healthier behaviours must seek to target the factors that influence their behaviours and ultimately seek to promote positive associations between masculinity and health. Men from lower socio-economic groups (SEG 5 and 6), those on low incomes, those with low educational attainment and young men (aged 18-35 years) often display poorer health-related behaviours than the general male population, and therefore should be targeted to support them to adopt healthier behaviours.

Strategies to promote gender competency in the delivery of health and social services

This policy highlights the need to develop and provide training and support for service providers on best practice while engaging with men. It is clear that both the integration of gender and men's health into relevant undergraduate and post-graduate courses, and the provision of professional training in men's health to existing health and allied health professionals, needs to be an integral part of policy development on men's health. It is also critically important to identify strategies and initiatives to increase men's participation in education and caring professions, as well as in community work.

Building gender-competent health services with a focus on preventative health

This policy draws attention to the need to improve men's access to more 'male-friendly'^[126, 127, 226] primary care services and the promptness with which men seek help, particularly for more serious and debilitating conditions. Healthcare, and the prompt use of health services in particular, needs to be portrayed as a strong ally of masculinity.^[106] In keeping with the primary healthcare strategy^[227], there is also a need to re-orientate the focus and capacity within primary health services from a medical 'diagnosis and treatment' model towards a 'prevention model' that promotes early intervention and integration with other services. The implementation of the primary healthcare strategy should, in particular, address the needs of communities experiencing poverty and marginalisation, and should consider the provision of outreach primary care services in community settings.

This policy calls for more gender-competent cancer preventative measures and endorses existing guidelines^[245] for prostate and colorectal cancer screening in Ireland. The policy endorses the recommendations in the 2006 *Report of the Expert Group on Mental Health Policy*^[136] and the 2005 *National Strategy for Action on Suicide Prevention*^[131], and also calls for an increased focus on the gendered nature of mental health in the context of men. In addition, there is a need for more gender-competent sexual health services^[39, 40] that give consideration to bringing services to men and that promote and advertise services as being relevant to men taking greater responsibility for their sexual and reproductive health.

Developing supportive environments for men's health

1. The home as a setting for men's health

This policy stresses the need for an increased priority on the home as a setting in which to target specific men's health policy initiatives that accommodate diversity within family structures and that enable men to take increased responsibility for their own health. The evidence to support an increased focus on fatherhood at both a policy and service delivery level is compelling.^[1, 276, 281, 282, 285-287] Measures that support and enable men to be more involved and active as fathers have beneficial effects not just for fathers themselves, but also for their wives/partners and children, and society as a whole. This policy recommends the implementation of a father-inclusive framework across all Government departments, based on existing national^[293] and international^[291, 292] models of best practice.

Consideration also needs to be given to the provision of paternity leave and to the increased uptake of existing parental leave by fathers as part of a gender-relations approach to equality in the workplace, and to childcare and domestic labour within the home. The provision of increased support services for separated/divorced fathers as part of the Family and Community Services Resource Centre Programme^[302] is also recommended. In addition, the policy proposes that the access entitlements of single fathers to their children should be monitored within the context of existing^[299] and future reports into the workings of the family law courts.

This policy supports the call for a National Carer's Strategy^[50] that can provide increased

support for men in their role as carers and proposes that the issue of poverty and sub-standard living conditions among men living alone should be addressed as a matter of urgency. The policy also highlights the necessity for increased intervention programmes for male perpetrators of domestic violence and for increased support measures for male victims of domestic violence that tackle, in particular, barriers to male victims accessing support services.

2. Education environment – Schools and third-level colleges

This policy stresses that men's health starts with boys' health. There is a need to provide a visible and integrated focus on boys' and men's health within primary and post-primary school curricula, including a focus on male-specific health issues and a fostering of positive models of personal and social development and sexual health delivery for boys.

There is a need to combat the practical and cultural barriers to the full implementation of the Social, Personal and Health Education (SPHE) programme, particularly in single-sex boys' schools.^[308-314] It is also imperative that the recommendations from previous evaluations^[309, 316] of the SPHE module 'Exploring Masculinities' are fully implemented in order to make it a viable resource within the context of SPHE in the future.

This policy stresses that research is necessary, in an Irish context, to establish if particular learning styles and teaching practices should be considered as key elements in addressing the educational needs of boys, and whether or not the current school system affirms boys in a positive way. The policy supports the expansion of the Home School Community Liaison (HSCL)^[333] Scheme under the DEIS^[335] action plan to foster improved links between the home and schools, which enable fathers to have an increased involvement at all levels of a child's education. The policy highlights the need to implement, in full, the actions in DEIS^[335], including those related to the expansion of School Completion Programme Services, and to adopt international models of best practice^[329] to address the high proportion of male early school-leavers. There is also a need to expand the number of places offered through second-chance education initiatives and to consider barriers to accessing these programmes for men.

It is imperative that school policies on bullying are clearly visible and fully implemented, and that increased efforts are made to establish best practice guidelines in dealing with bullying. This policy endorses the recommendations of the 2005 CLÁN Survey^[156] and draws attention to the need for gender analysis to inform the development of a health-promoting college model.

3. Promoting men's health in the workplace

This policy stresses the need for an increased priority on men's health in the workplace, one that embraces the workplace as a key setting for delivering men's health initiatives and that involves both employers and unions/representative bodies working in a cohesive way on promoting men's health. Work-life balance is increasingly seen as an issue that impacts on men as well as on women.^[28, 297] This policy has identified the need for an increased focus on family-friendly policies that give greater choice to men in this respect.

There is a need to recognise the gendered nature of occupational health and safety, and to have an increased focus on occupational safety, health and welfare in the workplace that is consistent with the Health and Safety Authority's (HSA) *Strategy Statement 2007-2009*.^[361] There is also much potential to promote an increased focus on men's health in the workplace through a partnership approach between the HSA, HSE and other relevant organisations.

Unemployment^[364-367], lack of security of job tenure^[369] and involuntary early retirement^[372] can have a potentially negative impact on men's health. Men who fall within these categories need to be prioritised within health and social services. There is also a need for an increased focus on the prevention and management of stress^[374] and bullying^[378] in the workplace.

4. Social spaces

Currently, there is a lack of recreational facilities and safe social spaces for young people throughout the country and this has been identified as a factor in the harmful health and risk behaviours of young men.^[379, 385-387] The 2007 National Recreation Policy for Young People^[388], *Teenspace*, outlines clear objectives to address this deficit. The consultation for the implementation of this policy, and any other policy that affects young people, must be inclusive of all young men to ensure that facilities are gender-sensitive and that the diverse needs among young men are met. There also needs to be a greater emphasis on the provision of appropriate recreation and leisure facilities for men across the lifespan in the National Spatial Strategy for Ireland.^[399] In particular, men in their mid- to late-30s, who are most inclined to retire from sport, should be supported to remain active via the provision of more community-based facilities.

Community development – Strengthening community action to support men's health

Many men in Ireland experience social isolation and disadvantage on a daily basis. These men have the worst health profiles of any category of men in our society and are most likely to die prematurely. In keeping with national policy^[49, 50, 55, 57, 131, 136, 227], this policy proposes to build social capital among these communities of men and thereby empower them to take control of their lives and their health. By doing so, they may ultimately be able to change the circumstances that contribute to their disadvantage. In order to achieve this, funding should be targeted at vulnerable men throughout the lifecycle, as advocated in the National Action Plan for Social Inclusion (NAPinclusion 2007-2016).^[50]

While traditionally men have neither tended to engage in community development projects nor mobilised themselves collectively for their health, there is evidence that men do engage in certain community development projects and that they are willing participants in both task-orientated^[22] and personal development work^[418]. Therefore, community workers must be supported (through training and financial resources) to work with men. An appropriate national organisation should be tasked with supporting community groups to access funding, education and training, and with informing public policy on the health needs of men at national level.

Policy Recommendations

Note: The numbering of the Strategic Aims (SA) and Recommendations (R) follow the Section numbers in Chapters 5-10 of this policy document
(e.g. R5.1.1 = Recommendation, Chapter 5, Section 5.1.1).

STRATEGIC AIM		
SA5.1	Develop appropriate structures for men's health at both national and local level to support the implementation of the policy and to monitor and evaluate its implementation on an ongoing basis.	
RECOMMENDATIONS		Lead Agency
R5.1.1	Oversee the implementation of the policy at an interdepartmental level and monitor and evaluate policy outcomes on an ongoing basis.	Dept. of Health and Children HSE
R5.1.2	Establish appropriate structures and secure resources to support the implementation of the policy.	Dept. of Health and Children HSE Other relevant Government depts.

STRATEGIC AIM		
SA5.2	Promote an increased focus on men's health research in Ireland.	
RECOMMENDATIONS		Lead Agency
R5.2.1	Establish a Centre for Research and Development in Men's Health.	Dept. of Health and Children
R5.2.2	Ensure that research continues to underpin the implementation and evaluation of the policy.	Dept. of Health and Children HSE

STRATEGIC AIM		
SA6	Develop health promotion initiatives that support men to adopt positive health behaviours and to increase control over their lives.	
RECOMMENDATIONS		Lead Agency
R6.1	Promote a holistic and positive focus on men's health that supports men to take greater ownership of their own health.	HSE Other relevant Government depts.
R6.2	Devise gender-competent health information and disseminate it through media that are appropriate for men.	HSE Other relevant Government depts.
R6.3	Fully implement existing Government policies ^[57, 95, 131-140] that target the health and risk behaviours of men in Ireland through health promotion initiatives. Ensure that their implementation adopts a gendered approach.	HSE Other relevant Government depts.
R6.4	Review the adequacy of existing legislation that is in place to deter risk-taking behaviour among men.	Dept. of Justice, Equality and Law Reform Dept. of Transport Dept. of Health and Children HSE

STRATEGIC AIM

SA7 **Develop health and social services with a clear focus on gender competency in the delivery of services.**

RECOMMENDATIONS		Lead Agency
R7.1	Develop specialised academic programmes on men's health and integrate modules on gender and men's health into the training syllabi of all health and allied health courses.	Institutes of Technology Ireland Irish Universities Association Third-level institutions Relevant professional bodies
R7.2	Develop training protocols and training courses on men's health that are tailored to the needs of those working in the health and allied health professions, and that offer a range of innovative methodologies.	HSE
R7.3	Promote strategies and initiatives to increase men's participation in education and caring professions, and in community work.	HSE Dept. of Education and Science Teaching Council

STRATEGIC AIM

SA8 **Support the development of gender-competent health services, with a focus on preventative health.**

RECOMMENDATIONS		Lead Agency
R8.1	Develop specific initiatives that enable men to access health services promptly, particularly for conditions that pose a serious threat to their health. Specific provisions should be made for marginalised subgroups of men (e.g. Traveller men, ethnic minority men, disabled men, isolated rural men).	HSE Irish College of General Practitioners
R8.2	Develop an increased focus on gender-competent cancer preventative measures and implement existing guidelines for cancer screening services.	HSE Dept. of Health and Children
R8.3	Implement the recommendations of the Expert Group on Mental Health Policy ^[136] and the National Strategy for Action on Suicide Prevention ^[131] , with a clear focus on the gendered nature of mental health.	HSE Other relevant Government depts.
R8.4	Ensure that there is a clear focus on the provision of gender-competent sexual health services and programmes for men.	HSE

STRATEGIC AIM

SA9.1 **Target specific men's health policy initiatives in the home that accommodate diversity within family structures and that reflect the multiple roles of men as husbands/partners, fathers and carers.**

RECOMMENDATIONS		Lead Agency
R9.1.1	Target the home as a setting for enabling men to take greater responsibility for their own health.	HSE
R9.1.2	Develop explicit and gender-competent father-inclusive policies and practices within all health and social services, and as an integral part of social inclusion.	HSE Other relevant Government depts.

R9.1.3	Develop a National Carer's Strategy ^[50] that can provide increased support for men in their role as carers.	HSE Dept. of Social and Family Affairs Dept. of Community, Rural and Gaeltacht Affairs
R9.1.4	Provide a range of measures to address sub-standard living conditions among men, within the context of <i>Delivering Homes, Sustaining Communities</i> ^[306] , that are sensitive to the needs of poorer men living alone.	Dept. of the Environment, Heritage and Local Government Dept. of Social and Family Affairs
R9.1.5	Increase support measures for male perpetrators of domestic violence.	HSE Dept. of Justice, Equality and Law Reform COSC
R9.1.6	Increase support measures for male victims of domestic violence.	HSE Dept. of Justice, Equality and Law Reform COSC

STRATEGIC AIM

SA9.2 **Develop a more holistic and gendered focus on health and personal development in schools, out-of-school settings and colleges within the context of the Health Promoting School and college models.**

RECOMMENDATIONS		Lead Agency
R9.2.1	Provide a clear and prominent focus on the development of positive and healthy masculinities among boys through both policy and practice within schools.	Dept. of Education and Science
R9.2.2	Establish within an Irish context if particular learning styles and teaching practices should be considered as key elements in addressing the educational needs of boys.	Dept. of Education and Science
R9.2.3	Establish improved links between the home and school that enable fathers to have an increased involvement at all levels of a child's education.	Dept. of Education and Science
R9.2.4	Reduce the rate of drop-out of boys from secondary school and expand the number of places offered through second-chance education initiatives.	Dept. of Education and Science Other relevant Government depts.
R9.2.5	Develop best practice guidelines on policy approaches to reduce school bullying and violence (within the context of health and education partnerships associated with SPHE and the Health Promoting School).	Dept. of Education and Science HSE
R9.2.6	Implement the recommendations from the CLÁN Survey and develop the health-promoting college model in a way that is informed by gender analysis.	Institutes of Technology Ireland Irish Universities Association Third-level institutions HSE

STRATEGIC AIM

SA9.3 **Target the workplace as a key setting in which to develop a range of men's health initiatives that are based on consultation and partnership-building with employers, unions, workers and other relevant statutory bodies.**

RECOMMENDATIONS		Lead Agency
R9.3.1	Adopt a more targeted and gender-specific approach to the development of health promotion initiatives in the workplace.	Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE

R9.3.2	Promote and encourage family-friendly policies in both the public and private sectors that enable men to exercise greater choice in the making of decisions regarding work-life balance.	Department of Enterprise, Trade and Employment
R9.3.3	Implement the Health and Safety Strategy Statement 2007-2009 ^[361] and provide assistance to the HSE and other relevant organisations to create increased opportunities for the promotion of men's health in the workplace.	Health and Safety Authority HSE
R9.3.4	Develop tracking systems at primary care level to monitor more closely the health of the long-term unemployed, those engaged in transient work and non-voluntary early retirees.	HSE
R9.3.5	Ensure that there is an increased focus on the prevention and management of stress in the workplace.	Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE
R9.3.6	Implement the recommendations of the 2005 <i>Report of the Expert Advisory Group on Bullying</i> ^[376] and the <i>Code of Practice for employers and employees on the prevention and resolution of bullying in the workplace</i> ^[378] .	Employers & Unions Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE

STRATEGIC AIM

SA9.4 Increase the availability of and access to facilities for sport and recreation for all men and safe social spaces for young people.

RECOMMENDATIONS

Lead Agency

R9.4.1	Provide increased investment in the development of facilities for sport and recreation and safe social spaces for young people.	Dept. of Arts, Sport and Tourism Irish Sports Council
R9.4.2	Ensure that young men are fully represented within existing structures at local and national level that give a representative voice to youth.	Office of the Minister for Children and Youth Affairs
R9.4.3	Consult with and involve young men in the development of policies, services and programmes designed to meet their needs.	Office of the Minister for Children and Youth Affairs

STRATEGIC AIM

SA10 Build social capital within communities for men.

RECOMMENDATIONS

Lead Agency

R10.1	Develop mechanisms and structures to support community work for men who experience disadvantage.	Dept. of Community, Rural and Gaeltacht Affairs Dept. of Enterprise, Trade & Employment HSE
R10.2	Name disadvantaged men as a vulnerable group to be supported through available funding streams under the National Action Plan for Social Inclusion (NAPinclusion 2007-2016). ^[49]	All relevant Government depts.
R10.3	Modify the current gender-proofing mechanisms to be inclusive of vulnerable men in our society, in accordance with international best practice. ^[34, 35]	All relevant Government depts.
R10.4	Incorporate a health agenda into all community development work for men, in consultation with the men in the community.	All relevant Government depts.



Part I:
Background and
Policy Context

1. Introduction

1.1 Why focus on men's health?

In recent years, there has been a growing awareness, and indeed concern, about the burden of ill-health experienced by men in Ireland.^[1, 2] Male life expectancy is almost 5 years lower than female life expectancy^[3] and men in Ireland have higher death rates for most of the leading causes of death and at all ages^[4-6]. It is also crucially important not to overlook the substantive differences in health status between different categories of men. For example, compared to men in the highest socio-economic groups (SEGs), men from the lower groups have poorer health outcomes and experience significantly higher mortality rates for the 5 major causes of death in Ireland.^[7] Young men (aged 18-35 years) are also a high-risk group – they are almost 4 times more likely to die earlier than their female counterparts^[8] and currently have the second highest rate of suicide among the 30 OECD Member States^[9].

Gender also has a crucial bearing on men's health. How men perceive themselves as 'masculine' impacts on the value they place on their health and how they manage their health within the healthcare system.^[1] For example, men who engage in health-damaging or risky behaviours often do so to 'prove' their masculinity to others.^[10] Similarly, men may avoid seeking help when they are unwell because of a fear of being labelled 'feminine' or 'effeminate'.^[11] A gendered focus on men's health is timely because, in the past, the focus on gender and health in Ireland has tended to be synonymous with women's health.^[12, 13] In the case of cardiovascular disease (CVD), for example, the gendered nature of CVD has been well documented in the context of women's health^[14-16], but is only more recently being understood in the context of men's health^[10, 14, 17]. It is crucially important, therefore, to consider how men actively construct beliefs, attitudes and behaviours that can impact on many different aspects of their health. Indeed, strategies designed to promote and improve men's health need to begin not only by looking at the behaviours or attitudes of individual men, but also by challenging the gendered values and systems within the institutions in which men live and work, and by giving due consideration to the broader determinants of men's health.

1.2 Responding to men's changing roles in Ireland

In Ireland, as in other developed countries, the challenge in more recent times to the position of men in gender relations has resulted in important changes in work practices, more 'democratic family structures'^[18] and the continued blurring of the traditional male and female roles. Permanent jobs are being replaced by short-term work contracts, rates of divorce are increasing, more children are born outside of marriage, and a long history of Irish emigration has been replaced by unprecedented numbers of foreign nationals moving to Ireland.^[19] For poorer unskilled men, labour market vulnerability and lack of security of job tenure are increasingly associated with poverty and social exclusion, and are issues that now have a greater bearing on their health than ever before.^[20] Access to affordable housing has become an issue for an increasing percentage of the population.^[21] The disintegration of rural communities has resulted in isolation, difficulties with access to services and specific adverse consequences for the mental health of rural men.^[22]

Such changes have occurred against a backdrop of an increasing shift towards secularisation and individualism.^[23]

Although there is now the widespread expectation that men need to respond to changing roles and expectations in society, it is also clear that this transition has been, and continues to be, problematic for many men. For example, while men are often considered 'hard work' by health service providers by not caring for their health^[24], society continues to reward and honour aspects of male identity associated with risk, daring and foregoing safety through gendered systems within politics, work and sport. In the context of industrial health, there has been little questioning, or conceptualisation as a health issue, of the disproportionate incidence of work-related injuries and fatalities among men, particularly working-class men.^[25] Indeed, men continue to dominate those industries that have high levels of occupational injury and death – the construction industry, work involving heavy machinery and dangerous tools, most transport work and most work in heavily polluted environments. Such occupations are traditionally associated with 'men's work' and taken for granted as part of normal and expected masculine practice.^[26]

While the traditional 'breadwinner' role has changed in Ireland in the past 30 years, this change does not appear to have been reciprocated in terms of men's input to childcare and domestic work.^[1, 27] Indeed, the complexities of balancing the notion of 'new fatherhood' with factors such as inflexible work demands, the harsh reality of economic necessity for many men and disapproval or ridicule from other men are often overlooked.^[28] These changes and the widespread 'socio-cultural transformations'^[29] that have marked this recent period in Irish history present many challenges to men's sense of place in Irish society. As Whitehead notes^[30], 'men are increasingly caught in the pincers of a culture that still expects them to "be at the helm", yet also requires them to engage in reflexive analysis of their masculinity'.

1.3 Defining 'men's health'

In keeping with the World Health Organization's globally recognised definition of health^[31], a healthy man is one who is 'empowered to experience optimum physical, mental and social well-being and who experiences health as a resource for everyday living'. It is important therefore to recognise that men's health status is more than simply a consequence of biological, physiological or genetic functioning, but that it is also affected by wider social, cultural and environmental factors. When defining men's health, it is also important to deviate from earlier definitions that have tended to focus on men's diseases of the reproductive organs, which inevitably resulted in a narrow, disease-focused approach to men's health.^[25] The need to move beyond this approach is now well documented and is especially apparent when one considers that male-specific disease mortality accounts for a relatively small proportion of overall male mortality. For example, men in Ireland are approximately 12 times more likely to die from cardiovascular disease than from prostate cancer.^[8]

It is within this broad determinants context of 'health', and with due regard to the gendered nature of men's health, that a male health issue is defined in this policy as *any issue that can be seen to impact on men's quality of life and for which there is a need for gender-competent responses to enable men to achieve optimal health and well-being at both an individual and a population level.*

1.4 Impetus for policy development

A number of important international developments have resulted in a raised profile surrounding men's health in recent years. The first World Congress on Men's Health was held in Vienna in 2001; there have been a number of national and international conferences on men's health since then – in Australia, the USA, Asia and Europe (including Ireland). Other international initiatives in recent years include the launch of the International Society for Men's Health (www.ismh.org), the commencement of an international Men's Health Week, the launch of the European Men's Health Forum (www.emhf.org) and the introduction of three academic journals devoted to men's health (*International Journal of Men's Health*, *Journal of Men's Health and Gender* and *American Journal of Men's Health*). The EMHF published a report in 2004 that provided, for the first time, a comprehensive overview of statistics on men's health across 17 Western European Member States.^[32] There has also been an increased focus internationally on gender-mainstreaming in relation to health^[33-35], although, to date, this has had more of a focus on women's health than on men's health.

The upsurge of interest and activity around men's health at international level has also been mirrored in Ireland. Men's health in Ireland has been greatly strengthened in recent years by research, advocacy work and by a variety of grassroots projects in both the statutory and non-statutory (community/voluntary) sectors. The Health Service Executive (HSE) has funded two research initiatives into men's health^[1, 2], has developed a number of regional strategies on men's health^[36-38] and has funded a range of community development-related health projects throughout the country. Since 1997, the HSE has funded the Men's Development Network (MDN) to support men affected by marginalisation via community-based initiatives. Today, the MDN operates nationwide (www.mens-network.net) and has been a key player at all stages in the development of this policy for men's health. It is also well positioned to both advise on and be directly involved in the implementation of the policy. The HSE also funds the Gay Men's Health Project in Dublin, which provides a wide range of clinical, outreach and counselling services for gay and bisexual men.

The Irish Cancer Society has conducted innovative campaigns directed at increasing awareness and early detection of cancers among men. The Crisis Pregnancy Agency has funded a number of research initiatives with a focus on men, including the barriers relating to men's use of sexual health services^[39] and men's experience of sex, contraception and crisis pregnancy^[40]. The Family Support Agency at the Department of Social and Family Affairs has also funded research on policy and practice issues in relation to vulnerable fathers.^[41] The Men's Health Forum in Ireland (www.mhfi.org) has been

engaged in work at an advocacy level since 2002 and it published a comprehensive report in January 2004 on men's health statistics in Ireland.^[2] The Institute of Public Health's 2006 publication entitled *All-Ireland Men's Health Directory*^[42] provides a worthwhile database of activity in the area of men's health on the island of Ireland. Other organisations operate to provide support for male victims of domestic violence (such as AMEN) and for separated/divorced fathers (such as Parental Equality).

All these initiatives have generated a considerable momentum in the area of men's health in Ireland and this momentum, from grassroots to statutory levels, has been a key factor in the development of this National Men's Health Policy 2008 – 2012. As outlined in Chapter 3, this policy has also been informed by an extensive consultation process, which, in addition to getting the views of all key stakeholders, also served to strengthen existing networks within men's health in Ireland.

1.5 Meeting the challenges of addressing men's health in the future

Many challenges lie ahead with regard to the implementation of this National Men's Health Policy. While it is incumbent on this policy to promote health-affirming changes to men's attitudes and behaviours in relation to their health, it is fundamentally important to create supportive environments, to promote gender-competent services and to strengthen community action to support men's health. This policy, therefore, calls for strategies that target interventions at both an individual and a population level. It proposes that the Implementation Group, tasked with driving the policy, identifies a clear timeframe for implementation and a clearly defined means of evaluating outcomes. The policy identifies best practice across a range of different aspects of men's health and offers a clear blueprint for promoting optimum health and well-being among men in Ireland in the years ahead.

2. Theoretical and philosophical principles underpinning the Men's Health Policy

This chapter sets out the theoretical and philosophical principles that underpin the National Men's Health Policy 2008 – 2013. It provides a backdrop from which to establish a way of approaching, thinking about and examining policy measures to address the broad range of men's health issues identified in Chapters 5-10.

2.1 Adopting a gendered and gender-relations approach

This policy adopts a *gendered approach to men's health* and recognises gender in the context of culturally defined masculine or feminine traits that are deemed to be socially appropriate to the sexes.^[43] As later chapters in this policy will show, many aspects of men's health practices can be seen as mechanisms for actively demonstrating different patterns of 'masculinities'^[26] that are in keeping with society's expectation of particular masculine roles. It is against particular norms of masculine behaviour that men must constantly negotiate their own behaviour in relation to how they manage their health. It is imperative, however, that gendered health practices are not seen as inherent or intractable male characteristics, but rather are learned masculine behaviours that typically reflect wider cultural and institutional masculine ideologies, such as those of schools^[44, 45] or sporting organisations^[46]. Patterns of masculinity are also frequently defined as the opposite of femininity. Men who are non-compliant with health advice or who present a 'brave front' in the face of illness may do so to avoid the ridicule of being labelled 'feminine' or 'effeminate'.

It is also important to adopt a *relational approach to gender* that focuses on addressing policy and service delivery measures that are equitable for both men and women. A 'gender-mainstreaming'^[33] approach recognises that gender equality is best achieved through the integration of men's and women's health concerns in the development, implementation and evaluation of policies, both within and beyond health. A relational approach to gender also enables an exploration of patterns of difference, as well as similarity, between men and not just a focus on differences between men and women. The category 'men' is not therefore a homogeneous group. From a health perspective, it is crucially important to understand gender in the wider socio-cultural context of men's lives and to consider how gender interacts with factors such as social class, education, age, employment status, race, ethnicity, sexual orientation and disability. Such an approach recognises diversity between men and is more sensitive to the needs of specific subgroups of men.

It should be stressed that the development of a men's health policy is not designed to play catch-up with women's health nor should it be at the expense of efforts to improve women's health. Whilst a focus on margins of difference in health outcomes between men and women has tended in the past to evoke a sense of 'mutual suffering and health disadvantage between the sexes'^[25], a relational approach recognises the reciprocal nature of men's and women's health. Indeed, policy measures designed to improve men's health can impact not just on men's lives, but can also have a positive influence on the lives of women and children, and on society as a whole. For example, absenteeism from work due to a man's ill-health is likely to have significant material repercussions for



single-income families in lower socio-economic groups. In the case of sexual health and mental health, interventions that are successful with men are also likely to have positive spin-offs for their wives/partners and families. Similarly, initiatives designed to support men to be more engaged as fathers are likely to have positive consequences not just for fathers, but also for children and families.

The positioning of men's health, therefore, within a *mainstreamed equality agenda* with a gender focus^[33] affords a more holistic approach than a focus on gender alone. In other words, an approach that strives for health equality among all men in Ireland is likely to offer a more constructive framework in which to advance men's health than one which focuses on margins of difference between men and women. Building on the Equal Status Acts 2000 to 2004^[47], this policy endorses the approach taken by Health Canada's *Gender-based Analysis Policy*^[34] and the Equal Opportunities Commission's *Gender Equality Duty Code of Practice*^[35] in England and Wales, and adapts these policies as potential frameworks from which to develop a gender-mainstreaming approach to men's health in Ireland, across all Government departments, in the future. Such an approach also offers the potential to forge strong links between the fields of men's health and women's health.

2.2 Adopting a social determinants approach

This policy adopts a social determinants or 'biopsychosocial' approach^[48] to defining men's health. It argues that men's health status is more than simply a consequence of biological, physiological or genetic functioning, but that it is also affected by much broader economic, social, cultural and environmental factors, which influence the way in which men perceive themselves and live as masculine within a specific culture.

Indeed, there is an increasing recognition that social and economic factors, including poverty, are key determinants of the health status of men.^[7] By recognising diversity within men as a population group, this policy acknowledges the right of all men in Ireland to the best possible health, irrespective of social, cultural, political or ethnic differences, which is consistent with the HSE's (2007) National Intercultural Health Strategy 2007-2012^[430]. Men who are particularly vulnerable include those who are homeless, disabled, from ethnic minority groups, from the Traveller community, prisoners and those isolated in rural parts of the country. This men's health policy aligns itself with existing strategies on social inclusion^[49, 50] that target the reduction of poverty in Ireland and that seek to tackle health inequalities by working in partnership with national anti-poverty networks (e.g. the Irish Traveller Movement and Irish Refugee Council) and the Community Development Programme.

In order to support men to look after their own health, men need to have access to:

- meaningful employment in a safe and healthy work environment;
- lifelong learning opportunities;
- adequate and affordable housing.

2.3 Adopting a community development approach

In recognition of the fact that one's community, defined by geography, culture or social stratification, is a valuable resource for health, this policy seeks to harness social capital among communities of men through a community development approach. A social determinants approach that requires intersectoral and interagency partnership work is fundamental for community development and both are central to the framework of this policy.

There are many communities of men living in Ireland, including rural men, single men, men as carers, farmers, gay, bisexual and transgender men, disabled men, young men, old men, homeless men, asylum-seeking/refugee men, substance-abusing men, unemployed men, separated men, Traveller men, male prisoners, fathers, male victims of domestic violence and men affected by other forms of social exclusion. Indeed, any one man may simultaneously be a member of many of these communities.

By adopting a community development approach to men's health and positioning this policy within the wider social inclusion policy of Government^[49-51], all communities of men in Ireland may be supported to achieve optimum health and well-being. While the recommendations made throughout this policy are relevant for all communities of men, certain communities require targeted support and, where appropriate, the needs of specific communities have been highlighted.

2.4 Adopting a health promotion, preventative approach

The growth in recent years in the fields of preventative medicine and health promotion bears testimony to the contention that health behaviours are critically important in terms of influencing health. Epidemiological studies implicate particular lifestyle patterns as a major factor in premature death rates among men.^[52-54] This has been confirmed by a growing shift in healthcare policy, both internationally^[54] and nationally^[55], towards the importance of individual health behaviours, disease prevention and lifestyle in determining health outcomes. These policy statements clearly implicate cigarette smoking, excessive alcohol consumption, physical inactivity, raised total cholesterol, hypertension and poor diet in the aetiology of many of the principal causes of mortality and morbidity, including cardiovascular and respiratory diseases, and some cancers.

In the context of supporting behaviour change and reducing premature mortality among men, there is a need to move beyond an understanding of men's behaviours to supporting men to change their behaviours.^[56] In this regard, this policy aligns itself with existing health promotion policy^[57] and centres on three core areas – settings (e.g. workplace), populations (e.g. young men) and topics (e.g. quitting smoking) – whereby lifestyle modification is targeted via key settings and topics through a life stage approach. The importance of targeting lifestyle modification early in life among those men engaged in health-damaging behaviours has been well recognised; as White and



Holmes^[53, p. 150] state, 'The seeds of death from degenerative conditions are probably sown in lifestyles established earlier'.

Therefore, young men have been identified in this policy as a key target group for such interventions. This policy also calls for a gendered approach to the implementation and evaluation of health promotion policy in Ireland.^[57]

2.5 Adopting an intersectoral and interdepartmental approach

This policy seeks to promote men's health in synergy with other policies and services within and beyond the health sector (*see Chapter 5*). Such an approach calls for the strengthening of alliances and partnerships with the community and voluntary sectors, as well as with the statutory sector in areas such as education, employment, environment and social affairs. The provision of appropriate structures for men's health policy at a national level can provide a strong mandate for this to occur and to ensure sustainable mechanisms are in place to coordinate the work of different agencies to avoid overlap and duplication.

2.6 Tackling men's health from a strengths perspective

This policy calls for a departure from the traditional focus on the 'deficiencies' of men with respect to their health. A healthy Irish society should be one that celebrates and nurtures boys and men. Unfortunately, public debate on men's health tends to be dominated by negative portrayals of men and masculinity, whereby men are blamed for failing the health services by not attending, for being violent and for taking risks. This policy endorses a positive and holistic approach to men's health, one that addresses the underlying causal factors that can be attributed to men's poorer health outcomes and that creates health-enhancing environments for boys and men. While it is imperative not to overlook the 'problems', it is equally important to build on the many strengths of men in Ireland and to challenge men to take increased responsibility for their own health. This approach is consistent with what has been described in an Australian context as a 'salutogenic'^{1*} approach to men's health.^[59] Such an approach acknowledges men's failings with respect to their health, but attempts to work with them in a positive and supportive way.

This policy acknowledges that men in Ireland have traditionally been a very positive

1 *'Salutogenic' is used both in its original context of human resilience (Antonovsky, 1968^[58] and 'salutogenesis') and in counter-distinction to 'pathogenesis', to convey the need to move away from a pathology-orientated, deficiency and disease-based model of medicine.

force as healthcare providers and as carers. Their willingness to take risks has been an important force in the economy, with consequent benefits for society. This policy does not seek to make men dependent on the healthcare system, but rather to facilitate them in looking after themselves and in their use of appropriate services for better health and quality of life.

2.7 Supporting men to become more active agents and advocates for their own health

This policy sets out to establish more supportive environments and to create a better climate in which to enable men to be better advocates for their own health. It is a notable paradox that despite men's prominent presence throughout the ages at the centre of health service policy and provision, men have been conspicuously silent and largely non-reflective in speaking out about their own health. Relatively few men have argued, lobbied or campaigned in the same way that women have for improvements to their health at a personal or individual level. Despite unparalleled advances in modern medicine and access to information and services in recent times, men continue to have worse health outcomes than women throughout the lifecycle and for all the major causes of death. Perhaps the dilemma that men face is, that by speaking out or becoming radical in relation to their health, they are acknowledging in a very public way their own vulnerability, 'weakness' and need for help – all of which have been shown to be at odds with the more traditional or dominant concepts of 'masculinity'. This policy promotes a range of initiatives designed to support men, in the statutory, community and voluntary sectors, to be stronger advocates for their own health.

3. Methodology for developing a men's health policy in Ireland

A number of key factors informed and created momentum for the development of this National Men's Health Policy. In 2001, the National Health Strategy, *Quality and Fairness*, called for the development of 'a policy for men's health and health promotion.'^[55] In accordance with principles of best practice for the development of effective policy^[60], a multi-level approach, centred around research and an extensive consultation process, was adopted for the development of this policy (see Table 3.1).

Table 3.1: Approach adopted for the development of National Men's Health Policy

Research	January 2002 – December 2004 3-year research project, <i>Getting Inside Men's Health</i> , on specific issues of men's health
Expert input	November 2004 appointment of National Steering Committee
National Conference	December 2004 1st National Conference on Men's Health
Nationwide consultation	February – December 2005 hosted 6 men's health days hosted 7 focus groups targeted and public call for submissions
Review of evidence	February 2005 – December 2006 and report back to National Steering Committee
Bilateral meetings	January – August 2007 meetings with key stakeholders and Government departments to finalise the Action Plan for the national policy
National policy for Ireland	December 2008 Publication of National Men's Health Policy 2008 – 2013

Research

In order to address the deficit of evidence-based research on men's health in Ireland, a 3-year research project on men's health was conducted, adopting both quantitative (questionnaire) and qualitative (focus groups and semi-structured interviews) methodologies. This research sought to explore specific health issues among a representative sample of over 600 men. The findings of this research, *Getting Inside Men's Health*, were launched at the first National Conference on Men's Health, held in Wexford in December 2004. The outcomes from this conference, attended by over 150 delegates, were also documented via a series of workshops and used to inform this policy.



National consultation

Under the terms of reference of the National Steering Committee, appointed in November 2004 to oversee the development of this policy, it was agreed that following an extensive nationwide consultation, both a policy (with higher order recommendations) and a specific action plan (with time-framed actions) would be developed.

The consultation process consisted of three distinct phases – workshops, focus groups and submissions – over an 11-month period during 2005. In recognition of the broader determinants of men's health, all phases of the consultation adopted a social determinants approach, as per the Ottawa Charter^[61].

- Phase 1 consisted of a series of men's health days, 6 in total, hosted around the country with a view to establishing key issues of concern, as well as garnering support for men's health through sharing of information and generating networks. Approximately 400 individuals and organisations attended these health days and small-group workshops were held in small groups to identify health needs and to structure actions to meet those needs. Facilitators were consistent throughout each of the 6 days to ensure continuity throughout the process and to ensure that this phase of the consultation was seen as an overall process rather than as discrete days.
- Phase 2 of the consultation involved 7 focus groups, consisting of subpopulations of men whose voices were not represented at the men's health days. As in Phase 1, facilitators were consistent throughout each of the focus groups.
- Phase 3 consisted of a call for submissions (from the public, as well as 94 targeted invitations) through advertisements in the national press. To inform discussion, reports from each of the workshops from Phase 1 were made available online (www.healthinfo.ie/menshealth). Letters were sent to all participants in Phases 1 and 2 to inform them that the reports were available for viewing and comment, with hard copies available on request.

Qualitative methodologies were used throughout the consultation (workshops, focus groups and submissions) and data were thematically analysed.

All relevant stakeholders, from a diverse range of organisations to individual men, were represented throughout the three phases of consultation (*see Table 3.2*).

Table 3.2: Summary of participants in 3 phases of consultation

Key stakeholders	No. of participants	Representation (%)
Male participants	343	69%
Female participants	157	31%
representing the following community, voluntary and statutory groups:		
• Health Service Executive (HSE)	128	26%
• Community groups or workers	51	10%
• Traveller men	15	3%
• Older men	24	5%
• Gay men	6	1%
• Disadvantaged men	80	16%
• Disabled men	6	1%
• Fathers	15	3%
• Homeless men	2	0%
• Rural men	16	3%
• Young men	27	5%
• Immigrant men/Refugees	6	1%
• Clergy	8	2%
• Health Service Executive (HSE)	128	26%
• Academics	32	6%
• Researchers	8	2%
• Sporting bodies and Local Sports Partnerships	9	2%
• Workplace representatives	36	7%
• Local Authorities	3	1%
• Government departments	3	1%
• Others	10	2%
• Unknown organisations and individual men	15	3%
Total	500	100%

Literature review

An extensive review of both the national and international literature on men's health was conducted to establish the efficacy of translating the issues raised through the various stages (research, conference, consultation and steering group) into policy recommendations. While the issues raised did guide the review of the literature, it was not solely limited to those issues. Other issues that emerged from the wider literature were also considered for inclusion in this policy.

The more detailed findings from the literature review, underpinning the rationales presented here and the recommendations and actions made throughout this policy and action plan, have been collated in a separate Reference Document^[62], available on request from the Health Promotion Policy Unit, Department of Health and Children.

4. Key statistics on men's health in Ireland

This chapter outlines some of the key statistics on the health of men in Ireland. While comparisons are made between male and female data to highlight the impact of gender on certain health outcomes and behaviours, particular attention is paid to the diversity of health profiles among men in Ireland. This diversity is reviewed in the context of age, social class and other socio-demographic factors known to affect health. Critically reviewing the statistics in this way serves as a backdrop for the broad determinants approach adopted by this policy. It also provides a platform from which to hone the spotlight on those subgroups of men in Ireland who experience a disproportionate burden of ill-health and for whom targeted support is required.

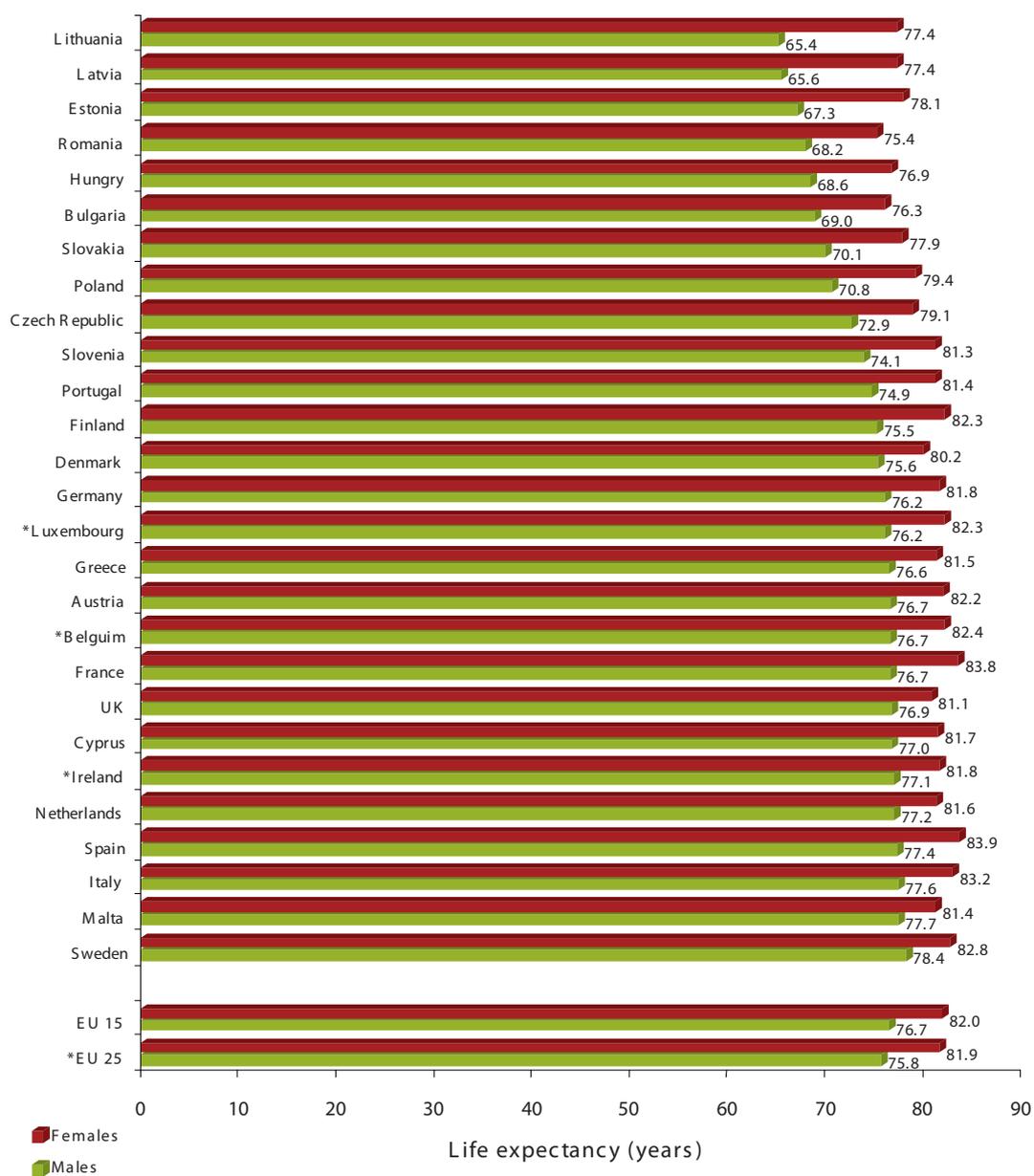
4.1 Life expectancy

Since the first life table compiled in 1926, the life expectancy of men in Ireland has increased by 20 years, so that today, at birth, men in Ireland have a life expectancy of 77.1 years (see *Figure 4.1*).^[3] Life expectancy for men in Ireland who are aged 65 is a further 16.8 years (i.e. 81.8 years), compared to 20 years for women (i.e. 85 years), and is slightly above the EU27 average (15.9 years).^[63, 64]





Figure 4.1:
Life expectancy at birth for males and females in 27 EU Member States, 2005



* Data are provisional Eurostat estimates.

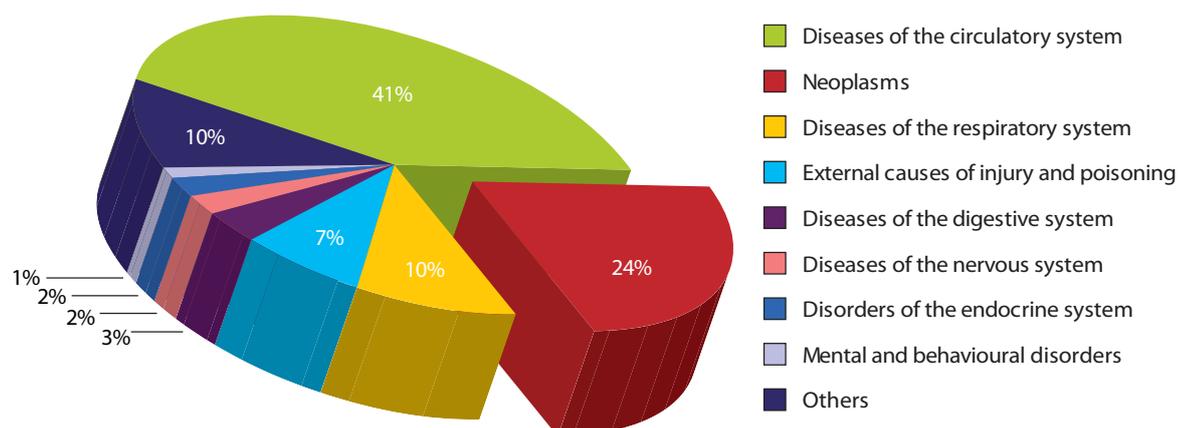
Source: CSO (2006)^[3]

There is currently no data available to examine life expectancy according to social class. However, based on data from England and Wales^[65], it is likely that life expectancy at birth for men in socio-economic group 6 (SEG 6) may be up to 8 years lower than that for men in SEG 1.

4.2 Mortality

Currently, 82% of all male deaths are as a result of a combination of circulatory diseases (41%), malignant neoplasms (24%), respiratory diseases (10%) and external causes of injury and poisoning (7%) (see Figure 4.2).^[4] Indeed, men in Ireland have the highest death rate among male Europeans for death due to diseases of the respiratory system.^[66]

Figure 4.2:
Causes of death among men in Ireland, by mean percentage, 1996-2005



Note: Death by external causes of injury and poisoning includes (a) suicide and self-inflicted injury; (b) road traffic accidents; (c) injury undetermined, whether accident or purposely inflicted; and (d) homicide and injury purposely inflicted by other persons.

Source: CSO (1996-2005)^[4]

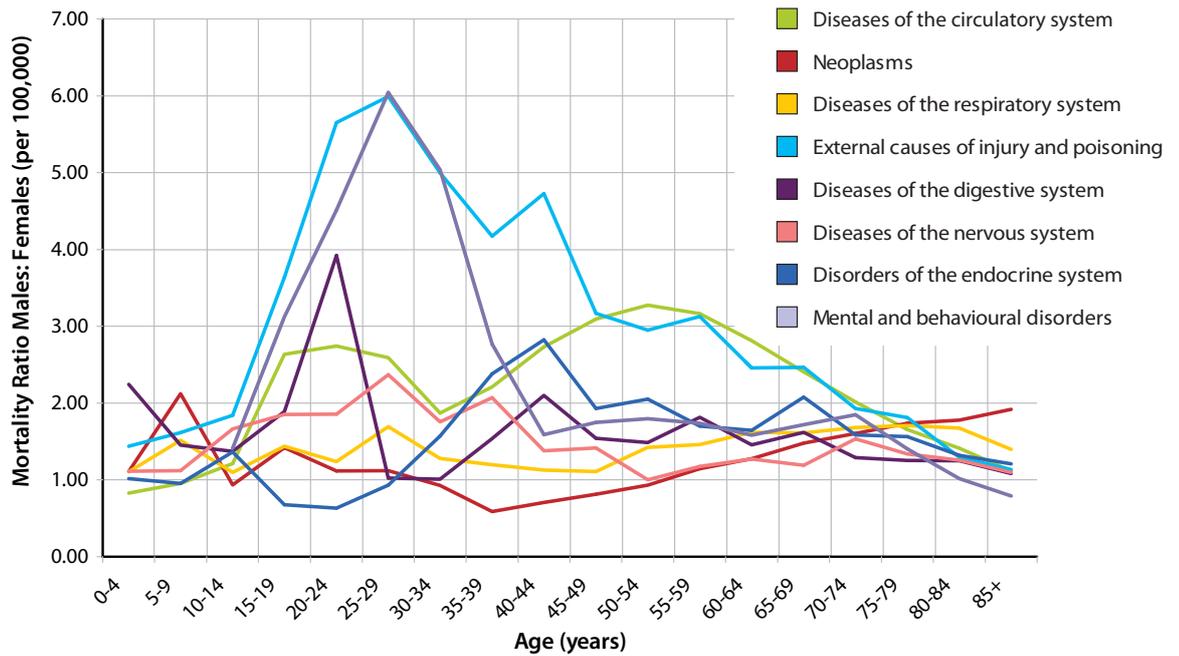
Since 1996, reductions in mortality rates for men have been demonstrated across a number of the leading causes of death^[4]; however, it is not possible to disaggregate this data according to socio-economic group (SEG) to assess whether health improvements have been experienced equally across SEGs. Significant increases, however, have been seen for the incidence of non invasive - cancers in men from 1994-2005, including prostate (7.1%) and kidney (3.7%)^[428], and this has resulted in increased deaths among men from these cancers.^[4]

In Ireland, men are more likely than women to die for all the leading causes of death and for all ages (see Figure 4.3).



Figure 4.3:
Mortality ratio of males:females per 100,000 of population for the 8 leading causes of death, 1996-2005

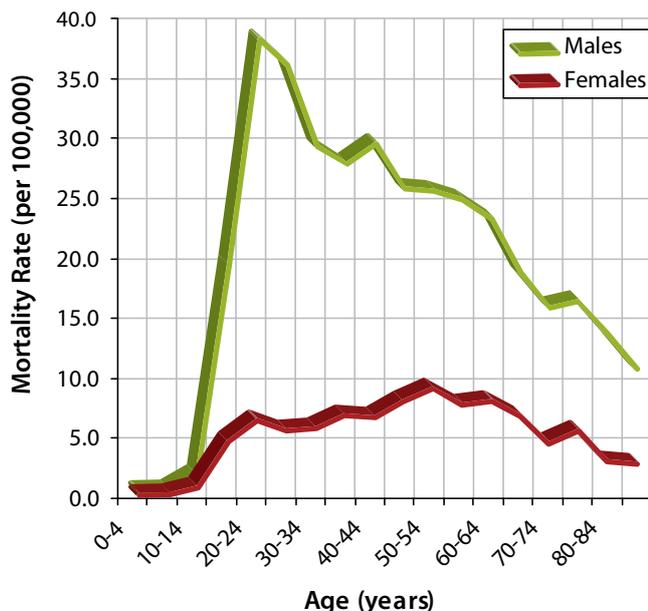
Note: Any value >1 is indicative of a greater number of male deaths.



Source: CSO (1996-2005, 2003, 2005)^[4-6]

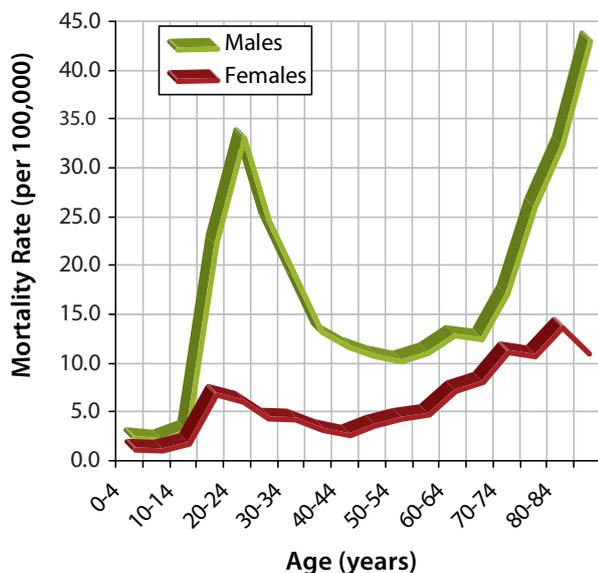
While the gap in male:female mortality for all causes of death is consistent across all age groups, it is most pronounced between the sexes aged 20-30 years, with men in this age group being approximately 3.5 times more likely to die than their female counterparts (see Figures 4.3, 4.4 and 4.5).

Figure 4.4:
Mean rate of death by suicide for all ages standardised per 100,000 of population, 1996-2005



Source: CSO (1996-2005, 2003, 2005)[4-6]

Figure 4.5:
Mean rate of death by road traffic accident for all ages standardised per 100,000 of population, 1996-2005*



* The data for elderly male deaths due to road traffic accidents (RTAs) should be viewed with caution since the low number of men in each category from 70 years skews the data presented in Figure 4.5. For example, at 85+ years, an average of only 6 men die from RTAs annually, in comparison to 58 men in the 20-24 age category.
 Source: CSO (1996-2005, 2003, 2005)[4-6]



Men in Ireland have experienced one of the fastest rising suicide rates in the world from 1980-2002 (2.7-fold).^[67] This rise has been most striking in young people (aged 25 years or under), who now have the second highest rate of suicide among the 30 OECD Member States.^[9]

An average of 391 male suicides are recorded each year, of which 48% are young men aged between 15 and 34 years.^[4] In addition, 55% of the 287 annual male deaths on Irish roads involve young men, aged 15-34.^[4]

Those in the lowest SEG carry a disproportionate burden of ill-health and mortality for all causes of death. For example, men in SEG 6 compared to those in SEG 1 are 3 times more likely to die from circulatory diseases^[68], 6 times more likely to die from respiratory disease^[68], 16 times more likely to die from alcohol abuse^[7], 17 times more likely to die from drug dependence^[7] and 4 times more likely to die from suicide^[69]. These poorer health outcomes may be attributable to a range of interrelated factors, which include lower educational attainment^[70], unemployment^[70, 71], poorer living conditions^[72], income inequalities^[72] and a lack of social capital within communities^[73-76]. For example, men in Ireland are 1.8 times more likely than women to discontinue second-level education and this gender gap is one of the highest reported by the 30 OECD Member States.^[77] Unemployed men in Ireland have a greater chance of remaining unemployed in the long term (for 6 months or more) than women^[78] and 61% of unemployed men in Ireland are at risk of poverty, after accounting for pensions and social transfers.^[79] Communities with high levels of unemployment are more likely to experience higher levels of crime and lower levels of social capital, thereby exacerbating risks to health (*see Chapter 10*).^[80] There is also evidence to suggest that men in lower socio-economic groups and men in minority groups experience poorer treatment within the healthcare system, which contributes to health disparities among men.^[81]

4.3 Morbidity

In 2003, it was estimated that men in Ireland could only enjoy, on average, 63.4 years of healthy living, free of disability and/or ill-health (Healthy Life Expectancy – HLE).^[82] This is lower than that reported for the average man in the EU15, at 64.5 years (data for the EU25 are not available). Given that men in Ireland have a life expectancy of 77.1 years (*see Figure 4.1*), this would suggest that for an average of 13.7 years of their lives, men in Ireland experience some form of ill-health or disability.^[82] Women, on the other hand, experience an average of 16 years of life with some form of ill-health or disability, which can be accounted for by their longer life expectancy (81.8 years on average).

This loss of almost 14 years of healthy life experienced by men in Ireland due to illness or disability comes at a cost. A man's inability to live a full and productive life is a considerable burden to the economy in terms of associated healthcare costs and loss of workplace productivity. There is also an immense personal cost to both himself and his dependants, with some studies showing that those in the lower SEGs may experience severe financial difficulty if the working male can no longer provide.

4.4 Health-related behaviours

4.4.1 Harmful use of alcohol

- Men in Ireland drink, on average, 14.3 litres of pure alcohol per annum – twice that reported for males among the countries involved in the European Comparative Alcohol Survey (ECAS).^[83] This figure is higher again for men aged 18-29 years (17.9 litres).
- 58% of all drinking occasions involve binge drinking (5 or more units).^[83] Those men with lower educational attainment and in lower SEGs are more likely to binge drink.^[1]
- Men in Ireland also experience more adverse consequences of drinking in comparison to their European counterparts, such as getting into a fight^[83], being in an accident^[83, 84] or engaging in unsafe sex^[83]. In fact, in 2003, 90% of drivers involved in fatal road traffic accidents, where alcohol was a contributory factor, were male.^[84]

4.4.2 Smoking

- 25% of men in Ireland currently smoke, although this figure rises to 46% (19-35 years) and 44% (36-60 years) when factored for age and to 52% when factored for age and socio-economic group (18-34 years and SEG 4).^[429]
- Unemployment is the strongest predictive factor of smoking among men.^[85]
- Compared to women, men tend to start smoking earlier, to smoke a greater number of cigarettes per day, to inhale more deeply and to smoke cigarettes without filter tips and that are high in tar and nicotine.^[11]

4.4.3 Illegal drug use

- Characteristics of a typical problem drug-user include being male, young and unemployed, having a low educational attainment and coming from an impoverished or deprived community.^[87-89]
- Men are up to 3 times more likely than women to use any illegal drug over their lifetime and over the last 12-month period.^[90]
- More than 1 in 4 people (27%) aged 25-34 reported ever using an illegal drug.^[90]
- Those with third-level education have a higher lifetime prevalence of cannabis and cocaine use^[91, 92], which is more likely to meet the criteria for recreational drug use, as opposed to problem drug use.

4.4.4 Physical activity and diet – Overweight and obesity

- The prevalence of overweight (46.3%) and obesity (20.1%) among men in Ireland^[93] is currently ranked 8th in the EU25^[94, 95] and is rising at a rate of 1% per annum^[96]. It is projected that 33% of men on the island of Ireland will be clinically obese by 2015.^[97]
- The proportion of obese men increases almost 5-fold between the age categories of 25-44 years.^[96]
- Men with third-level education and with professional occupations are least likely to be obese.^[96]
- Almost 20% of men 'hardly ever' make conscious efforts to try and eat healthily^[93],



while 15% consume fried foods more than 4 times per week^[96].

- Only 48% of men engage in some form of regular physical exercise^[96], with those reporting as sedentary almost doubling between the age categories of 18-29 and 30-39 years (9.9% to 18.3% respectively)^[1].

4.4.5 Sexual health behaviours and sexually transmitted infections

- 31% of males aged 18-24 years had their first sexual experience before the age of 17.^[98]
- 58% of men (specifically men aged 18-29 and those in SEGs 5 and 6) attributed alcohol consumption to having unplanned sexual encounters^[1, 98] and 54% of men reported that alcohol had contributed to them having sex without a condom^[99].
- In a study examining men's experience of crisis pregnancy, 23% of respondents had direct experience of a crisis pregnancy.^[40]
- Since 1989, the rate of reported sexually transmitted infections (STIs) in Ireland has increased 3.7-fold.^[100]
- Only 54% of men (aged 18 and over) have ever heard of Chlamydia^{1*} and only 37% have a good knowledge of it.^[98]

4.5 Risk behaviours

- Only 38% of men (aged 18 and over) 'always' adhere to speed limits while driving, while 15% and 52% of men do not always wear seat belts while travelling in the front or back of a car respectively.^[1]
- Men aged 18-29, those in SEGs 1 and 2, and those with third-level education are more likely to drive under the influence of alcohol and to speed.^[1]
- While 56% of men report using sunscreen 'infrequently' at best, men aged 18-29 and less educated men are more likely to expose their skin to the harmful effects of the sun.^[1]

4.6 Violence among men and domestic violence

- In 2005, 92% of violent crimes were committed by men.^[101]
- Men are also more likely than women to be the victims of homicide (85%) and serious assault (77%).^[78]
- The data on the prevalence of domestic violence experienced by men in Ireland is inconsistent^[102-104], but it is evident that domestic violence *is* experienced by many men.
- Men are less likely than women to report an incident of domestic violence (5% men compared to 29% women).^[102]

1 * Chlamydia is a widespread, often asymptomatic STI, caused by *Chlamydia trachomatis*, a major cause of non-gonococcal urethritis in men and pelvic inflammatory disease and ectopic pregnancy in women.

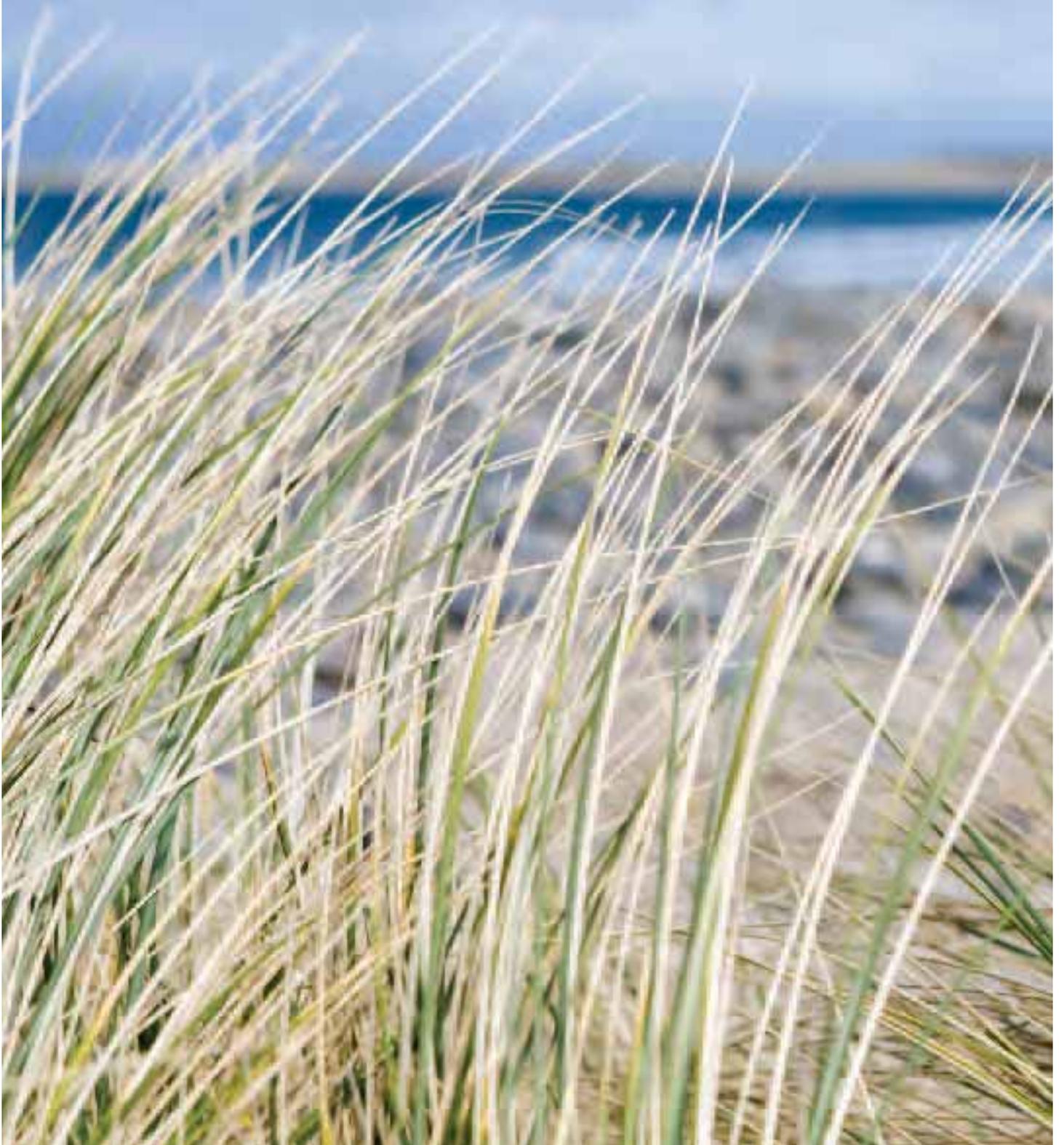
4.7 Summary

The data presented in this chapter highlight the current health profiles of men in Ireland. It is evident that men experience a considerable burden of ill-health and mortality, which is particularly pronounced for those men in SEGs 5 and 6, young men (aged 18-34 years) and subgroups of marginalised men.

The factors underpinning these statistics are complex and require multiple avenues of intervention at an individual, whole community and environmental/societal level. For example, unemployment is the strongest predictive factor of smoking among men, so therefore training and educational opportunities that support men to gain employment are recommended.

The approach that this policy takes to addressing these statistics and the theoretical and philosophical framework underpinning the approach is outlined in Chapter 2. While it is incumbent on this policy to support all men in Ireland to achieve optimum health and well-being, priority needs to be given to those men in our society who are most in need of this support. As a result, many of the programmes and services recommended are targeted at men in SEGs 5 and 6, men aged 18-34 years and subgroups of marginalised men.

Part II:
Framework for
National Men's Health Policy
in Ireland



5. Strengthening public policy on men's health

5.1 Structures to support an integrated and intersectoral approach to men's health

In formulating this policy, it was clear that there was a need for appropriate structures, both national and local, to be put in place to support and monitor its implementation on an ongoing basis. The consultation process also highlighted the absence to date of a structured and coordinated approach to tackling men's health, pointing to the need for an interdepartmental and intersectoral approach with support from all relevant stakeholders. This chapter provides a contextual backdrop to the development of a men's health policy in Ireland. Recommendations are made at the end of the chapter on the basis of the evidence presented.

5.1.1 Challenges facing men's health policy

Despite compelling evidence across the Western world on the gravity of health outcomes experienced by men, to date, Ireland is the only country to translate this increased focus on men's health into a national policy. An examination of why men's health has been slow to emerge on policy agendas elsewhere may flag some of the challenges in moving from the formulation of a men's health policy in Ireland to policy implementation.

Men traditionally seen as 'the privileged sex'

In a historical context, men have generally been seen to occupy a position of privilege relative to women.^[26] Unlike women's health, which evolved from a broader women's social and political movement, advocates of men's health policy lack such a broad, sustaining impetus.^[105] The relative absence of a 'men's movement' has resulted in the health needs of men not being represented at a political level from the ground up.

Health traditionally seen as 'women's business'

In most Western countries, women have traditionally occupied the roles of carer and nurturer, while boys tend not to develop the same self-nurturing attitudes and behaviours that girls do. The lack of male-targeted specialties (such as obstetrics or gynaecology) or healthcare programmes has hindered the surveillance capability for men's health problems and men's ability to identify as participants in healthcare.^[106]

Medical dominance

Despite some movement towards a broader determinants approach, the medical curative or 'diagnosis and treatment' model of health is currently the predominant framework within which health service providers operate in Ireland. This approach tends to overlook the broader context in which health problems occur. This policy adopts a social determinants (and gendered) approach to health, espousing the 'prevention' model, and the challenge therefore in the future is to develop this approach within the Irish healthcare system.

'Men's health' – not well understood

'Men's health' is often interpreted as male-specific health issues, such as prostate cancer.



There is a need to promote and market a broader and more holistic definition of men's health (*see Chapter 6, Section 6.1*) and this is clearly an important challenge for a men's health policy. This needs to be underpinned by ongoing work that strengthens the evidence base on best practice when working with men.

Absence of training and declining numbers of male workers in education and caring professions

There has been a general absence to date of training for service providers in Ireland on how to engage effectively with men. Indeed, men are often seen as 'hard work' by health service providers, which in the past may have resulted in the prioritisation of scarce resources to areas other than men.^[24] There is also a growing absence of male workers in the education and caring professions. Addressing each of these factors has a significant role to play in the overall implementation of the policy (*see Chapter 7*).

Need to account for gender in a 'person-centred' approach to health

While a focus on gender is implicit in a 'person-centred' approach to health^[55], the reality of a curative system-based approach is that gender is often overlooked. The challenge facing this policy is to ensure that a gendered approach to men's health is not overlooked in the context of a person-centred health system.

5.1.2 Overcoming the challenges

In order to overcome these challenges and to ensure that this policy is effectively implemented, it is critically important to put in place appropriate structures and to establish a strong support base to sustain men's health policy in Ireland in the future. These structures are necessary from both an overall strategic perspective and in terms of policy implementation on the ground. They are particularly important in the context of the following:^[60]

- Successful policy initiatives require effective communication, collaboration and coordination across agencies and with key stakeholders, and are dependent on multiple avenues of intervention targeted at different levels – local, regional and national, as well as individual, whole community and environmental level. The putting in place of appropriate structures is therefore crucially important to enable such policy initiatives to happen. This can be further enhanced by a 'whole of government' approach to policy development and implementation.
- Leadership is also an integral aspect of successful policy implementation and has a crucial role to play in developing mutual trust between the various parties. The putting in place of structures to implement this policy is necessary to facilitate clear top-down and within-sector leadership, as well as a clear delineation of roles and responsibilities for each agency in accordance with the agreed action plan (*see Chapter 11*).
- The putting in place of structures for men's health is necessary to provide a stable base of support and to provide sustainable mechanisms and resources to implement the policy and action plan.
- Finally, appropriate structures are necessary to ensure that specific plans and resources are in place from the outset in order to monitor and evaluate the implementation of the policy and action plan.

The structures proposed by this policy to support an integrated and intersectoral approach to men's health in Ireland are outlined in Figure 5.1, which proposes specific roles for both the Department of Health and Children and the Health Service Executive (HSE).

The Department of Health and Children will have responsibility for:

- Implementing the policy at an interdepartmental level;
- Working in partnership with the HSE, Equality Authority and other relevant Government departments to develop a framework for gender-mainstreaming men's health across all Government departments in line with international models of best practice^[34, 35] and in a way that is consistent with the development of a National Equality Strategy Framework^[107], as called for in the National Action Plan for Social Inclusion^[50];
- Monitoring and evaluating the policy;
- Providing ongoing support for research into men's health.

The HSE will be responsible for the development of an Implementation Group to oversee the implementation of the policy.

- This group will liaise closely with the Department of Health and Children and with the Community and Voluntary sectors.
- With regard to specific recommendations made throughout this policy, the Implementation Group will liaise directly with the lead agency identified for each recommendation and proposed action. Such an approach should give due regard to the development of clear, time-framed performance indicators and health outcomes for men's health that are consistent with the recommendations and actions identified in the policy's action plan (*see Chapter 11*).
- This approach can also build effectively on existing structures and staffing that have been developed in the area of men's health in recent years, with the primary focus being on the integration of men's health into existing structures and services, rather than on the development of a separate 'canon' of men's health.
- The implementation of the policy should be carried out in accordance with the standards set by the Health Information and Quality Authority.



Figure 5.1: Proposed structures to support the National Men’s Health Policy and Action Plan

5.1.3 Conclusions and Recommendations

- The successful implementation of this policy needs to take account of the factors that have impeded men’s health reaching policy agendas in the past.
- It is important that the structures underpinning the policy are developed in accordance with best practice in relation to policy development^[60] and that they reflect the theoretical and philosophical framework underpinning men’s health as proposed in Chapter 2.
- In order to ensure that the targets set out in the policy can be achieved, the Department of Health and Children and the Health Service Executive (HSE) should create the impetus for appropriate structures to be put in place and for the appropriate re-orientation and integration of existing resources and services.

With due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

SA5.1 Develop appropriate structures for men’s health at both national and local level to support the implementation of the policy and to monitor and evaluate its implementation on an ongoing basis (see Figure 5.1).

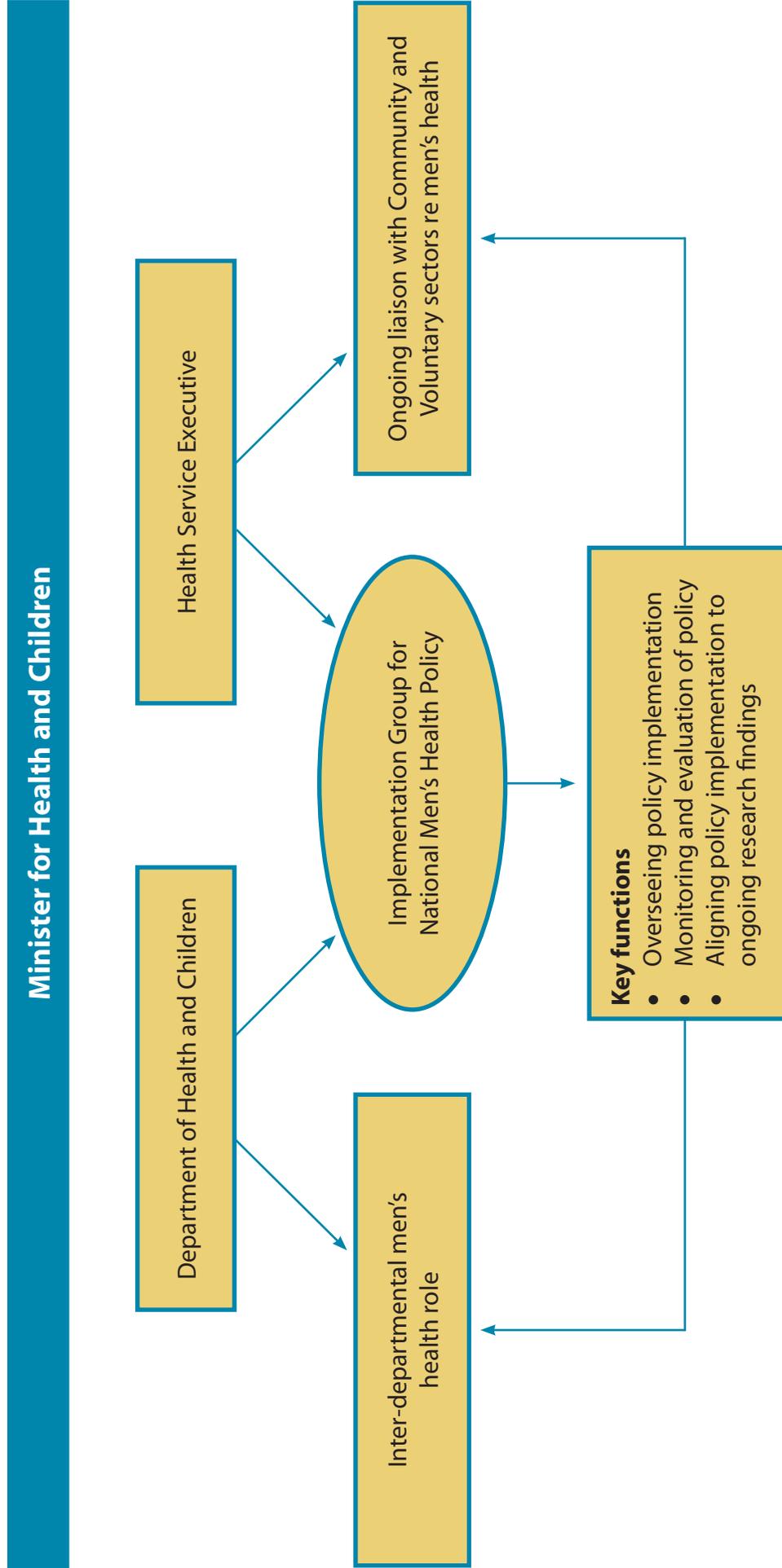
RECOMMENDATIONS		Lead Agency
R5.1.1	Oversee the implementation of the policy at an interdepartmental level and monitor and evaluate policy outcomes on an ongoing basis.	Dept. of Health and Children HSE
R5.1.2	Establish appropriate structures and secure resources to support the implementation of the policy.	Dept. of Health and Children HSE Other relevant Government depts.

See Actions A5.1.1 – A5.1.2 (1-5) in Part III: Action Plan

5.2 Research and information

In formulating this policy, it was clear that there was a need to strengthen the evidence base in relation to men’s health in Ireland. The consultation process called for increased funding for both clinical and applied research in the area of men’s health. The absence was noted of a dedicated research centre that would promote an increased focus on research into men’s health and that would actively seek funding for that research from existing sources. The following section presents a rationale for an increased and more integrated focus on such research in Ireland.

Figure 5.1 Proposed model to monitor and support the implementation of the National Men's Health Policy





5.2.1 Strengthening the evidence base on men's health in Ireland

While some important research work on men's health has emerged within Ireland in recent years^[1, 2, 108], there is clearly more to be done in terms of establishing a stronger evidence base to support the ongoing development of policy and services for men. Chapters 6 to 10 highlight a broad range of international research findings that have influenced policy and service delivery measures on different aspects of men's health in other countries. For example, research findings in relation to the provision of more 'male-friendly' and outreach primary care services have had an important bearing on the targeting of primary care services to men in the UK (*see Chapter 8*). Such findings highlight the deficit that frequently exists within an Irish context and the need for a more concerted effort to broaden the research base on men's health in Ireland in the years ahead.

There is therefore a need to develop a National Men's Health Research Framework and Network that will develop a strategic and coordinated approach to research work on men's health in the years ahead. This is of particular importance in order to establish baseline measures across different aspects of men's health that can be monitored to evaluate changes in men's health status over time.

In order to meet these requirements, this policy endorses the need for a Centre for Research and Development in Men's Health to be established within Ireland. Such a Centre would facilitate the development of more interdisciplinary research on men's health. In the context of this policy's broad determinants approach, this could lead to the linking of biomedical and epidemiological research with social science research. A stronger research focus on the gendered aspects of men's health, and on the interaction between gender and factors such as social class and education, could lead to a better understanding of disparities in health outcomes between different subgroups of men. Ultimately, such research would help to inform policy interventions that address the causal pathways relating to such disparities in health outcomes. The Centre would also ensure that research findings are disseminated in an appropriate way to inform best practice for service providers. In addition, it would promote an increased focus on men's health in the delivery of undergraduate and post-graduate health and allied health courses within Ireland.

5.2.2 Translating research into policy and practice

The issue of engaging men, particularly those subgroups of men who are disproportionately affected by ill-health, needs to be addressed by locating increased research initiatives in the community, workplace and other settings where men feel at ease and where those men in most need are targeted. Good practice may also be developed through pilot programmes that can be adopted elsewhere. One practical way of addressing this would be the building-in of research budgets, or seeding grants, to the overall funding of Community Development Projects. Statutory agencies awarding research funding should also include men's health in their funding programmes and qualitative, applied research proposals piloting service provision and

support services for men should be prioritised. The need to consider the gendered nature of men's health also has implications for new and existing policy, both within and outside the health arena. A gendered approach to policy is required to safeguard against the specific needs of men being overlooked.

5.2.3 Conclusions and Recommendations

- There is clearly a need to broaden and expand the research base on men's health in Ireland. A crucial first step in this regard is the development of a National Men's Health Research Framework and Network.
- In order to facilitate this, it is proposed that a Centre for Research and Development in Men's Health^{1*} be established, to be run on an initial pilot basis for 3-5 years. It is proposed that the Centre would be based in an academic institution (the housing costs to be borne by the institution) and that external funding would be sought for two research posts and a 'start-up' research budget. (Consideration could also be given to a public/private partnership model to fund such a Centre.) Once established, the proposed Centre would actively compete for research funding from existing sources in which research funds are disseminated. It is imperative that the Centre would develop close working links with local HSE and community/voluntary agencies.

With due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

SA5.2 Promote an increased focus on men's health research in Ireland.

RECOMMENDATIONS		Lead Agency
R5.2.1	Establish a Centre for Research and Development in Men's Health.	Dept. of Health and Children
R5.2.2	Ensure that research continues to underpin the implementation and evaluation of the policy.	Dept. of Health and Children HSE

See Actions A5.2.1 – A5.2.2 (1-3) in Part III: Action Plan

1 * A similar Research Centre has been running very successfully for a number of years at the University of Western Sydney, Australia (see <http://menshealth.uws.edu.au>)



6. Promoting men's health: Marketing, health information and programmes

In formulating this policy, it was clear that there was a need to promote and market a more holistic and positive view of men, masculinities and men's health. Throughout the consultation process, attention was drawn to the need to challenge what were perceived to be negative and stereotypical portrayals of men and masculinity, particularly in the media and popular press, and to de-stigmatise so-called 'taboo issues', such as depression or erectile dysfunction. The consultation process also highlighted the importance of enabling men to access appropriate health information, disseminated through innovative and accessible media that take account of the needs of different populations of men. The Internet was seen as a potentially valuable resource for the provision of such targeted health information and support to men.

The consultation process also highlighted the relationship between health behaviours (physical activity and dietary habits, stress management, drug use (alcohol, tobacco and illegal drugs), sexual health behaviours and risk behaviours) and health outcomes for men. It was considered important to account for the influence of gender when supporting men to adopt healthier behaviours. The absence of health promotion initiatives that specifically target men was also cited. This chapter presents the current evidence on these issues and makes recommendations on the basis of the evidence provided.

6.1 Marketing men's health

6.1.1 Challenging contemporary stereotypes of men and masculinity

Much of the spotlight on men's health in the media and popular press has tended to focus on the 'problem' with men and to reinforce stereotypical male images that link masculinity to power and dominance.^[109] Violence and aggression have come to be seen as normal and natural expressions of masculine identity. In more recent times, men have been portrayed in both the media and children's picture books as clumsy father figures, inept at parenting and household skills.^[110] This rather deficit-based, men 'in crisis'^[111] or 'men behaving badly'^[59] approach to masculinity and men has tended to implicate boys and men as the instigators of their own adverse health outcomes, without giving due consideration to underlying contextual factors or to the social determinants of men's health.

There has also, in recent years, been a strong consumerist focus on men's health in the media and popular press, particularly in the portrayal of the idealised male body. The Internet, too, hosts an array of websites dealing with a similar agenda on 'men's health', while many others, driven by the pharmaceutical industry, promote treatments for male-specific health issues, such as erectile dysfunction. This tends to reinforce an understanding of men's health as being primarily constituted by diseases of the male reproductive organs. Men's self-help books, and even health promotion literature, also reinforce stereotypes of masculinity.^[112]



6.1.2 Promoting a more positive and holistic image of men's health

In light of this pattern of negative and stereotypical portrayals of men, masculinity and men's health, there is clearly a need to promote a more positive and holistic image of men's health. It has been proposed that social marketing campaigns offer the greatest potential for addressing a variety of health concerns relevant to men.^[113, 114] For example, the use of personal testimony by prominent men (e.g. sports stars) could be used to challenge unhealthy social norms among men more generally. Similarly, increased strategies that focus on reducing stigma and normalising 'taboo' subjects (e.g. depression, erectile dysfunction) could be used to bring about changes in men's resistance to seeking help for such health problems. Such strategies need to clearly show that by taking charge of their health and by seeking help in a timely fashion, men can maintain or regain their potential productivity, vitality and strength.^[106]

Social marketing campaigns must adopt the recognised 6-stage approach, namely:^[115]

1. Develop plans and strategies using behavioural theory.
2. Select communication channels and materials based on the required behavioural change and knowledge of the target audience.
3. Develop and pre-test materials.
4. Implement the communication programme or campaign.
5. Assess effectiveness in terms of exposure and awareness of the audience, reactions to messages and behavioural outcomes.
6. Refine the materials for future communications.

Audience segmentation should be a key factor in any campaign to target subpopulations of men effectively.^[115]

Maintaining media interest in men's health also needs to be underpinned by good quality information from a range of reputable sources.^[116] The promotion of men's health as an important social issue also depends greatly on the profile of men's health in public debate and in Government research and policy formulation.^[117]

6.2 Targeting health information to men

Previous health strategies in Ireland^[118-120] emphasise the importance of appropriate and targeted consumer health information. The literature points to a 'knowledge deficit' in Irish men's knowledge of basic health issues^[1], which has been associated with men delaying to seek help from a medical practitioner because of failing to recognise symptoms of serious ill-health^[10, 121]. Conversely, there is strong evidence, both in Ireland^[122] and elsewhere^[123, 124], that cancer awareness campaigns targeted at men are associated with increasing their knowledge about cancers, which is an essential element of enabling early recognition of symptoms and prompt help-seeking.

Shortcomings have been highlighted on the effectiveness of existing health information targeted at men.^[125] This fact emphasises the need for a thorough evaluation of the

effectiveness of written health education and promotion materials to be carried out in the context of men in Ireland, including the media used to present health messages and the social and cultural contexts in which they are presented.^[1]

The literature indicates that men have a preference for health services that are less formal, easy to access, anonymous and confidential.^[24, 126] There is also evidence that the provision of such facilities may act as a 'stepping stone' towards the use of primary care services.^[127] The use of existing reputable men's health websites is evidence of men's 'appetite' for an interactive, electronic health advice service.^[126] With the Internet, the same message can be produced at different levels of complexity, tailored to attract different socio-economic groups and meet different literacy levels.^[128] Similarly, the use of help-lines has been shown to have a special appeal for men. For example, 'Mensline Australia'^[129] provides confidential counselling, information and referral, primarily for men with family and relationship concerns; the ongoing high demand for the service bears testimony to the potential for such a service to be provided in Ireland.

6.3 Health promotion programmes for men

Health and risk-taking behaviours differ considerably between the sexes, with males often displaying fewer positive health behaviours and more risk-taking behaviours than females (see Chapter 4, Sections 4.4-4.5). Gender is one of the most important determinants of health behaviour.^[130] Men who adopt more traditional attitudes about manhood tend to have greater health risks than men with less traditional attitudes, and this holds true regardless of education level, race or ethnicity.^[11] Therefore, in order to support men to adopt healthier behaviours, there is a need to consider how behaviours that are damaging to health can, in effect, be active expressions of masculinity. In other words, there is a need to examine how such behaviours can be repeatedly used either to 'prove' one's masculinity (e.g. binge drinking) or to avoid the ridicule of being labelled 'weak' or 'effeminate' (e.g. dieting). A man's health behaviours are also determined by broader factors such as age, social class and income level, with young men and those in lower socio-economic groups (SEGs) often displaying poorer health behaviours.

Such traditional male attitudes were expressed by various participants in Phrase 2 of the consultation process, for example: *'It's for the same reason as we learned as a child, don't play with dolls. Play with toy guns instead or something. It's the same thing going on in your head, that's all. And if you were any different than that, at least in the house I grew up in, you were told, "Ah you're like an old woman" ... I mean, probably by the time all of us was two or three years of age ... you knew that you were male anyway.'*

Government policies have been developed that address a broad range of health and risk behaviours at a population level that are discussed here.^[57, 95, 131-140] Apart from the recent HIV and AIDS Education and Prevention Plan 2008-2012^[432], a sexual health strategy has not been developed at national level to date. Existing policies have, traditionally, overlooked gender as a key variable in health and risk behaviours. Consequently, while this men's health policy endorses the full implementation of existing policies in these



areas, it calls for the adoption of a gendered approach to their implementation. Gender must also be accounted for in the monitoring and evaluation of these policies. Evidence supporting the need for such an approach is presented below.

6.3.1 Diet and physical activity – Overweight and obesity

a. Diet

The consultation process highlighted a number of issues relating to the dietary habits of men in Ireland. These include poor dietary behaviours in general, a lack of nutritional knowledge and a lack of control over food choices.

Some 19% of men in Ireland ‘hardly ever’ make a conscious effort to eat healthily^[93], with men in SEGs 5 and 6 reporting a poorer diet than men in SEG 1^[96]. Many men also have poor nutritional knowledge^[141] and tend not to know the nutritional content of foods^[142], a factor that would significantly impact, in particular, on the dietary habits of single men living alone^[143]. For many men in relationships, the purchasing and preparing of food are more likely to be the responsibility of the women in their lives and consequently they lack control in terms of food choices.^[144] It has also been well established that men who endorse more traditional beliefs about masculinity will reject the notion of ‘healthy eating’^[145, 146] and healthy-eating messages^[143, 146]. Such men also tend to eat larger meals at a faster rate^[147] and to eat more meat and less fruit and vegetables than women^[146, 148].

According to the National Task Force on Obesity^[95], all State agencies and Government departments are responsible for developing, prioritising and evaluating schemes and policies that encourage healthy eating (Recommendation R1.2). This is reflected in the identification of 94 recommendations across a number of sectors – including education, social and community, health and physical environment – which are the responsibility of a variety of different Government departments and agencies. Those involved in the production and supply of food were also named as key stakeholders in the implementation of this policy.

Given the level of nutritional knowledge among men, education may be a significant factor in supporting healthy eating among men. There is also a need for all stakeholders to challenge the traditional stereotype that ‘healthy eating’ is predominantly a female behaviour. Therefore, any dietary intervention targeting men must account for male gendering if it is to be effective. There is evidence that health information that emphasises personal choice and responsibility, and that contains explicit information on how to change diet has been shown to be well received by men.^[143] Such information should also portray very appetising healthy foods in large portions that appeal to men.^[143]

b. Physical activity

The consultation process raised the issue of an overemphasis for boys and men on competitive sport in Ireland. A lack of opportunities for men and boys to participate in physical activity for social and health benefits was also highlighted and named as a

factor in youth drop-out and early retirement from activity among men in Ireland.

For men, sport and exercise are seen as being more relevant for health than diet^[141] and therefore men are more likely to engage in physical activity to improve their health as opposed to restricting their diet^[149]. Unlike women, however, men tend to engage in more vigorous forms of physical activity, ones that will increase their muscularity (e.g. high-resistance training)^[150] because they perceive that muscularity will enhance their feelings of masculinity, confidence and improve their attractiveness^[151, 152]. Men also tend to engage in sports that are physically dangerous^[153, 154], to take greater risks in sport than women do^[155] and consequently to suffer more sporting injuries as a result^[156].

For many men, the transition from their 20s to their 30s is signified by becoming sedentary.^[1] As one participant in Phase 2 of the consultation put it, *'So when you actually finish playing, through injury or retirement, the natural thing is to do the next thing ... just give up and concentrate on family or building a house or something'*. Factors that contribute to this sedentary lifestyle in later years include an inability to maintain more youthful levels of physical fitness and sporting performance, and the difficulties associated with maintaining a work – life balance. The limited recreational facilities throughout the country may also be a contributing factor to non-participation and early drop-out (see Chapter 9, Section 9.4). Given the potency of physical activity as a defence against all of the chronic illnesses associated with modern living, it is imperative that men and boys are supported to remain at least moderately active throughout their entire lifespan.

A key focus of the National Task Force on Obesity is the promotion of active living.^[95] All Government departments and State agencies have a role to play in this. In particular, the physical environment, in terms of where men live, work and play, was identified as a key resource for physical activity. For example, the provision of opportunities during working hours to engage in physical activity – opportunities such as flexible working hours, reduced rates for gym membership, incentives for cycling or walking to work, access to shower and changing facilities – would all support many men who struggle to be active while trying to maintain a work – life balance (Recommendation R6.16).

When promoting active living among young men, the social benefit of being active should be emphasised. For older men, the intrinsic value of staying active to maintain strength, power, virility and good health should be highlighted. National governing sporting bodies should also be supported to provide a range of activities for men who retire from competitive sport.

c. Overweight and obesity

Male obesity poses a specific challenge to health professionals in Ireland. The male perception of weight status tends to associate a large muscular body frame and general 'bigness' with good health, physical attractiveness, masculinity, status, confidence and success.^[157, 158] Consequently, many men strive for 'enlargement' and may be unable to



distinguish between a healthy and an unhealthy weight. Indeed, only 22% of men in Ireland consider themselves to be overweight, with none identifying themselves as obese. This, despite the fact that 46% of the male population is currently overweight, with a further 20% in the obese category.^[122]

One of the high-level goals of the National Task Force on Obesity^[95] is to empower individuals to tackle overweight and obesity, and to develop sensitive interventions that support them to do so. In order to empower men to manage their weight, the traditional perception of weight status among men must first be challenged through the provision of appropriate information. Gender-competent weight management programmes for men should also be developed. In other countries, effective weight loss programmes for men have focused on giving information and instruction on how to become active, regularly measuring weight changes (most effective when gadgets are used, such as a skin-fold callipers) and demonstrating tangible changes (e.g. filling 1kg sand bags) when monitoring weight loss.^[142, 159, 160] Such weight loss programmes may be delivered through health promotion initiatives in such settings as the workplace or as part of an overall community-based GP referral programme. Health professionals should also be given gender-specific brief intervention training to support men to manage their weight.

6.3.2 Stress management

Stress was identified as a significant threat to the health of men in Ireland throughout the consultation process. In particular, it was felt that there was a lack of recognition in society of the prevalence of stress among men, that there were significant barriers preventing men acknowledging stress and that the coping mechanisms adopted by many men to deal with stress were poor.

Some 31% of men in Ireland 'regularly' or 'constantly' experience stress and almost 20% of men are either 'somewhat' or 'completely' ineffective at managing stress.^[1] A man's capacity to manage stress effectively decreases the lower his socio-economic group, and this causes great harm to his health.^[161] Problems relating to stress or mental health pose a clear threat to a man's masculinity and consequently many men choose to self-care and to remain stoic rather than to seek help.^[1, 156, 162, 163] Alcohol and other such drugs are used by some men as coping mechanisms for stress since they are seen as more masculine ways of coping.^[164, 165] Taking medications, on the other hand, can be viewed as a sign of weakness.^[163] Men are also slower than women to recognise a mental health problem^[166] and therefore poor stress management among men may also be due to an inability to recognise the symptoms of stress.

A typical view expressed during the research that informed this policy^[1] was: *'I would not tell anyone that I was depressed ... I'd just hold it back in there and go on about my business.'*

In light of the impact of stress on health, coupled with the current suicide rate among young men in particular, there is an urgent need to support men to cope effectively with stress. The National Suicide^[131] and Mental Health^[136] Strategies outline a clear

framework for suicide prevention and mental health service provision that will support men who experience stress in their lives. In particular, the development of alliances with the media and the development of a positive mental health promotion campaign to reduce the stigma of mental health problems are important to encourage men to seek help (Recommendations R9.4^[136] and R10.1^[131]). Targeted support for young men is also essential to support this vulnerable group in our society (Objective 20^[131]). In fact, mental health promotion should be available for all age groups (Recommendation R2^[136]) across all settings^[131]. Therefore, a partnership approach between relevant stakeholders should be central to any intervention; a good example of such an approach working is the Department of Education and Science and the Department of Health and Children in the delivery of Social, Personal and Health Education (SPHE) to schools. The workplace is also a key setting in which to address stress among men (see *Chapter 9, Section 9.3*).

6.3.3 Harmful use of drugs

a. Alcohol

The consultation process highlighted a number of issues relating to the harmful use of alcohol among men in Ireland. As one participant said, during Phase 1 of the consultation, *'If I can't skull 16 pints, I'm not a real man'*. It was acknowledged that the way in which men in Ireland drink (excessive and binge drinking) is problematic and has very serious consequences not just for the man himself, but also for his family. The consultation process also highlighted that drinking for many men is an expression of masculinity and that this should be considered when supporting men to change their drinking behaviour. The strong alcohol culture in Ireland, particularly in the sporting arena, was highlighted for its role in the harmful use of alcohol among men. The use of alcohol to cope with mental health problems (see *Section 6.3.2 above*) and the lack of alcohol-free alternative spaces for recreation (see *Chapter 9, Section 9.4*) were also raised.

Alcohol use can be a significant factor in demonstrating or proving one's masculinity and this is especially true for young men. Some would argue that alcohol use is, in fact, symbolic of being male^[167] and that heavy and persistent drinking behaviour, in particular, is often used as a very public display of allegiance to male peer groups^[1]. The targeted advertising of alcohol and the sponsorship of sporting events by the drinks industry have contributed to nurturing this association.^[167, 168] Currently, alcohol sponsorship of sporting events is the norm in Ireland and very strong and traditional masculine overtones are prominent in many campaigns used to promote these events.

The Strategic Task Force on Alcohol, in its two reports dated 2002 and 2004, identified 10 key areas to address the issue of alcohol in Irish society.^[132, 133] In 2006, a Working Group on Alcohol Misuse, representing the partners of *Sustaining Progress*, built on the work done by the Strategic Task Force by identifying 11 key areas for targeted action to address alcohol misuse in Ireland.^[139, 169] The recommendations of the Working Group on Alcohol Misuse will be implemented as part of the current Programme for Government.

^[169]



With respect to alcohol consumption among men, the following should be considered:

- The need to control the promotion of alcohol through sports sponsorship has been identified (Recommendation R2.2^[133]) and this is particularly relevant for alcohol consumption among men. National governing sporting bodies should be supported to find an alternative to alcohol sponsorship and, in that regard, the joint GAA/HSE Alcohol Programme is an important development.
- Most men who drink excessively still do not appear to consider their drinking behaviour to be problematic^[1], nor do they associate their level and pattern of alcohol consumption with potential health outcomes^[170]. There is therefore a need to tackle community 'norms' via a multilevel approach (Strategic Area S3^[133] and Action A1^[139]) and, in doing so, to emphasise the damaging effects of alcohol misuse on health among men in our society. Any community mobilisation initiative should also seek to challenge the association between harmful drinking and masculinity. In particular, the negative effects of alcohol on sexual and sporting performance should be emphasised to young men through alcohol-awareness campaigns (Strategic Area S6^[133] and Action A3^[139]). The health promotion campaigns proposed, as part of the Programme for Government in relation to Alcohol (2007)^[169], should adopt a gendered approach and be evaluated in order to establish best practice in Ireland.

b. Illegal drugs

The impact of illegal drug use on men in Ireland, and in particular on male prisoners and homeless men (as well as their immediate families and the wider community), was highlighted in the consultation process for this policy. The association between drug use and male suicide was also raised, as was the need to support men to manage their drug problem.

Illegal drug use can be categorised as either occasional (experimental and/or recreational) or problem (opiate use and where an individual has sought treatment for their drug use). In comparison to women, men in Ireland are more likely to engage in both occasional^[90] and problem^[87-89] drug use. Problem drug use, however, is often initiated through a recreational habit, with many problem drug users citing cannabis as their primary drug of use.^[87] The typical profile of a problem drug user in Ireland is a young male who is unemployed, has a low educational attainment and comes from an impoverished or deprived community.^[87-89] Problem drug use (including the harmful use of alcohol) has been associated with psychological problems and psychiatric illness (dual diagnosis)^[171], suicide, criminality^[172-176] and homelessness^[177], and all these factors are inextricably linked.

The National Drugs Strategy was developed around the four pillars of supply reduction, prevention, treatment and research.^[134] Local Drugs Task Forces (LDTFs) have been established to ensure a coordinated approach to the prevention and treatment of drug misuse at local level via interagency cooperation and community involvement. The proposed development of the range of projects undertaken by the LDTFs, as part of the Programme for Government in relation to Drugs (2007)^[169], is significant. According to

the National Advisory Committee on Drugs, projects for the prevention of drug misuse should be integrated with social inclusion measures, such as the prevention of early school-leaving and the provision of educational opportunities in disadvantaged areas (e.g. Youthreach projects run by the Department of Education and Science^[178]). This is particularly relevant for young men, who are 1.8 times more likely to drop out of formal education than young girls.

Drug prevention programmes can be delivered in a variety of settings, such as schools, youth clubs, community centres and in workplaces.^[178] It is essential that participants of such programmes are actively involved rather than merely passive recipients of information. In that regard, the Social, Personal and Health Education (SPHE) programme, currently running in schools up to Junior Certificate level, is consistent with best practice. It is also worth noting that sensation-seeking underpins illegal drug use for many men, and occasional drug use among young men in particular.^[179] High sensation-seekers tend to have a lower perception of risk and to underestimate their susceptibility to risk.^[180] Consequently, they do not realise the possible negative outcomes of their behaviour. There is therefore a need to target young men in pilot drug prevention programmes that challenge the association between drug use and sensation-seeking.

c. Smoking

The consultation process highlighted that while advances have been made in recent years in generating a downward trend in smoking among men, further progress must be made in the future. Another area of concern raised during the consultation was the use of smoking by many men as a means of coping with stress.

There is a lack of awareness among men that smoking is the most frequent cause of death in Ireland^[181] and that smoking can cause erectile dysfunction^[182], which itself is often a symptom of a more serious condition^[182, 183], such as vascular disease. Younger men, those on lower incomes and those with lower educational attainment are not only more likely to smoke^[96], but are also more likely to underestimate the relative importance of smoking as a cause of death^[181]. Gender also plays an important role in tobacco use, hence its prominence in tobacco promotion.^[184] For example, smoking may be an expression of masculinity for many men^[185], young men in particular^[186]. Therefore, to ignore gender in tobacco policy would be a significant oversight.^[184, 187]

The report of the Tobacco-free Policy Review Group outlines a comprehensive, multisectoral approach to tobacco control in Irish society.^[137] With respect to changing attitudes (Policy Objective 1) and supporting and empowering individuals to quit smoking (Objective 2), specific focus needs to be placed on raising awareness among men of both the general health effects of smoking and the male-specific effects. This can be done through existing smoking-cessation programmes and social marketing campaigns. Men attending maternity services with pregnant partners should also be supported to quit smoking. This policy also focuses on children for targeted action via a multilevel approach (Objective 4). Any intervention aimed at children should address



the current association between smoking and masculinity in order to protect young boys from starting smoking.

6.3.4 Sexual health behaviours

According to the consultation process, many young men engage in risky sexual health behaviours that stem from a lack of sexual education and peer group pressure to be sexually active. The consultation also highlighted that the issue of sexuality and sexual orientation is not discussed with young men; this can be a source of stress and may even be a factor in young male suicide.

Sexual achievement and sexual conquest^[188] have been identified as markers of masculinity, whereby a man is judged by both numbers of sexual 'conquests' and by his sexual performance^[189]. Peer pressure that is placed on many young men to initiate sexual activity can be intense^[190] and many young men feel that they cannot say 'No' to sex^[191]. Young men in Ireland believe that they, rather than females, should lead, direct and know how to act in sexual encounters.^[192] They also fear being jeered by their peers if, for example, previous sexual partners express negative opinions about their sexual prowess or if it became public knowledge that their sexual experience was limited.^[193] Coupled with this pressure to be sexually active, sex education and information is poor among many men and the use of condoms is neither widespread nor consistent.^[40] Both of these factors have been shown to play a significant role in unplanned or crisis pregnancies.^[40]

Heterosexuality is synonymous with more dominant expressions of masculinity and this can have a significant impact on young men who are unsure of their sexuality or who are gay, bisexual or transgender. A study in Northern Ireland^[431] found that homophobia was directly related to suicide attempts in about one-quarter of young gay men under the age of 25, which would suggest that targeted support is required for this vulnerable subgroup of young men.

Apart from the recent HIV and AIDS Education and Prevention Plan 2008-2012^[432], there is currently no national sexual health strategy in Ireland to address the sexual and reproductive health needs of the population. However, many agencies do play a role in sexual health promotion and it is important that these agencies challenge the association between traditional masculinity, sexual performance and sexual conquests among men in the future. Research should be carried out to investigate how to support men in moving away from traditionally masculine sexual practices to healthier practices.^[40] It is also incumbent on all stakeholders to deliver and evaluate sex education programmes, from primary school onwards, that teach boys about how the male and female body works and how pregnancy occurs.^[40, 194] (This is particularly important in the context of Relationships and Sexuality Education (RSE), see *Chapter 9, Section 9.2.*) Such programmes should also address intimate relationships, fears and uncertainties, and other factors that will support them should a crisis pregnancy occur.^[40] The RESPECT programme, piloted in secondary schools in the former South-Eastern Health Board area, is an example of one such programme that has attempted to do this.^[195] The

Health Promotion Agency in Northern Ireland placed sexual health advertising in toilet cubicles and found that this campaign was well received and worked particularly well for 18-25 year-olds.[196] Other strategies known to be effective in reaching men include peer education campaigns, large-scale media programmes, workplace health programmes and community outreach.[194]

The Gay Men's Health Project should also continue to be supported in promoting the health of gay and bisexual men in Ireland, and in particular to support vulnerable young men who struggle with their sexuality.

6.3.5 Risk behaviours

While acknowledging that risks are associated with the health-related behaviours discussed above (see Sections 6.3.1-6.3.4), the following discussion addresses the factors that influence risk behaviours associated with driving (e.g. drink driving, speeding, not using safety belts) and preventative health behaviours (e.g. use of sunscreen and self-examinations for cancer). These risk behaviours were identified throughout the consultation process; typically, many participants took the view, *'If your life is going to be worthwhile, there must be some risk to your health. That's inherent in it [living], I think'*.

Young men are particularly prone to taking great risks with their health. They tend not to accurately assess the risks associated with dangerous situations or behaviours, and this is fundamentally a factor of their poor knowledge of health risks.^[11, 197-202] There may also be a tendency for many young men to underestimate their own susceptibility to risk of illness or injury.^[203-206] For example, men generally perceive that they are less susceptible to skin cancer than women^[197] and underestimate the risks associated with skin exposure^[198, 207], which is reflected in their poor use of sunscreen^[1, 207]. Despite the fact that women are more likely to contract melanoma of the skin (1.6 times), the death rate for melanoma of the skin is the same for men and women in Ireland.^[208] Young male drivers are also much more likely to overestimate their driving skills.^[200, 201] This significantly contributes to their inability to properly evaluate a risky situation^[202], which is correlated with their greater involvement in accidents and violations compared to women^[209]. For many young men who are looking for an increase in stimulation and arousal, risk-taking is a form of sensation-seeking^[153, 179, 180, 210] and, as stated earlier, high sensation-seekers tend to have a lower perception of risk than low sensation-seekers^[180]. The enforcement of legislative measures will also serve to reduce the prevalence of these risk-taking behaviours. Such measures are particularly relevant for young men.^[11]

The Cancer Control Strategy^[138] and the Road Safety Strategy^[140] outline a multilevel approach to the control of these issues. In the implementation of these strategies, there is a need not only to raise awareness among men of the risks associated with their behaviours, but also to emphasise their susceptibility to that risk. Gender-specific strategies that address risk-taking behaviours among men should be developed and piloted. To support the development of these strategies, research should be conducted to examine the 'sensation-seeking' factor underpinning many risk behaviours among men. With respect to the prevention and treatment of cancer, there is a need to examine



the help-seeking behaviour of men and, in particular, the relationship between gender and social class, ethnicity and other markers of inequality.^[259] It has been shown that for prostate cancer, women and the media can play a significant role in making men aware of the issues around early detection and encouraging them to seek help.^[211] When men do seek help, it is crucial that their relationship with the health professionals involved is based on autonomy and mutual respect.^[211] Greater emphasis should also be placed on symptom recognition as a component of health improvement campaigns, with particular attention being paid to the need for male-sensitive communication strategies.^[259]

6.4 Reaching men with health promotion programmes

The need to target men as a population group and to identify and develop models of working with them was identified in the Health Promotion Strategy.^[57] In order to meet national objectives, a number of former health boards have developed regional men's health strategies.^[36-38] Notwithstanding the recent progress made, to date, there has been a general absence of a specific health promotion focus on men. It is only in more recent times that national health awareness campaigns, such as that of the Irish Cancer Society, have begun to have a focus on men.

There is a need for a greater focus on specific health promotion initiatives that target men. These should account for both the influence of male-gendering on men's health behaviours and also the broader factors that can influence a man's behaviour. Principles of best practice when working with men have been defined^[212-215] and should be adhered to when engaging in health promotion work. These include:

- Adopt a positive approach to men's health work.
- Create non-threatening and male-friendly environments.
- Make services and programmes easily accessible.
- Use language that is positive and focused on solutions.
- Use opportunistic and innovative ways to market men's health work and make initial contact.
- Consult and involve men in programme development and delivery, and provide individual responses to individual needs.
- Find a 'hook' and a 'way in' that will appeal to men.
- Adopt a hands-on approach and make sure there is clear focus to the work.
- Plan small and realistically.
- Strive for higher standards of best practice in the future.

Internationally, there is a scarcity of evaluated health promotion programmes that target men. A good example of one such evaluation is that of the 'Alive and Well', Suicide Awareness Programme, run in the Wheatbelt of Western Australia.^[216] The key factors underpinning the success of this programme include using a community-based approach that targeted men where they gathered and the use of a variety of strategies that included presentations, training and on-site counselling. 'Men's Sheds' organisations in southern Australia are another good example of community-based health promotion targeting men.^[217] Since the mid-1990s, 192 of these organisations

have been established, engaging mostly with older men who are no longer working in paid employment and who have proved difficult to engage in conventional health, education and training initiatives. Through the provision of 'mateship' and a sense of belonging through positive and therapeutic informal activities, 'Men's Sheds' achieve outcomes of positive health, happiness and well-being for those men who participate, as well as for their partners, families and communities.

Within an Irish context, members of the Department of Public Health and Primary Care in Trinity College, Dublin, delivered a primary care initiative specifically targeting men in Tallaght.^[170] This study engaged with men by calling to their homes and the service was delivered after hours in the local GP surgery. Again, this service was directed by the needs defined by the men themselves.

Given the effectiveness of brief interventions in supporting individuals to modify their health behaviour, health promotion programmes that incorporate male-specific brief interventions should be developed and piloted. Any new initiative should be piloted and the health outcomes (effect size, penetration and sustainability of the intervention) should be evaluated to ensure good practice into the future.

6.5 Conclusions and Recommendations

- Many challenges lie ahead in terms of promoting and marketing a more positive and holistic interpretation of men's health and fostering in boys and men a positive sense of self.
- There is a need to devise promotional and marketing strategies for men's health that both challenge and support traditional notions of masculinity. In other words, develop health messages that appeal to men by *challenging* them to take greater responsibility for their own health so that they will be able to fulfil their traditional *support* role as provider, protector, husband and father.
- This policy endorses the recommendations from previous health strategies on the need for good quality and accessible health information and highlights in particular the need for more creative and gender-competent ways of making appropriate and 'male-friendly' health information available and accessible to men.
- Public health policy measures across a number of areas have been developed at a population level to address the harmful health and risk behaviours discussed in Section 6.3 of this chapter.^[57, 95, 131-140] While such policies are welcomed, there is a need to ensure that their implementation takes account of the gendered nature of health behaviour.
- Any health promotion programme developed to support men to adopt healthier behaviours must seek to target the factors that influence their behaviours and ultimately seek to promote positive associations between masculinity and health.
- Some health and risk behaviours are more prevalent among certain subpopulations of men. Men from lower socio-economic groups (SEGs 5 and 6), those on low incomes, those with low educational attainment and young men generally display poorer health-related behaviours than the general male population. Health



promotion initiatives should be targeted at those subpopulations most in need in order to support them to adopt healthier behaviours. It should be noted that prior to engaging in health promotion initiatives, some men may require support to build their capacity (e.g. self-confidence, self-esteem, life skills) so that they can engage in such initiatives.

With due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

SA6 Develop health promotion initiatives that support men to adopt positive health behaviours and to increase control over their lives.

RECOMMENDATIONS		Lead Agency
R6.1	Promote a holistic and positive focus on men’s health that supports men to take greater ownership of their own health.	HSE Other relevant Government depts.
R6.2	Devise gender-competent health information and disseminate it through media that are appropriate for men.	HSE Other relevant Government depts.
R6.3	Fully implement existing Government policies ^[57, 95, 131-140] that target the health and risk behaviours of men in Ireland through health promotion initiatives. Ensure that their implementation adopts a gendered approach.	HSE Other relevant Government depts.
R6.4	Review the adequacy of existing legislation that is in place to deter risk-taking behaviour among men.	Dept. of Justice, Equality and Law Reform Dept. of Transport Dept. of Health and Children HSE

See Actions A6.1 – A6.4 (1-14) in Part III: Action Plan

7. Promoting gender-competency in the delivery of health and social services

In formulating this policy, it was clear that there was a need for the provision of training and support for service providers on best practice in engaging effectively with men and for increased measures to attract more men into the education and caring professions. As one submission (Phase 3 of the consultation process) noted:

At both secondary and primary care level, we need to understand factors that influence men's perception of health, the nature of their response to health threats and their pattern of interaction with the health services. Our training programmes for all healthcare workers need to include modules on gender in order to give future healthcare providers sensitivity in handling and promoting the healthcare of both men and women.

The consultation process also highlighted the need for the inclusion of professional training in men's health within relevant undergraduate and post-graduate health and allied health courses. This chapter presents the current evidence on these issues and makes recommendations on the basis of the evidence provided.

7.1 Provision of training in the area of men's health

Whilst there has been an increased focus in the academic literature on men's health in recent years, this is only now beginning to translate into more formal structures and programmes within academic institutions. It is to be hoped in the future that there will be an increased focus on the development of further specialised academic programmes on men's health and on the integration of modules on gender and men's health into the training syllabi of all health and allied health courses. Institutes of Technology Ireland (IoTI), the Irish Universities Association (IUA), individual third-level institutions and the relevant professional bodies have an important role to play in this regard.

It is also only in recent times that attention has been drawn, in the context of men in Ireland, to the need for a gender-sensitive approach in the provision of health and social services.^[1, 108] Previous reports have stressed the importance of targeting training at health service providers that both sensitises them to specific men's health issues and that shows how men can be targeted more effectively.^[116] It has been argued that such training would help minimise the discomfort that some men feel when they engage with health and other support services.^[127] Training should also take account of best practice when engaging with men (*see Chapter 6*).^[213, 214, 218] The need to develop mechanisms for sharing best practice on delivering healthcare programmes to different subpopulations of men has also been identified, including disabled men^[219] and men in poverty^[220].

To date, there has been limited training in the area of men's health either in Ireland or elsewhere, and there is no available data on the effectiveness of such training. There is clearly much work to be done on the development, piloting and evaluation of men's health training within an Irish context. Consideration needs to be given to the way in which such training is tailored to meet the needs of different health and allied health professionals. The use of online or distance learning tools could be developed, either as a support or as an alternative to more conventional training courses. Existing examples of best practice include distance-learning courses on men's health provided by the



Royal College of General Practitioners (RCGP)[221] and the Australian ‘Lifescrpts’^[222] and ‘Flinders Model of Chronic Condition Self-Management’^[223] programmes. The tailoring of existing brief intervention training models, to take account of best practice when engaging with men, should also be considered.

It is critically important that the development and delivery of men’s health training within an Irish context occurs in close consultation with service providers and their relevant governing bodies and professional associations (i.e. doctors, nurses, health promotion officers, social workers, etc) and with men (as service users). Training protocols should be monitored and evaluated on an ongoing basis and should also be adapted to reflect up-to-date research findings on men’s health.

7.2 Increasing men’s participation in education and caring professions

In recent years, there has been an overall decline in the proportion of men entering the education and caring professions. To date, two reports have been published in an Irish context that were commissioned to inform strategies to promote increased numbers of males into primary teaching^[224] and social care^[225].

7.2.1 Primary teaching

The Minister for Education and Science established the Primary Education Committee in 2003 to make recommendations on strategies and initiatives to increase the number of males entering primary teaching. The Committee’s report^[224], published in 2005, indicated that approximately 18% of primary teachers were male in that year. The report stressed the importance of school pupils having both male and female teachers, so that children experience positive role models of both sexes and so that the school environment mirrors society more generally. With this in mind, a number of recommendations were made by the Committee on how to attract more men into primary teaching. In 2006, the Department of Education and Science commissioned a national campaign aimed at highlighting the variety of skills that a primary teacher uses and promoting the rewards of being a teacher; the campaign targeted young males and mature students, as well as parents, teachers and guidance counsellors.

7.2.2 Social care

Less than 10% of students currently enrolled in social care programmes are male, adding to the existing lack of qualified males engaged in front-line practice throughout Ireland.^[225] A number of barriers have been identified to men working in social care environments. The need for an overall cultural shift, whereby social care is seen as a credible and worthwhile career for males, has also been highlighted.

There is a need to conduct further research to establish strategies to promote increased numbers of males entering other caring professions (e.g. nursing, health promotion and social work).

7.3 Conclusions and Recommendations

- It is clear that both the integration of gender and men's health into relevant undergraduate and post-graduate courses, and the provision of professional training in men's health to existing health and allied health professionals, needs to be an integral part of policy development for men's health.
- It is also critically important to identify strategies and initiatives to increase men's participation in the education and caring professions, as well as in social care and community work.

With due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

- SA7 Develop health and social services with a clear focus on gender competency in the delivery of services.**

RECOMMENDATIONS		Lead Agency
R7.1	Develop specialised academic programmes on men's health and integrate modules on gender and men's health into the training syllabi of all health and allied health courses.	Institutes of Technology Ireland Irish Universities Association Third-level institutions Relevant professional bodies
R7.2	Develop training protocols and training courses on men's health that are tailored to the needs of those working in the health and allied health professions, and that offer a range of innovative methodologies.	HSE
R7.3	Promote strategies and initiatives to increase men's participation in education and caring professions, and in community work.	HSE Dept. of Education and Science Teaching Council

See Actions A7.1 – A7.3 (1-8) in Part III: Action Plan

8. Building gender-competent health services with a focus on preventative health

In formulating this policy, it was clear that specific strategies were necessary to address the barriers to health service usage by men. In seeking to improve men's use of health services, it became clear that barriers needed to be tackled not just within health services, but also within men themselves. Indeed, the importance of providing 'male-friendly' health services was highlighted throughout the consultation process for this policy and has also been noted elsewhere.^[126, 127, 226] A 'male-friendly' health service was described during the consultation process as one that is:

- accessible;
- affordable;
- provides a waiting area in which men feel at ease;
- focuses on the man, not the symptoms;
- endeavours to treat patients promptly, in a friendly way, respectfully and sensitively;
- operates to an agreed standard consulting time;
- ensures that all paperwork is user-friendly;
- recognises that some men may be reluctant as patients and thus facilitates ease of communication between health service provider and male patient;
- supports men to make sense of health information;
- allows for medical issues and procedures to be explained in 'layman's terms'.

There was also a call for a change in the focus of primary care services from what was seen as a medical 'treatment' model towards a preventative approach, focusing on health and well-being. Previous health strategies^[55, 227] have endorsed such a preventative approach. The need for increased gender competency in the provision of cancer services, mental health services and sexual health services was also highlighted.

A better understanding of the issues underpinning sex differences in the use of health services can be used to inform public policy in service provision. Specific consideration will be given below to primary care services (*see Section 8.1*), cancer services (*see Section 8.2*), mental health services (*see Section 8.3*) and sexual health services (*see Section 8.4*).

8.1 Need for more gender-competent primary care services

8.1.1 Understanding why men tend not to use primary care services

It has been consistently shown that men of different ages, ethnicities and social backgrounds access health services less frequently than women do for both physical and mental health problems.^[162, 199, 228, 229] Indeed, it is also well established that men tend not to use pharmacies despite their potential as a source of advice, information and self-treatment.^[230] When men do avail of primary care services, their consultation times tend to be shorter than those of women and they tend to ask fewer questions.^[48] Men's underutilisation of the health services is likely to be associated with their experiencing higher levels of potentially preventable health problems and having, on average, lower life expectancies at any point throughout the lifespan.^[10, 231]

It is imperative that men seek help in a timely fashion for more serious and debilitating

conditions, and that they are educated to distinguish between these and other self-limiting conditions in order that they can make more informed decisions about their health (see Chapter 6.1). To promote a more prompt use of health services by men, it is also important to identify potential limitations within existing services in not meeting men's needs and also possible barriers within men themselves in not seeking help.

a. Barriers within the services

As highlighted within an Irish context^[1], a range of factors have been identified at a service level that can be described as barriers to men's more frequent or more prompt use of health services. These include cost, missing out on work (and inflexible work patterns), not enough time, lack of flexibility in opening hours for health services, excessive waiting times for consultations to begin, rushed consultations and a perception that GP waiting rooms are designed around the needs of female patients. These findings are supported in the wider literature on men's health.^[126, 232, 233] Lack of awareness of the eligibility criteria for General Medical Services (GMS) entitlement has also been highlighted.^[108] Robertson and Williams^[234] recommend that audits be used to determine service delivery gaps for men and propose a framework for auditing the primary care environment and health professional's interpersonal approach. The implementation of the primary healthcare strategy^[227] should, in particular, address the needs of communities experiencing poverty, including prisoners, ethnic minority men, Traveler men, drug users, disabled men, homeless men and men living in rural isolation.^[220] The issue of access to acute, rehabilitative and population health services has been highlighted as an area of particular concern for men with disabilities.^[219]

b. Communication barriers

Within an Irish context^[1], approximately one-third of men surveyed (571 respondents) expressed dissatisfaction with different aspects of how doctors communicated with them as patients, with men in lower socio-economic groups being significantly more likely to be dissatisfied with aspects of doctor-patient communication. The importance of doctor-male patient communication has also been highlighted in an international context.^[211, 235-240] The most important characteristics valued by men during a medical encounter are a professional attitude and approach on the part of the physician; a relationship built on trust, confidentiality and respect; courtesy during a physical examination; time for meaningful information exchange; and the opportunity to discuss health-related concerns with a non-judgemental, competent and respectful healthcare provider.^[235]

c. Barriers within men themselves

Men's lack of knowledge and awareness of more fundamental issues concerning their own health may be associated with a delay in seeking help when they are unwell. The transition to manhood tends to be marked by expectations of being tough, resilient and not showing any vulnerability in the face of personal problems or ill-health.^[1] This may explain why many men appear to legitimise health service usage only when a perceived threshold of ill-health has been exceeded.^[1, 162] There is also a tendency among men to play down symptoms or to view potentially serious symptoms as simply

signs of 'growing old'.^[241, 242] Fear has also been identified as a reason why many men fail to access primary care health services and this may be an even greater issue in the context of mental and sexual health services.^[1, 243-245] One of the key challenges facing men's health is to reverse the concept that 'being sick' or 'going to the doctor' somehow represents a failure or personal weakness, and instead to portray seeking help as a responsible and manly choice.^[106]

8.1.2 Primary care and community-based men's health checks and screening initiatives

a. Health checks and 'well man' clinics

The establishment of 'well man' clinics in the 1980s, particularly in the UK, were designed to entice more men to access primary care. In terms of effectiveness, they received a mixed response.^[229, 246-249] Those that did work tended to offer flexible opening hours, longer consultation times, at sites that were separate from primary care, and offered individualised and male-specific health assessments. Other characteristics of successful clinics included targeted advertising, the provision of personalised letters of invitation to prospective male patients, the provision of lifestyle and behaviour modification programmes, and the inclusion of a comprehensive referral system.^[226] Similar findings have been reported in an Irish context.^[170] It has also been reported, however, that men who present for health screenings tend to be older, wealthier, more likely to have dependants, routinely use health services and have attended primary care in the preceding two years.^[250] Therefore, it is important to adopt a targeted approach to the provision of screening services in primary care in order to target those most in need of such services.

b. Community-based services

A key focus of the Primary Health Care Strategy was the provision of an integrated, accessible service for people within their own community.^[227] This policy supports the Government target of achieving 500 primary care teams by 2011.^[50] In the context of men's health, pubs^[247], sports clubs^[81] and schools^[251] have been identified as worthwhile community settings in which to target outreach primary care services to those men who may be less likely to use more conventional services.

In the UK and Australia, there has been a growing popularity in the use of 'MOT' checks, which are based on the analogy of a man's body to a car (e.g. comparing blood pressure with oil levels; mental health with shock absorbers). The UK Men's Health Forum (www.menshealthforum.co.uk) has developed a range of men's self-help books on health (Haynes Manuals), designed to encourage men to look after their bodies as they would their cars.

McKinlay^[81] stresses the important role that community health nurses can serve in delivering outreach services to men and in supporting community-based men's health initiatives. The role of community health nurses in facilitating the transition of men with a new diagnosis of diabetes to everyday life has also been highlighted.^[252] It has



been found that poorer, ethnic minority men are significantly more likely to participate in health screenings when delivered in a community setting.^[253] The Men's Health Centre, Baltimore, USA, is another example of an effective outreach community-based primary care service that was devised in response to a survey of the type of services that local unemployed or underemployed men felt they needed – dental care, physical examinations, HIV testing, pharmacy services and eye examinations.^[254] The success of the Centre, which ran in collaboration with a local fathers and family workplace development centre, was attributed to its capacity to respond to local need and to its focus on supporting men's place in the family.

The importance of developing services that are seen to respond to the specific needs of men has also been highlighted elsewhere, particularly with regard to ethnic minority men.^[81, 255] In Ireland, the operation of mobile health units in the context of the Construction Workers' Health Trust (CWHT) have proven to be quite successful, whereby workers can access a 'heart health' assessment or cancer awareness programme on-site; the initiative has the support of both management and unions, is free to the worker (subject to a nominal subscription) and does not require official time-off from work. Further evaluation of such programmes, designed to measure equity of access, sustainability and follow-up, should be considered in the future. The 'Beyond Borders Community Well-being Project' (Dundalk Institute of Technology) is another example of an innovative approach to taking health services to where men congregate. The establishment of nurse-led walk-in centres in the UK in the late 1990s was found to be particularly attractive to young men.^[256]

The report of the Taskforce on Sudden Cardiac Death^[257] sets out a number of recommendations on the establishment and maintenance of surveillance systems regarding this condition in Ireland.

8.2 Need for more gender-competent cancer preventative measures and screening services

8.2.1 Cancer prevention

As highlighted in Chapter 4, cancer rates are much higher in men than in women. A briefing paper produced by the UK Men's Health Forum during Men's Health Week 2004 stated:^[258] 'The disparity between men and women in the incidence of cancer is extremely marked. Such disparities would undoubtedly (and rightly) be the subject of targeted strategies if they were related to social class or ethnic origin rather than gender. The conclusion here is clear – that present policies for the prevention of cancer are failing men.'

Primary care services are crucially important in cancer detection, with an estimated 80% of patients with cancer presenting in primary care.^[81] The findings from a recent UK expert symposium^[259], established to examine why cancer incidence and mortality were so much higher in men, made a number of recommendations directed at addressing such disparities, including:

- the need for a systematic review of existing evidence in relation to men and cancer;
- further research to establish why some patients delay presenting with cancer symptoms, and how and why this varies according to gender;
- the development of gender-specific information packages to optimise the uptake by men of non-sex-specific cancer screening programmes;
- greater emphasis on symptom recognition as a component of health improvement campaigns;
- further research to investigate the psycho-social aspects of cancer diagnosis and treatment, and whether interventions aimed at providing greater support for men would be useful;
- an increased focus on cancer prevention programmes that take an outreach approach to engaging with men, that offer them advice, information and routine health checks, and that act as a gateway to enabling them to make better use of mainstream services.

8.2.2 Cancer screening

With ongoing improvements in cancer treatment, procedures and screening technologies, secondary prevention and prompt presentation to health services are increasingly playing a key role in reducing mortality from the disease.^[260] The recent Strategy for Cancer Control^[138] sets out criteria for guiding decisions concerning national population-based screening programmes. In the context of this policy, the following discussion will focus on the efficacy of cancer screening for prostate and colorectal cancer.

a. Prostate cancer screening

Despite widespread advocacy for prostate screening in the mass media, the majority of expert medical organisations^{1*} either recommend against screening or state the lack of sufficient evidence to justify recommending its use.^[261, 262] Prostate cancer screening clearly identifies disease, raises incidence rates and the rate of interventions (e.g. radical prostatectomy and radiotherapy).^[262] However, the problem of 'over-diagnosis' remains, whereby large numbers of screened men are diagnosed with prostate cancer that do not necessarily require treatment. This tends to result in 'over-treatment', which is a cause of great concern because treatment can result in problems such as impotence and urinary incontinence.^[263]

The Royal College of Surgeons in Ireland^[264] states that 'a selective approach to investigation by prostate specific antigen (PSA) testing and digital rectal examination (DRE) is warranted'. However, the recent Strategy for Cancer Control^[138] states that, pending the results of randomised controlled trials to assess the benefits of PSA and DRE as screening tools, there is currently insufficient evidence to recommend the introduction of a prostate screening programme.

1 * These include the US Preventive Services Task Force, the American College of Physicians, Canadian Urology Association and the Medical Research Councils in the UK and Australia.

b. Colorectal cancer screening

A number of studies have demonstrated the effectiveness of colorectal cancer (CRC) screening in reducing colon cancer-specific mortality.^[265] The recent Strategy for Cancer Control^[138] states that a 'colorectal cancer programme should be established to encompass population screening, high-risk screening and necessary developments in symptomatic colorectal cancer screening services'. It calls on the Department of Health and Children, under the aegis of the National Cancer Forum, to address a range of implementation issues, with due regard to the following: defining a clear population screening programme; organisation of services; quality assurance; call and recall system; symptomatic services; and high-risk screening. Consideration should also be given to approaches that are likely to make such a screening programme attractive to men.

8.3 Need for more gender-competent mental health services

There is considerable evidence to suggest that mental health is highly gendered and requires a gendered focus at a policy and service delivery level.^[56] Mental health issues can pose a threat to a man's masculinity, as evidenced by the way many men conceal symptoms, reject help-seeking and rely on more 'acceptable' male outlets, such as alcohol abuse or aggression, to deal with a mental health issue.^[266, 267] There is also a perception that in the context of a curative medical model of health, previous approaches to mental 'health' have, in effect, focused on the symptoms of mental ill-health. The concept of a 'mental health continuum' provides greater scope for a more holistic understanding of mental health and for paving the way for support to be sought before a mental health issue reaches a crisis point. Recent reports on mental health policy^[136] and on suicide prevention^[131] are a welcome development in this regard. This policy endorses the call for a stronger focus on mental health promotion as part of a preventative approach to mental health and emphasises the need for a gendered approach in the development of community-based mental health services.

8.4 Need for more gender-competent sexual health services

The rise in unplanned pregnancies^[268] and sexually transmitted infections (STIs)^[269] in recent years has drawn increased attention to the area of sexual and reproductive health. As highlighted in Chapter 6 (*see Section 6.3.4*), previous studies have shown that the practice of unsafe sex and of having multiple partners is considered to be a sign of potency and sexual prowess for men^[270] and a legitimate way of validating their sexuality^[56]. Much of the existing policy and practice in the area of reproductive and sexual health has been targeted primarily at women.^[271, 272] A 2007 report on barriers to men's use of sexual health services calls for an explicit and gendered focus on men's sexual health and their use of sexual health services as a core element of an overall national sexual health strategy.^[273] The report calls for initiatives to increase men's awareness of existing sexual health services, to challenge existing perceptions that sexual health services are primarily for women, to provide more outreach sexual health services to target men in different settings, and to provide confidential and anonymous

sources of sexual health information for men. Another report, also published in 2007, focused on men's experiences of sexuality and crisis pregnancy, and concludes by calling for services to be more inclusive of and sensitive to men's needs in the context of crisis pregnancy.^[40]

8.5 Conclusions and Recommendations

- There is a need to improve men's access to primary care services and the promptness with which they seek help, particularly for more serious and debilitating conditions. Healthcare, and prompt use of health services in particular, needs to be portrayed as a strong ally of masculinity.
- In keeping with the Primary Health Care Strategy^[227], there is a need to reorientate the focus and capacity within primary health services from a medical 'diagnosis and treatment' model towards a prevention model that promotes early intervention and integration with other services. The implementation of the Primary Health Care Strategy should, in particular, address the needs of communities experiencing poverty and marginalisation, and should consider the provision of outreach primary care services in community settings.
- This policy calls for more gender-competent cancer preventative measures and endorses existing guidelines^[264] for prostate and colorectal cancer screening in Ireland.
- This policy endorses the recommendations in the report of the Expert Group on Mental Health Policy^[136] and the National Strategy for Action on Suicide Prevention^[131], and calls for an increased focus on the gendered nature of mental health in the context of men.
- There is also a need for more gender-competent sexual health services that give consideration to bringing services to men and that promote and advertise services as being relevant to men taking greater responsibility for their sexual and reproductive health.

With due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

SA8 Support the development of gender-competent health services, with a focus on preventative health.

RECOMMENDATIONS		Lead Agency
R8.1	Develop specific initiatives that enable men to access health services promptly, particularly for conditions that pose a serious threat to their health. Specific provisions should be made for marginalised subgroups of men (e.g. Traveller men, ethnic minority men, disabled men, isolated rural men).	HSE Irish College of General Practitioners
R8.2	Develop an increased focus on gender-competent cancer preventative measures and implement existing guidelines for cancer screening services.	HSE Dept. of Health and Children
R8.3	Implement the recommendations of the Expert Group on Mental Health Policy[136] and the National Strategy for Action on Suicide Prevention[131], with a clear focus on the gendered nature of mental health.	HSE Other relevant Government depts.
R8.4	Ensure that there is a clear focus on the provision of gender-competent sexual health services and programmes for men.	HSE

See Actions A8.1 – A8.4 (1-18) in Part III: Action Plan



9. Developing supportive environments for men's health

9.1 The home as a setting for men's health

The home is an important setting in which to target specific men's health policy initiatives, particularly as the setting within which most key relationships take place. The consultation process for this policy drew attention to the wider influence of relationships on men's health and the diverse and sometimes multiple roles that men play in the home – as husbands/partners, fathers and carers – as well as the roles of single, divorced/separated and gay men. The need for increased support measures to support men in their role as fathers was consistently highlighted, as was the need to provide greater support to separated/divorced and single fathers. The consultation process also drew attention to the need for multiple and sustainable measures to tackle poverty and substandard living conditions of men living alone, particularly in rural areas. The need for improved services to deal with male victims of domestic violence, and for increased sensitivity on the part of service providers in dealing with them, was also identified.

9.1.1 Understanding the influence of relationships on men's health

This section will focus primarily on the influence on men's health of relationships between men and women. Whilst the focus will be on the caring influence of women on men's health, this is not to negate the significance of same-sex relationships in terms of gay/bisexual men's health, although there is less evidence in the literature to support this. From a policy perspective, however, the principal issue is that of challenging and supporting all men to take greater responsibility for their own health.

It has been consistently shown that marriage is a predictor of good health and longevity for men more than for women.^[274-276] The research suggests that women in Ireland continue to exert a very positive influence as gatekeepers or custodians of men's health and men also report higher levels of practical support from the person they identify as closest (usually a spouse or partner).^[1] The health benefits accruing from relationships, and from marriage in particular, are most pronounced when a marital relationship is disrupted through divorce or the death of a spouse, when the consequences are more detrimental to the health of men than women.^[277-279] This may reflect the persistence of more traditional gender roles, which continue to give women much of the overall responsibility for care-giving and with brokering healthcare for their spouses.^[279]

The role of women in Ireland in encouraging 'reluctant' men to go to the doctor and in providing support to men for emotional/mental health issues^[1] strongly suggests that women's role in men's health should not be overlooked when planning men's health initiatives. On balance, however, it would appear that whilst policy initiatives directed at men's health should take cognisance of the potential role of women in supporting such initiatives, the primary focus of policy must be to support men to take greater responsibility for their own health^[280], particularly in light of the growing number of men in Ireland who are not in relationships with women.



9.1.2 Men as fathers

The need to support men in their role as fathers

Like marriage, fatherhood has been shown to have a very positive and protective influence on men's health.^[1, 276] The more involved a father is with his children, the more beneficial it is for them in terms of their overall development and well-being.^{[281-283]1*} Children are also less likely to develop anti-social or delinquent behaviours if their fathers are available and attentive to them.^[284] Longitudinal studies show that children from one-parent households (usually headed by mother) are at greater risk for negative adult outcomes (including lower educational and occupational attainment, school drop-out and health problems) than children from two-parent families.^[285, 286] It has also been well established that it is the quality of the parent-child relationship rather than the gender of the parent that is most important in child development.^[287]

Against a backdrop of widespread change in family roles and gender relations in recent years, there is the assumption that the more traditional male provider and female nurturer roles have been substantially eroded. With an increasing shift towards double-income families and more 'democratic family structures'^[18], Irish fathers are now expected to adopt a more hands-on approach as fathers, compared to previous generations. However, the transition to more involved 'active' fathering has been constrained by the wider absence in Ireland of a concept of men as active caring fathers^[281], as well as by the following practical barriers:

- **Juggling work with fatherhood:** There is an anomaly between what men in Ireland aspire to in terms of being engaged as active fathers *versus* the reality of their working lives, which can often compromise the fathering role.^[1, 23, 28, 288] Long and inflexible working hours, long commuting times and the economic reality of having to work have all been highlighted as particular constraints. As a result, the reconciliation of work and family life continues to fall primarily to Irish women.^[1, 288]
- **The absence of father-friendly work practices and public services:** The promotion of active fatherhood needs to be seen by policy-makers and practitioners as a form of social inclusion – from the moment of pregnancy awareness through to the early months and years of the child's life.^[41]
- **The absence of paternity leave and the minimal uptake of (unpaid) parental leave by fathers in Ireland:** While the provision of maternity leave in Ireland now exceeds the minimum EU requirement and statutory paternity leave with full pay has become the norm in other European countries^[28], there is no statutory entitlement to paternity leave for men in Ireland outside of the Civil Service (3 days paid leave). Similarly, while many countries pay a flat rate to employees when taking parental leave, parental leave in Ireland remains unpaid. It has been reported that the introduction of paid paternity leave in Scandinavian countries has been instrumental in changing employers' views on fathering, creating an accepting corporate atmosphere toward parenting and increasing fathers' participation in childcare and family life.^[289] Consideration needs to be given in Ireland to the provision of paternity leave and to the

1 * It should be acknowledged that in certain circumstances, such as may be defined by the Courts or social services, children's welfare may be better served by a father's absence.

increased uptake of existing parental leave by fathers as part of a gender-relations approach to equality in the workplace and to childcare and domestic labour within the home.^[1, 23]

It should also be noted that changing demographic trends (such as increased single-parent households, reduced marriage rates, increased rates of separation and divorce) mean that future generations are less likely to experience sustained involved fathering than the generations that preceded them.^[290]

Promoting more father-inclusive practices in Ireland

The 'Father Inclusive Practice Framework' in Australia considers the key competencies required for service providers to be more inclusive of fathers across a range of different services and settings.^[291] It describes a capacity-building framework for father-inclusive practice in the areas of health, family support, parenting and community, and early childhood and education. It covers areas such as running a fathers' group, recruiting fathers to early childhood centres, working with antenatal fathers and raising staff awareness and acceptance of fathers. This Australian framework stemmed from a 'Father Inclusive Practice Forum' and was informed by extensive consultation with practitioners, managers, educators and policy advisors. It provides a strong rationale for father-inclusive policy and practice based on: (i) equality legislation, promoting equality of opportunity between men and women; (ii) the benefits that can accrue to children and families, including the influence that father involvement has on children's emotional, social and cognitive development; and (iii) the potential impact on wider health and social policy, such as the role fathers can play in the establishment and maintenance of breastfeeding and promoting improved literacy among children. The Framework is based on a set of nine principles, each of which offers a set of key questions in respect of the design and delivery of training and education for staff.

The 'Fatherhood Quality Mark' in the UK similarly offers evidence-based standards for father-friendly practice, through which an agency can demonstrate that it is working to understand and meet the needs of fathers and children in relation to one another.^[292] Accredited training for staff and resources for service users are also provided.

Both the 'Father Inclusive Practice Framework' and the 'Fatherhood Quality Mark' provide worthwhile examples of best practice in terms of promoting and developing more father-inclusive policies and practices in Ireland. Within an Irish context, an example of best practice in this regard is the 'Da Project' in Ballyfermot, Dublin, which seeks to increase the involvement of fathers in the lives of their children. The recent evaluation of the project^[293], together with guidelines on best practice in engaging with fathers arising out of the project^[294, 295], provides a blueprint for best practice within an Irish context in working with fathers. This policy recommends a number of additional pilot initiatives in relation to father-inclusive practices in Ireland, upon which outcomes can be measured and the sustainability of such practices established.



Separated/divorced fathers and child-custody issues

Fathers who lose custody of their children are placed at significantly higher risk of chronic health conditions, psychological impairment and suicide.^[276, 296] Despite this, there appear to be very few services to cater for the needs of fathers in this situation. Among the more prominent matters to be raised during a consultation process undertaken by the Department of Social and Family Affairs^[297] on issues of concern to families were the issue of access and the frequency with which fathers are rendered powerless in child custody situations; 'parent alienation syndrome', whereby one parent acts to turn the child against the other; the extent to which some public policy measures, such as 'One Parent Family' payments, can serve to undermine a father's involvement in family life^[41, 298]; and the importance of children having a continuing relationship with the non-custodial parent (except where the Courts or social services may adjudge such an arrangement to be inappropriate) in the interests of their continued well-being.

With the strict operation of the 'in camera' rule in the family law courts in Ireland, there has been much speculation about what has frequently been construed as an adversarial family law system, with fathers' rights groups – such as Parental Equality (www.parentalequality.ie) and Unmarried and Separated Fathers of Ireland (www.usfi.ie) – highlighting issues of concern relating to access and custody for separated/divorced fathers. However, Coulter's 2007 report for the Courts Service of Ireland highlighted that 90% of divorce and judicial separation cases over a month-long period were settled by consent.^[299] This is the first of what will be a series of reports by the same author and the findings of future reports should inform policy in this area. An Australian report has highlighted the need for increased support measures for separated fathers, including legal advice relating to the family law system and child-custody obligations, advice on housing and accommodation options, and information on appropriate support services for separated men.^[300]

In the context of lone fathers, the National Network of Local Lone-Parent Self-Help Groups (OPEN) in Ireland (one of the submissions in Phase 3 of the consultation process for this men's health policy) refers 'to the dearth of research in relation to the experience and needs of lone fathers in Ireland'^[301] and calls for an increased research focus on issues such as income adequacy, housing and accommodation, health and childcare.

Building on the recommendations of the report of the Commission of the Family, this policy calls for an increased focus on the needs of separated/divorced and lone fathers, as part of the Family and Community Services Resource Centres Programme.^[302] It also recommends the continued monitoring of current practices relating to the access entitlements of single fathers to their children within the context of existing^[299] and future reports into the workings of the family law courts.

9.1.3 Men as carers

One in three carers (34%) in Ireland is male, with a total of 57,480 Irish men providing regular unpaid care to a relative or friend in 2002.^[79] Among the health issues for carers are the psychological effects of isolation, increased risk of persistent distress and stress.^[303] Recent reports emphasise the importance of making care-giving a public health issue, putting carers on a health inequalities agenda and increasing support services for carers.^[297, 303] These issues should be prioritised in the development of a National Carer's Strategy, as called for in the current National Action Plan for Social Inclusion.^[50]

9.1.4 Men residing in sub-standard living conditions

The social partnership agreement, *Towards 2016*^[304], identifies as one of its objectives the availability of good quality housing for all. The consultation process for this policy made repeated reference to the issue of poverty and sub-standard housing conditions of men living alone. A recent report by the Combat Poverty Agency^[305] highlighted that poverty levels were highest in Border and Western counties, and among Local Authority tenants. A report investigating the social isolation of single, rural men in Leitrim^[22] highlighted multiple levels of disadvantage, including poor living conditions that impacted on them, and stressed the need for an increased focus on such men as a specific disadvantaged group. These issues should be considered within the context of the Government's recent integrated policy approach to affordable housing, *Delivering Homes, Sustaining Communities*.^[306]

9.1.5 Men and domestic violence

Male perpetrators

The recent development of intervention work with male perpetrators of domestic violence^{2*} starts from the premise that domestic violence is unacceptable under any circumstances and works with men to change their violent behaviour. It also highlights that the primary focus of such intervention work is always to increase the safety of women and children (and other men) as part of a multiagency approach to programme delivery. The experience of those delivering these programmes is that male participants experience a cycle of adverse health outcomes, including mental health issues and addictions, arising from their violent behaviour. There is therefore a need for increased research and evaluation to be carried out on the impact that the perpetration of violence has on the health of perpetrators themselves, particularly in relation to mental health, the use of anger and alcohol abuse, and the effectiveness of intervention programmes in reducing violent behaviour and in improving the health status of perpetrators.

2 * Programmes coordinated by the South-East Domestic Violence Intervention Programme (managed by the Men's Development Network) in the South-East and by 'MOVE' Ireland – both funded by the National Office for the Prevention of Domestic, Sexual and Gender-based Violence (COSC).



Male victims

Tackling domestic violence as an issue for male victims has been constrained in the past by a general consensus that victims were female and perpetrators were male, and by a reluctance on the part of male victims to report incidents of domestic violence to the police, An Garda Síochána.^[102, 103] There is a need for the provision of increased training and raising of awareness for all those involved in dealing with male victims of domestic violence – police, social workers, doctors and other service providers – so that they are sensitive to the fact that victims can be male as well as female, and to the potentially wide-ranging impact of domestic violence on victims.

9.1.6 Conclusions and Recommendations

- There is a need for an increased priority on the home as a setting in which to target specific men's health policy initiatives that accommodate diversity within family structures and that enable men to take increased responsibility for their own health.
- The evidence to support an increased focus on fatherhood at both a policy and service delivery level is compelling. Measures that support and enable men to be more involved and active as fathers have beneficial effects not just for fathers themselves, but also for their wives/partners and children, and society as a whole. This policy recommends the implementation of a father-inclusive framework across all Government departments, based on existing national^[293] and international^[291, 292] models of best practice.
- Consideration also needs to be given to the provision of paternity leave and to the increased uptake of existing parental leave by fathers as part of a gender-relations approach to equality in the workplace and to childcare and domestic labour within the home.
- This policy calls for an increased focus on support services for separated/divorced fathers as part of the Family and Community Services Resource Centres Programme^[302] and recommends the continued monitoring of the access entitlements of single fathers to their children within the context of existing^[299] and future reports into the workings of the family law courts.
- This policy supports the call for a National Carer's Strategy^[50] that can provide increased support for men in their role as carers.
- There is an urgent need to address the issue of poverty and sub-standard living conditions among men living alone.
- Increased intervention programmes are necessary for male perpetrators of domestic violence. Support measures also need to be put in place for male victims of domestic violence, which also tackle barriers to male victims accessing support services.

With due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

SA9.1 Target specific men's health policy initiatives in the home that accommodate diversity within family structures and that reflect the multiple roles of men as husbands/partners, fathers and carers.

RECOMMENDATIONS		Lead Agency
R9.1.1	Target the home as a setting for enabling men to take greater responsibility for their own health.	HSE
R9.1.2	Develop explicit and gender-competent father-inclusive policies and practices within all health and social services, and as an integral part of social inclusion.	HSE Other relevant Government depts.
R9.1.3	Develop a National Carer's Strategy ^[50] that can provide increased support for men in their role as carers.	HSE Dept. of Social and Family Affairs Dept. of Community, Rural and Gaeltacht Affairs
R9.1.4	Provide a range of measures to address sub-standard living conditions among men, within the context of <i>Delivering Homes, Sustaining Communities</i> ^[306] , that are sensitive to the needs of poorer men living alone.	Dept. of the Environment, Heritage and Local Government Dept. of Social and Family Affairs
R9.1.5	Increase support measures for male perpetrators of domestic violence.	HSE Dept. of Justice, Equality and Law Reform COSC
R9.1.6	Increase support measures for male victims of domestic violence.	HSE Dept. of Justice, Equality and Law Reform COSC

See Actions A9.1.1 – A9.1.6 (1-17) in Part III: Action Plan

9.2 The education environment – schools and third-level colleges

In formulating this policy, schools and third-level colleges were identified as important settings for the delivery of early interventions with regard to men's health policy initiatives. The literature on men's health draws attention to the critical influence that attitudes, behaviours and values developed early in life have on men's health practices in later life. The consultation process for this policy highlighted the need for an increased focus on personal development and health education in schools for boys, and for a stronger focus on the school as a key setting in which to promote and nurture positive masculine identities in boys. Other issues that emerged during the consultation process included the need to consider possible gender differences in learning and



development in the context of the 'under-achievement' of boys in schools; the need for improved links between schools and homes/communities; the need to address the high drop-out rate from school for boys; and the need for more careful monitoring of school policies on bullying. Finally, the consultation process highlighted the need for more targeted and gendered health promotion interventions in third-level colleges, addressing in particular stress/mental health, sexual health and risk-taking behaviours among male students.

9.2.1 The development of healthy masculinities among boys

A consultative paper on senior cycle education^[307] identified 'education for personal well-being' as an area that was in need of increased focus in the curriculum than was currently the case. Previous reports have indicated that the personal and social development of boys receives less attention within the educational system than does their academic achievement and preparation for the labour market.^[308, 309] This has tended to be an issue in particular for single-sex boys' secondary schools.^[310, 311] While the Social, Personal and Health Education (SPHE) programme (supported by the SPHE Support Service at junior cycle second-level) does go some way towards achieving this aim, it is a cause of some concern that the lowest level of implementation of SPHE (57%) is among boys' secondary schools.^[312] The need for engaging more male teachers in the delivery of SPHE has also been documented.^[313, 314]

While 'Exploring Masculinities'^[315] is one of a number of SPHE modules that may be offered to Transition Year or senior cycle boys in single-sex schools, it appears that the uptake of this programme is quite low. The recommendations from previous evaluations of the programme^[309, 316] provide a clear blueprint for its future development and, on implementation, may increase the uptake of the programme. A discussion paper on SPHE^[317], published in 2003, notes that 'young people's lifestyle choices are often not health-promoting in the areas of diet, exercise, alcohol, drugs, smoking and sexual health'. Consultation on a draft curriculum framework for SPHE at senior cycle is currently being undertaken by the National Council for Curriculum and Assessment and is to be welcomed.

All recognised primary and second-level schools are required to offer Relationships and Sexuality Education (RSE). Section 4 of the Rules and Programme for Secondary Schools requires schools to have an agreed policy for RSE and a suitable RSE programme in place for all students at both junior and senior cycle. At junior cycle, the RSE programme is part of SPHE. It is the responsibility of the school's Board of Management to ensure that the RSE programme is made available to all students. A report investigating the learning barriers for boys in relation to RSE in co-education schools makes a number of recommendations with regard to the successful delivery of RSE to boys.^[318] Recent reports from the Crisis Pregnancy Agency (CPA) have drawn attention to the need for an increased focus on sex education for boys in schools.^[40, 319] A 2007 report from the CPA^[320] details a number of recommendations regarding RSE implementation within the context of SPHE in post-primary schools; it makes specific reference to the need for fully implementing SPHE/RSE in schools serving mainly boys and for an appropriate

gender balance in the teaching of both subjects.

By setting out to promote a holistic approach to health for men in Ireland, this policy asserts the importance of beginning this process early with boys. It is therefore imperative that boy's self-esteem and communication skills are nurtured from an early age. It is also important that boys and young men are encouraged to acquire a language for expressing emotional distress and to be more open and 'honest' about seeking help, particularly for emotional problems. Consideration should also be given to a greater focus on more creative subjects for boys, such as art and drama, as media for expression of feelings.

9.2.2 Gender differences in learning and development

The increased focus on male/female differences in educational attainment at primary^[321], second-level^[40, 322-324] and third-level^[311, 325] has turned attention to possible gender differences in learning and development. While a recent UK report^[326] cautions against generalisations on the basis of gender, other reports suggest that both the format of examinations^[322] and boys 'laddish' behaviour^[327] may be causal factors in girls 'outperforming' boys. Professor Paul Connolly's book, entitled *Boys and Schooling in the Early Years*, provides a strong rationale for tackling the problem of boys' lower educational performance in the early years and highlights a number of practical ways in which the problems facing young boys in education can be addressed.^[328] A report from the Department of Education, Science and Training in Australia^[329] identified learning styles and teaching practice as key elements in addressing the specific educational needs of boys. The same report highlighted that positive male role models for students are an important vehicle for helping boys to re-evaluate their understanding of roles, beliefs and values. Attention has also been drawn to the benefits of mentoring for boys.^[330]

9.2.3 The need for improved links between school and home/community

Article 42 of the Irish Constitution states that 'the primary and natural educator of the child is the family'. This places in its historical context the close relationship that has existed between schools and parents in terms of education provision in Ireland. A report from the Council of Europe's Committee on Culture and Education^[331] stresses the importance of improved communication, interaction and adopting a 'partnership approach' between children, parents and schools. There is also evidence to support fathers' involvement in their children's education and learning, with positive father involvement being associated with better exam results, better school attendance, less criminality, better quality interpersonal relationships and good mental health.^[332] This policy supports the ongoing expansion of the Home School Community Liaison (HSCL)^[333] Scheme under the Department of Education and Science's DEIS action plan, with a view to developing closer cooperation between parents, teachers and the wider community.



9.2.4 Early drop-out rates for boys and second-chance education

A significant gender gap exists between the retention rates (to Leaving Certificate) for males (72.1%) and females (83.8%) in second-level schools.^[77] While this pattern of higher drop-out among boys was mirrored in many other OECD countries at upper second-level (Leaving Certificate equivalent), only four countries had a gap as large as Ireland. Similarly, almost two-thirds (64%) of those who drop out early from school with no qualifications are male.^[334] It should also be noted that early school-leaving is heavily concentrated among students from working class backgrounds.^[311] An Australian report^[329] highlights a number of strategies to prevent early drop-out, including the early identification of 'at risk' boys, reinforcing the role of teachers in establishing good relationships with students and taking an interest in their welfare and achievements, and making early contact with parents if problems seem likely to arise.

In the Irish context, the Department of Education and Science's DEIS action plan, launched in 2005, provides a targeted approach to addressing the educational needs of children and young people from disadvantaged communities, from pre-school through second-level education.^[335] The key principle of early intervention underpins many of the measures in DEIS, including those to address early school-leaving. Under the DEIS action plan, School Completion Programme services provide targeted supports on an individual and group basis to children and young people who may be at risk of early school-leaving. This programme will be expanded and developed to provide services through 125 school clusters nationwide.

A range of measures are currently in place that provide second-chance education to those who have left school early. The Back to Education Initiative currently provides approximately 8,000 places to adults who did not complete upper second-level schooling; this is due to be expanded by an additional 2,000 places by 2009 (as outlined in the National Action Plan for Social Inclusion^[50]). The Post-Leaving Cert programme provides further vocational education and training for young people to enhance their prospects of employment or progression to other studies. The Youthreach^[336] programme is an interdepartmental initiative directed at early school-leavers, without formal qualifications. The programme provides opportunities for basic education, personal development, vocational training and work experience over a 1-2 year period. Studies have also shown a decrease in aggression and other anti-social behaviours among isolated and disadvantaged young people participating in these programmes.^[337, 338] The Daybreak programme^[339], developed by the Donegal Youth Service, works with early school-leavers, poor attendees and young people returning from and going into care. Although primarily designed to provide additional academic support to participants, the programme has additional social and personal development benefits and includes a focus on improved communication skills. Parent support programmes are also important in this sector in terms of improving parent-teen communication^[340] and this may be particularly important in the context of the provision of fathering programmes and the development of local community initiatives that involve fathers. The National Action Plan for Social Inclusion^[50, p. 45] has called on the National Office for Equity of Access to Higher Education to set goals and targets and to develop baseline data for 'the participation [in third-level education] of students with a disability,

mature students and those from socio-economically disadvantaged backgrounds, including Travellers and other minorities over the period 2007-2013'. AONTAS promotes the development of a learning society 'through the provision of a quality and comprehensive system of adult learning and education, which is accessible to and inclusive of all'.^[341]

9.2.5 Bullying

In a nationwide study on bullying in Irish schools^[342], it was found that 43% of children at primary school and 26% of children at post-primary schools were involved in bullying, either as victims, bullies or bully-victims. Homophobic bullying has also emerged as an issue in Irish schools, with the highest reported incidence being in boys' single-sex schools (94%).^[343] The Equality Authority, in association with the 'Belong To Youth Project', has developed a booklet aimed at counteracting homophobic bullying in second-level schools.^[344]

Being bullied at school is significantly associated with depression and suicidal ideation.^[345] This highlights the importance of school policies on bullying being clearly visible and fully implemented, and that ongoing efforts are needed to establish best practice guidelines in dealing with bullying, including supporting teachers to address their own issues in relation to bullying. An example of best practice is the former North-Eastern Health Board's 'Cool School Initiative'^[346], which adopts a whole school approach to the prevention of bullying. The prevention of bullying should also be an integral part of a written Code of Behaviour and Discipline in all primary and post-primary schools.^[347] This should include a school policy with specific measures to deal with bullying behaviour and should be promoted by the school managerial authorities on an ongoing basis. The National Educational Welfare Board (NEWB) is currently developing updated guidelines for schools on Codes of Behaviour, as provided for under Section 23 of the Education (Welfare) Act 2000. The Department of Education and Science will revise its 1993 *Guidelines on countering Bullying Behaviour* to reflect the outcome of this work.

9.2.6 Adopting a gendered approach to male college students' health

A recent national survey of student health (CLÁN^[156]) highlights significant gender differences between male and female college students on many issues, including work versus study, health information, mental health, dietary habits, exercise habits, accidents and injuries, sexual health, substance use and alcohol-related harm. Many young men tend not to seek help because it is seen to run counter to appearing independent, while peer pressure and adherence to group norms could also militate against seeking help.^[348]

The World Health Organization^[349] has drawn attention to the potential for institutions of higher education to promote the health of student populations. The Health Promoting College Model^[350] outlines a clear framework for promoting optimum health among student populations in Ireland. The National Working Group on Alcohol in Higher Education^[351] addresses the issue of alcohol in third-level colleges within a wider context of a holistic and integrated approach for student well-being.



In order for male college students to take more personal responsibility for their own healthcare, they need the reassurance, support and guidance of peers, support groups, healthcare providers and the third-level institute.^[348]

9.2.7 Conclusions and Recommendations

- Men's health starts with boys' health. There is a need to provide a visible and integrated focus on boys and men's health within primary and post-primary school curricula, one that includes a focus on male-specific health issues and that fosters positive models of personal and social development, and sexual health delivery for boys.
- There is a need to combat the practical and cultural barriers to the full implementation of the SPHE programme, particularly in single-sex boys' schools. It is also imperative that the recommendations from previous evaluations^[309, 316] of the SPHE module 'Exploring Masculinities' are fully implemented in order to make it a viable resource within the context of SPHE in the future.
- Research is necessary in an Irish context to establish if particular learning styles and teaching practices should be considered as key elements in addressing the educational needs of boys and whether or not the current school system affirms boys in a positive way.
- This policy supports the expansion of the Home School Community Liaison (HSCCL)^[333] Scheme under the DEIS^[335] action plan, to foster improved links between the home and schools that enable fathers to have an increased involvement at all levels of a child's education.
- There is a need to implement in full the actions in DEIS^[335], including those related to the expansion of School Completion Programme services, and to adopt models of international best practice^[329] in addressing the high proportion of male early school-leavers. There is also a need to expand the number of places offered through second-chance education initiatives and to consider barriers to accessing these programmes for men.
- It is imperative that school policies on bullying are clearly visible and fully implemented, and that increased efforts are made to establish best practice guidelines in dealing with bullying.
- This policy endorses the recommendations of the CLÁN^[156] Survey and draws attention to the need for gender analysis to inform the development of a health-promoting college model.

With due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

SA9.2 Develop a more holistic and gendered focus on health and personal development in schools, out-of-school settings and colleges within the context of the Health Promoting School and college models.

RECOMMENDATIONS		Lead Agency
R9.2.1	Provide a clear and prominent focus on the development of positive and healthy masculinities among boys through both policy and practice within schools.	Dept. of Education and Science
R9.2.2	Establish within an Irish context if particular learning styles and teaching practices should be considered as key elements in addressing the educational needs of boys.	Dept. of Education and Science
R9.2.3	Establish improved links between the home and school that enable fathers to have an increased involvement at all levels of a child's education.	Dept. of Education and Science
R9.2.4	Reduce the rate of drop-out of boys from secondary school and expand the number of places offered through second-chance education initiatives.	Dept. of Education and Science Other relevant Government depts.
R9.2.5	Develop best practice guidelines on policy approaches to reduce school bullying and violence (within the context of health and education partnerships associated with SPHE and the Health Promoting School).	Dept. of Education and Science HSE
R9.2.6	Implement the recommendations from the CLÁN Survey and develop the health-promoting college model in a way that is informed by gender analysis.	Institutes of Technology Ireland Irish Universities Association Third-level institutions HSE

See Actions A9.2.1 – A9.2.6 (1-21) in Part III: Action Plan

9.3 Promoting men's health in the workplace

It was clear from the consultation process for this policy that the workplace was a key setting in which to target specific men's health policy initiatives. The consultation process for the policy drew attention to the need to promote men's health as a productivity issue and to emphasise that a healthy workforce makes good economic sense. Attention was also drawn to rigid work structures and a general absence of family-friendly initiatives that would allow for a better work–life balance. While the consultation process welcomed the progress made in recent years in the area of workplace health and safety, there was a call for stricter enforcement of health and



safety legislation in the workplace, as well as a more explicit focus on the 'health' aspect of 'health and safety'.

In light of the importance of work as a defining aspect of many men's lives, the consultation process also drew attention to the potentially negative impact on men's health of unemployment and retirement, and to the lack of security of job tenure and rapid change in work practices that have taken place in recent times. Finally, the issues of stress and bullying in the workplace were repeatedly highlighted and there was a call for the continued development of models of good practice in these areas.

9.3.1 Improving productivity and reducing absenteeism

In a historical context, paid work has occupied a central focus in men's lives and traditional masculine values in Ireland have tended to centre on the 'hard-working' man and the 'good-provider' role.^[23] Traditionally, men have also been more likely to be employed in work environments and gendered work practices that have had the potential to damage their health (e.g. mining, fire-fighting, fishing, agriculture, construction, military and the police).^[26, 352]

A recent report^[353] estimates that occupational injury now costs the Irish economy approximately €3.3 billion each year, on top of the considerable personal loss to those involved in such accidents and to their families. Furthermore, a report from the Irish Business and Employers' Federation (IBEC)^[354] estimates that the direct cost of sick pay, overtime and staff replacement, coupled with the indirect costs associated with impaired production and quality, amounts to €1.5 billion annually. This equates to a total of 14 million workdays being lost every year, or approximately 7.8 days per person employed. There is therefore an urgent need to reduce these costs. Reducing absences due to men's health issues in the workplace should contribute to this reduction.

The workplace is considered to be an ideal setting for health promotion initiatives^[355] – approximately one-third of waking hours are spent at work and it provides regular access to a relatively stable population, many of whom are men. Importantly, workplace health promotion is associated with a reduction in health risks and with improvements in economic and productivity factors, including reduced medical costs, compensation benefits, employee absenteeism and increased job satisfaction. The value of workplace health promotion was identified in the Health Promotion Strategy^[57] and in the policy document *Developing a Health Promoting Workplace*^[355], which provides a framework and guidelines for the development of workplace health promotion policies.

Successful initiatives on men's health in the workplace are those that are (i) topic-specific and personalised; (ii) combine health assessments with medical follow-up; (iii) involve sustained interventions, with an emphasis on long-term maintenance of employee behaviour change; and (iv) allow for health promotion to become institutionalised as part of the organisational culture of the workplace.^[356, 357] To date, the most successful large-scale men's health initiative in the workplace, driven by primary care services, that has taken place in Ireland has been the Construction Workers' Health

Trust (CWHT), with the operation of mobile health units proving particularly successful (see Chapter 8, Section 8.1.2(b)).

9.3.2 Work–life balance

Towards 2016 recognises that the development of family-friendly policies and appropriate measures to assist in the reconciliation of work–life balance are important to underpinning economic, social and equality objectives.^[304] Reports by the Department of Social and Family Affairs^[297] and the Department of Enterprise, Trade and Employment^[28] also focus on work–life balance as an issue that increasingly affects men (and not just women) and call for increased measures and incentives to increase men's uptake of work–life balance initiatives.

The promotion of work–life balance emphasises a number of potential gains. These include direct benefits (such as improved job satisfaction, morale, productivity and loyalty among staff) and indirect benefits (such as retention of staff, reduction in recruitment/training, and reduction in development costs of replacing valued staff). It is also recognised that policies designed to improve work–life balance can serve an important wider role in terms of equality and gender relations. However, while employers may recognise the benefits of work–life balance policies, competing organisational priorities have tended to impede the translation of this into family-friendly work arrangements.^[28, 358, 359]

Changes in the labour market in recent years have brought about an intensification in the pace of work and longer working hours. It is recognised that long working hours and expanding commuting times pose major challenges to policy-makers in targeting the provision of transportation, traffic management, childcare, housing policy and working-time arrangements.^[28] It is also acknowledged that successfully implementing family-friendly work–life balance arrangements goes beyond HR policy and practice, and in effect implies implementing a programme of cultural change and challenging the way work is done within an organisation.^[28, 297, 359] It is imperative, for example, that employees do not see the uptake of part-time working/job-sharing as a threat to their career prospects. Clearly, therefore, policies that are designed to improve work–life balance must be carefully thought through, so as not to penalise (even if unintentionally) those workers availing of such options in their attempt to reconcile paid work with caring and other responsibilities. The provision of increased childcare and crèche facilities within the workplace should also be prioritised under the National Childcare Investment Programme (NCIP) 2006–2010.

9.3.3 Health and safety

The 2005 Safety, Health and Welfare at Work Act^[360] sets out a broad range of strategies for the prevention of workplace accidents, illnesses and dangerous occurrences, and focuses on the organisational and structural arrangements necessary to achieve better safety and health within the workplace. Section 43 of the Act provided for the development of the recently published Health and Safety Authority's (HSA) *Strategy*



Statement 2007-2009^[361], which aims to foster and protect a national culture of workplace safety for Ireland. In light of the gendered nature of occupational health and safety (see Chapter 4), the principal goals of the strategy are consistent with the wider remit of this men's health policy. There is, therefore, a need for an increased focus on occupational safety, health and welfare in the workplace – one that is consistent with the HSA Strategy Statement^[361] and that seeks to:

- raise the level of general awareness of occupational safety, health and welfare in the workplace among employers, employees and society in general;
- foster a culture of safety within the workplace through early and continued interventions in the education and training systems;
- make relevant and specific information and guidance easily available to those who manage and promote workplace safety;
- enforce occupational safety, health and welfare legislation through targeted and prioritised inspections and through legal action where necessary;
- develop a research programme on current, emerging and future high-risk areas in workplace safety, health and welfare.

The HSA is also strategically placed to provide more indirect support to other initiatives on men's health in the workplace. This policy calls for an increased focus in the future on a partnership approach between the HSA, HSE and other relevant organisations to promote men's health in the workplace. For example, the HSA could assist other organisations (e.g. Irish Heart Foundation, Irish Cancer Society) in the development of workplace health promotion campaigns with a focus on men's health; it could provide an advisory role on initiatives to enable men to take increased responsibility for their own health (e.g. skin protection in construction sector, manual handling training in retail sector); and it could support the HSE in promoting an increased focus on men's health research in the workplace and in developing evidence-based fact sheets on men's health based on efficacy of work site health projects.

9.3.4 Loss of work and the impact on men's health

Approximately two-thirds of the long-term unemployed in Ireland are men.^[362] Unemployment is also concentrated within populations of multiple social disadvantage, particularly in relation to poverty and lack of education^[363], and is associated with a range of adverse effects on health^[364-367]. For example, it has been reported that the loss of 'purposeful activity' and social support brought on by unemployment has an important negative influence on mental health.^[367] Those that are unemployed for more than one year are 6 times more likely to die by suicide than those recently unemployed (less than 6 months).^[368] For many men, it seems that work is central to their sense of identity and self-esteem, and can also be instrumental for developing social networks and support.

A consistent theme to emerge from the consultation process for this policy was the uncertainty and lack of security of job tenure that the introduction of temporary and fixed-term contract work had brought. Unskilled and semi-skilled workers in particular were very concerned about their lack of leverage in the workplace and tended to regard

themselves as dispensable cogs in a rather impersonal labour market. Frequent job change has been associated with a higher incidence of health risk behaviours.^[369] As more workers become employed on a contract basis, increasing competition for the more desirable contracts results in a tendency for workers to spend increasing hours at work and to pay less attention to their personal life or to their health.

Although it has been repeatedly reported that retirement does not adversely affect physical health^[370], the impact of retirement on mental health is less clear. It has been shown, however, that a common perception of men prior to retirement is one of uncertainty and sometimes crisis^[371], which points to the desirability of supportive pre-retirement interventions that emphasise working out emotional difficulties posed by the anticipation of ending work. Australian and UK data show that men who retire below the retirement age of 65 had consistently higher rates of mental disorders than working men, but that poor mental health appears to be linked to being retired below this age rather than to any stable characteristic of those who retire early.^[372]

9.3.5 Stress in the workplace

The 1998 and 2002 SLÁN surveys^[96, 373] found that men in Ireland identified the reduction of stress as their top requirement for improving general health. High levels of work-related stress are associated with high absenteeism and staff turnover, interdepartmental conflict, deterioration in industrial relations, reduction in long-term productivity, general dissatisfaction, low morale and poor work performance.^[374] Lack of reward in the workplace has been identified as a particular source of stress for men, with long-term exposure to effort–reward imbalance (work reciprocity) increasing the risk of stress-related disorders.^[375] The HSA has produced a number of publications to support employers and employees in identifying and managing stress in the workplace.^[374]

9.3.6 Bullying in the workplace

The 2005 *Report of the Expert Advisory Group on Bullying* provides a blueprint for the reduction of workplace bullying.^[376] A recently published report by the ESRI documents the results of two national surveys on workplace bullying, commissioned by the Department of Enterprise, Trade and Employment.^[377] The first, relating to individuals at work, highlights the incidence of bullying in Irish workplaces and correlates the causes and characteristics of the phenomenon. The second survey, concerning public and private sector employers, was conducted to explore how employers viewed the problem of bullying in their workplaces. A recently revised Code of Practice, under the Safety, Health and Welfare at Work Act 2005, is aimed at preventing and dealing with bullying where it happens in Irish workplaces and is directed at both employers and employees.^[378]



9.3.7 Conclusions and Recommendations

- There is a need for an increased priority on men's health in the workplace, one that embraces the workplace as a key setting for delivering men's health initiatives and that involves both employers and unions/representative bodies working in a cohesive way to promote men's health.
- Work–life balance is increasingly seen as an issue that impacts on men as well as women. This policy has identified the need for an increased focus on family-friendly policies that give greater choice to men in this respect.
- There is a need to recognise the gendered nature of occupational health and safety and to have an increased focus on occupational safety, health and welfare in the workplace that is consistent with the HSA *Strategy Statement 2007-2009*.^[361] There is also much potential to promote an increased focus on men's health in the workplace through a partnership approach, consistent with the HSA strategy, between the HSA, HSE and other relevant organisations.
- Unemployment, lack of security of job tenure and involuntary early retirement can have a potentially negative impact on men's health. Men who fall into these categories need to be prioritised within health and social services.
- There is a need for an increased focus on the prevention and management of stress^[374] and bullying^[378] in the workplace.

With due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

SA9.3 Target the workplace as a key setting in which to develop a range of men's health initiatives that are based on consultation and partnership building with employers, unions, workers and other relevant statutory bodies.

RECOMMENDATIONS		Lead Agency
R9.3.1	Adopt a more targeted and gender-specific approach to the development of health promotion initiatives in the workplace.	Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE
R9.3.2	Promote and encourage family-friendly policies in both the public and private sectors that enable men to exercise greater choice in the making of decisions regarding work–life balance.	Dept. of Enterprise, Trade and Employment
R9.3.3	Implement the Health and Safety Strategy Statement 2007-2009 ^[361] and provide assistance to the HSE and other relevant organisations to create increased opportunities for the promotion of men's health in the workplace.	Health and Safety Authority HSE
R9.3.4	Develop tracking systems at primary care level to monitor more closely the health of the long-term unemployed, those engaged in transient work and non-voluntary early retirees.	HSE
R9.3.5	Ensure that there is an increased focus on the prevention and management of stress in the workplace.	Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE
R9.3.6	Implement the recommendations of the 2005 <i>Report of the Expert Advisory Group on Bullying</i> ^[376] and the <i>Code of Practice for employers and employees on the prevention and resolution of bullying in the workplace</i> ^[378] .	Employers & Unions Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE

See Actions A9.3.1 – A9.3.6 (1-17) in Part III: Action Plan

9.4 Social spaces as a setting for men's health

In formulating this policy, the value of one's social space as a resource for health was identified. The consultation process, however, highlighted the lack of alcohol-free social spaces and the lack of green spaces and recreational facilities in many communities throughout Ireland. It was felt that the lack of appropriate social spaces is particularly relevant to the health of young men and that there is a need both to provide such



facilities for young people and to consult with them when planning local youth services and facilities. The presence of recreational facilities was also identified as an important factor for the health of older men to ensure their continued involvement in activity throughout their lifespan.

9.4.1 Safe social and recreational spaces for young people

The lack of recreational facilities and safe social spaces for young people in Ireland has been raised by a number of sectors in recent years^[95, 133, 139, 379-381] and by young people themselves through their representative body, Dáil na nÓg (National Youth Parliament), since 2004^[382, 383]. The lack of appropriate facilities denies many young people their right to become involved in activities that interest them, as defined under the 1989 United Nations Convention on the Rights of the Child (Article 31)^[384] and the 2000 National Children's Strategy^[381]. Conversely, the presence of such facilities serves to promote healthy living through encouraging physical activity^[385-387] and reducing risk behaviours, such as underage drinking^[379]. Alcohol-free alternative spaces for young people have been recommended as part of an overall community-wide approach by both the Strategic Task Force on Alcohol (Recommendation R3.15)^[133] and the Working Group on Alcohol Misuse (Action A4), representing the partners of *Sustaining Progress*^[139]. The provision of safe social spaces for young people has also been prioritised in *Teenspace*, the National Recreation Policy for Young People (Objectives 2, 3, 4 and 6).^[388]

A number of youth cafés have been developed around the country that offer young people a safe social space and in which a number of their health needs can be met.^[389-395] The first of these initiatives, the Gaf Youth Café, was set up in Galway in October 2001 by the former Western Health Board as a social health project and has proved a most successful initiative.^[389] Central to its success has been the appointment of a youth advisory committee, which plays an active role in the day-to-day running of the café and project. Young men are represented on the advisory committee and their presence ensures that programmes offered are gender-sensitive and meet the diverse needs of young men. The personal and social development of the young people is a core component of all programmes, while specific health information and topic-specific health seminars are also delivered.

To date, there are a limited number of youth cafés around the country and all of those that have been established are based in urban areas. Furthermore, due to limited resources, the opening times of the cafés are restricted, with some only opening at weekends and often closing too early on the days that they are open.^[379, 382] The 2007 Programme for Government relating to drugs and alcohol^[169] has proposed that a fund for the provision of a countrywide network of youth cafés be established to ensure that young people can meet in a safe, legal, alcohol-free and healthy environment. This investment is essential for young people and it is important that young men are an integral part of the planning process for these proposed youth cafés. The Office of the Minister for Children and Youth Affairs is the leading Government agency involved in the research and consultation process for these proposed youth cafés.

Currently, the Young People's Facilities and Services Fund (YPFSF) supports 'at risk' young people (10-21 years) in disadvantaged areas by attracting them into purpose-built

facilities with activities that divert them away from the dangers of substance abuse.^[396] While it is essential that disadvantaged areas continue to be funded, capital investment is also needed elsewhere. According to the National Youth Work Development Plan, a capital investment scheme should be established to provide youth centres in selected areas other than those currently covered by the YPFSF (Action A3.12).^[397] The National Youth Work Development Plan also calls for a review of funding (Action A3.7) and the provision of adequate (Action A3.9) and long-term funding (Action A3.8) for youth services in general.^[397]

In keeping with its responsibility under the UN Convention on the Rights of the Child^[384], the Office of the Minister for Children (OMC) published the National Play Policy in 2004^[398] and the National Recreation Policy for Young People in 2007^[388]. The full implementation of both policies will ensure that all young people have access to a wide range of recreational and social activities that meet their diverse needs. In order to meet the needs of young men in Ireland, it is essential that they continue to be consulted throughout the implementation of this men's health policy via Dáil na nÓg structures, both locally and nationally, and through participation in the OMC's Children and Youth People's Forum.

Safe places for young people to gather may also be provided through youth services offered in out-of-school settings. Under the Youth Work Act 2001, Youth Work Committees (YWC) and Local Youth Voluntary Councils (LYVC) have been established in each Vocational Education Committee (VEC) area. Youth Development Officers have been appointed who work with the YWC and LYVC to develop and implement local Youth Work Development Plans. Through these structures, local youth work programmes and services (education or otherwise) are developed in partnership with other agencies, such as City/County Development Boards (CDBs). These partnerships should continue to be supported locally and nationally, and should strive to seek funding from all bodies involved in the provision of youth programmes and services. Mechanisms by which these programmes and services can be made attractive for boys and young men should be investigated. Incentives should also be provided to commercial investors to fill the gap in this market.

9.4.2 Recreation and leisure facilities for all men

Currently, the development of recreational and leisure facilities is part of the National Spatial Strategy for Ireland (2002-2020)^[399], whereby the development of any such facilities will be considered as part of the overall planning process. In this strategy, the planning process maps out how the development of excellence in sporting and other facilities in medium-sized towns should service those towns, as well as the rural hinterland, by improved access to public transport.

The development of all recreation programmes and facilities are supported by the Irish Sports Council and its Local Sports Partnerships^[400], with the support of the Sports Capital Programme from the Department of Arts, Sport and Tourism. Youth participation and the needs of disadvantaged areas are prioritised in these programmes. Given the importance of physical activity on all aspects of a man's health, it is essential that, in the future, these programmes target men across their lifespan. In particular, programmes that target those men in their mid- to late-30s, who are most inclined to retire from sport, should be piloted and developed. Such programmes should account for the challenge that many men experience in trying to balance their work and family commitments.

With regard to the Sports Capital Programme, the requirement for matched funding was reduced to 10% for designated disadvantaged and RAPID areas in the 2007 Programme for Government.^[169] Capital investment is also available for designated disadvantaged areas via the Young People's Facilities and Services Fund. While considerable investments have been made to date to improve recreational and leisure facilities, it is evident that a greater investment and spread of funding is required to meet the diverse needs of all men.



The investment of €2 million to develop 21 skateboard facilities throughout the country by the end of 2007 is a good example of local authorities catering for the diverse needs of young people. However, the provision of cycle lanes and well-lit walkways, with clearly marked routes, are also needed to support older men to become active. Importantly, the provision of such facilities will enable men to become active without the expense of paying a membership fee to a gym.

9.4.3 Conclusions and Recommendations

- Currently, there is a lack of recreational facilities and safe social spaces for young people throughout the country and this has been identified as a factor in the harmful health and risk behaviours of young men in particular. The 2007 National Recreation Policy for Young People^[388] outlines clear objectives to address this deficit.
- Young people must be consulted in the planning and implementation of any policy that affects them. Consultation with young people must be inclusive of all young men to ensure that outcomes are gender-sensitive and that the diverse needs among young men are met. In that regard, young men must be equally represented on youth representative bodies at national and local level.
- While physical activity is essential to support the healthy development of young people, there needs to be a greater emphasis on the provision of appropriate recreational and leisure facilities for men across their lifespan. In particular, men in their mid- to late-30s, who are most inclined to retire from sport, should be supported to remain active through the provision of more accessible community-based facilities.

In order to ensure that the social and recreational needs of young men in our society are met, this policy recommends the following:

STRATEGIC AIM

SA9.4 Increase the availability of and access to facilities for sport and recreation for all men and safe social spaces for young people.

RECOMMENDATIONS		Lead Agency
R9.4.1	Provide increased investment in the development of facilities for sport and recreation and safe social spaces for young people.	Dept. of Arts, Sport and Tourism Irish Sports Council
R9.4.2	Ensure that young men are fully represented within existing structures at local and national level that give a representative voice to youth.	Office of the Minister for Children and Youth Affairs
R9.4.3	Consult with and involve young men in the development of policies, services and programmes designed to meet their needs.	Office of the Minister for Children and Youth Affairs

See Actions A9.4.1 – A9.4.3 (1-7) in Part III: Action Plan

10. Community Development - Strengthening community action to support men's health

The national consultation process for this policy consistently highlighted the need to harness community potential to improve the health of men. There was a call, in particular, for the need to adopt a community development approach and to create social networks for men. Specific issues for marginalised groups of men were raised, which included isolation and social exclusion, transport, poverty, unemployment, language barriers, illiteracy, racism and prejudice, lack of understanding of rights, lack of equity to health and social services, and the links between imprisonment, homelessness and drug use. Through empowering men and building social capital among communities of men, it is believed that these issues, and ultimately health inequalities among men, can be addressed.

Social capital refers to features of social organisation, such as networks, norms and social trust, that facilitate coordination and cooperation for mutual benefit.^[401] Two critical features of social capital appear to be the level of trust among citizens (social cohesion/trust) and the density and rate of voluntary associations and local organisations (civic engagement).^[402] Other features of social capital include a willingness among individuals to intervene on behalf of the common good (collective efficacy) and social norms that support individuals to make healthy choices.^[80] The benefits of social capital seem to be associated with the extent of the social networks, their perceived adequacy^[403] and the degree of interaction between individuals and their social networks^[404]. Variables such as educational attainment, employment rate and the distribution of income are predictors of social trust and civic participation.^[74, 405] Conversely, the absence of social norms concerning labour force participation and educational attainment is a critical factor in criminality.^[80] There is also considerable evidence that social capital can have a positive influence on an individual's subjective mental and physical well-being^[73, 75], as well as objective health outcomes^[74, 406]. This holds true even after accounting for socio-demographics^[74] and age^[406].

Two mechanisms through which social capital can influence health have been identified:^[407]

- directly, through interactions with one's social environment;
- indirectly, by facilitating effective coordinated action within a community:
 - by improving the local physical and social environment and services;
 - by improving other socio-economic circumstances of individuals;
 - by providing social support to community members;
 - through more general psychosocial factors.

The value of one's community, and in particular the presence of social capital within communities, has been recognised by the State as a resource for health that should be harnessed.^[75] This philosophy is evident in public health policy across a number of areas^[55, 57, 131, 136, 227] and, in particular, underpins the National Anti-Poverty Strategy (NAPS), whereby the third objective of that strategy is to develop social capital, particularly for disadvantaged communities^[49]. Indeed, one of the factors underpinning the current National Action Plan for Social Inclusion (NAPinclusion 2007-2016) is the desire to build viable and sustainable communities, improve the lives of people living in disadvantaged areas and build social capital.^[50]



This chapter will focus on building social capital among communities of men in Ireland, whereby one's community can be defined by geography, culture or social stratification. The communities of men that exist within Irish society today, however, are many and diverse, and it is beyond the scope of this policy to focus on each specific individual community of men. Rather, an approach to building social capital via a community development approach will be discussed that is relevant to *all* communities of men.

10.1 Community development for men's health

A community development approach to health is one that recognises the central importance of social support networks^[408] and aims to empower people to gain control over the factors influencing their health^[409]. Essentially, it is a process by which a community defines its own health needs, considers how those needs can be met and decides collectively on priorities for action.^[410] By their very nature, community development approaches to health tackle the root causes of health inequalities and, in doing so, adopt a broad perspective on what determines 'health'. Partnership work is also central to the success of community development work. This is in keeping with the interagency and social determinants approach to men's health adopted in this policy (see Chapter 2). Communities of men in Ireland are quite diverse and can be shaped by social class, location, age, ethnicity, sexuality and/or ability. Many communities of men are vulnerable to health inequalities and it is important, therefore, to recognise the needs of different subcommunities of men in order to develop appropriate policy and practice.^[127]

As outlined in the Introduction to this policy, Ireland has experienced considerable social change in recent years – commuting times are longer, the cost of living has dramatically increased and the influence of religion on daily living has significantly waned for many. Indeed, modern Ireland has emerged from the era of the Celtic Tiger as a new, diverse and multicultural society. While there is much to be celebrated in modern Ireland, the rapid social change, coupled with the increased economic disparity between rich and poor, has served to marginalise certain communities.^[20] Many men suffer the impact of marginalisation due to such social and economic change, as well as other factors such as unemployment, poor education, poverty, poor living conditions and/or male gendering. Men who experience such socio-economic disadvantage (those in SEGs 5 and 6) experience a greater burden of ill-health, mortality and premature death.^[68] Data elsewhere have shown that the gap in life expectancy between the lowest and highest SEGs is greater for men (8.4 years) than for women (5.7 years), which suggests that social disadvantage has a greater impact on the life expectancy of men than of women.^[411] Single men living in rural areas, in particular, experience multiple forms of disadvantage, with subsequent negative health outcomes.^[22, 412, 413] Education and unemployment are measures of social disadvantage. Currently, 15% of all men aged 18-24 years are early school-leavers (with the Junior Certificate as the highest level of education or training attained), in comparison with just 9% of women.^[79] The unemployment rate for early school-leavers is almost 3 times that for all persons aged 18-24 years.^[414] Compared to women, men are also more likely to be long-term

unemployed^[415] and those in employment tend to do more of the unskilled, manual labouring work, which can cause health risks^[78]. Many of the jobs occupied by men in the lower SEGs and men in minority groups (e.g. labourers) are characterised not only by low levels of income, but also by high levels of stress (due, for example, to lack of job tenure). While literacy levels are relatively constant between men and women, the percentage of those who access literacy tuition through the adult literacy service of the Vocational Education Committees has remained around 60% for women and 40% for men since 2000.^[416] This would suggest that men are less proactive in seeking support and that more targeted approaches may be necessary to support these men to access services.

Men with disabilities are also much more likely to be predisposed to disadvantage. People with disabilities are more likely to leave school early, two and a half times less likely to have a job and earn less in a job, and are twice as likely to be at risk of poverty.^[417] Consequently, they are more likely to experience poor health.^[417] In addition, men are at greater risk of injury from road traffic accidents, work and sporting accidents that may cause disability. There is, therefore, a need to specifically target preventative programmes at men to reduce their likelihood of acquiring a disability (*see Chapter 6, Section 6.3*).

Male prisoners, homeless men and Traveller men also experience health inequalities. Criminality and homelessness are inextricably linked and in many cases are associated with drug use^[172, 173, 177] and mental illness^[177, 432-435]. Therefore, any programme targeting prisoners and homeless men should aim to re-integrate them with society by supporting them to address the complexity of issues in their lives. An excellent example of this was the CONNECT programme that was run in Dublin's Mountjoy Prison. This programme adopted a positive sentence management approach, which enabled prisoners to move from welfare to work on release, thus allowing them to have a positive role in society.^[436] The full implementation of the current Drug Policy and Strategy^[437] for Irish prisons and the Homelessness Strategy^[438] will also serve to reduce the health inequalities experienced by these communities of men. The findings from the All-Ireland Traveller Health Study (currently being conducted) will inform policy to support Traveller men to improve their health. A good model of supporting Traveller men that could be adopted in the future is the Traveller Men's Group, established in the south-east area; it meets regularly and has been involved in a number of initiatives, including a 10-week health programme.^[439]

Given the importance of education as a determinant of social disadvantage (*see Chapter 9, Section 9.2.4*), men experiencing educational disadvantage should be supported through initiatives that will enable them to gain meaningful paid employment, such as the Education Equality Initiative, Back to Education Initiative, Vocational Training Opportunities Scheme (open to those who are over 21 and at least 6 months unemployed), post-Leaving Certificate courses, adult literacy and community education. The Adult Education Guidance Initiative is a useful source of confidential advice and guidance that can help these men to make an informed decision on the most appropriate programmes available. During the initial stages of returning to the



education process, however, primacy should be given to the human potential/social cohesion paradigm over the human resource/employability paradigm.^[215] This principle is central to the Men's Education Project (MEP), run by the Men's Development Network (MDN). The MEP recognises the many barriers for men in supporting them to return to education and aims to provide continual support to them while studying or training.^[418] Other good examples of education initiatives include the Men's Education Initiative, run by the Mevagh Family Resource Centre in Co. Donegal^[419], and the Nexus Europe Ltd. Education Equality Initiative Project involving men on the Dingle Peninsula and in East Mayo^[420]. These models should be replicated throughout the country to support all men who experience educational disadvantage.

Many men in Ireland are also vulnerable to ill-health and have become socially isolated due to marriage breakdown/separation. As highlighted in Chapter 9 (*see Section 9.1.5*), separation may generate a number of issues for men that include care for their children, a loss of social networks, housing problems and financial difficulties, anger and loss. While there is an absence of data on the impact of separation per se on the health of men, research has shown that fathers who lose custody of their children through separation are placed at significantly higher risk of chronic health conditions, psychological impairment and death.^[276] Social isolation and marginalisation for men can also be a consequence of their sexuality, experience of domestic violence and as a result of a transition in a man's life (e.g. retirement and ageing). The provisions of appropriate support services to these distinct communities of men need to be sensitive to the specific needs of each community.^[234]

In recent years, a number of organisations have emerged to offer essential supports for specific communities of men. Forever Fathers^[421] and Parental Equality^[422] are examples of two organisations that offer support to men who have been separated from their children, such as income and social support and housing. Similarly, the AMEN organisation^[423], supports and advocates on behalf of male victims of domestic violence, while the Older Men's Organisation of Ireland^[424] offers a range of services for older men in our society. The Gay Men's Health Project^[440] offers a range of services to gay and bisexual men, and is part of the Gay Health Network^[86] of organisations, which offers similar services to men throughout the country. All these organisations support men by bringing them together, thereby developing social cohesion among them. In the long term, men are empowered to support themselves and each other in addressing their own health needs. This essential work should be supported to continue and develop in the future through the provision of targeted funding.

All community work for men should be underpinned by service-level agreements between community organisations and funding bodies, and be independently evaluated at the end of 3 years in accordance with good practice. Evaluating community work will not only support existing services to develop, but will also enable the body of evidence of good practice in an Irish context to expand and support future work.

The current National Action Plan for Social Inclusion (NAPinclusion 2007-2016) has adopted a lifecycle approach to achieving its high-level goals, with a particular focus

on building communities.^[50] All vulnerable groups will be supported throughout the lifecycle through education, income support, employment and participation measures, the provision of community care and housing, as well as locally based health services. The integration of migrants has also been identified as a high-level goal. Locally, Social Inclusion Measures (SIM) Working Groups in the City/County Development Boards are responsible for coordinating social inclusion activities at local level and, consequently, have a key role in supporting the coordination of services at local level for vulnerable men. The implementation of the NAPinclusion will be monitored at various time points and it is essential that it be reviewed on the 9 grounds of equality, including gender, to ensure that the needs of vulnerable men are addressed. This gender-proofing should be done in accordance with international best practice^[34, 35] at both local and national level.

10.2 Approaching community development work for men

The best practice guidelines for community development work should be adhered to when supporting communities of men.^[425] The principles of best practice in engaging men in health promotion and health awareness initiatives^[212-215] are also relevant to community development work for men. In an Irish context, the need to adhere to three methods of working, discussed below, has been further highlighted when engaging and working with men within communities – adopt a targeted approach, with a clearcut and appealing message; vary the nature of the community programmes to support different aspects; and remove barriers to participation by working exclusively with men.

10.2.1 Engaging with men

Involving men in community development initiatives requires a targeted approach. Experience has shown that men often need to be personally invited to participate by means of a phone call^[213, 214], a letter of invitation^[426] or even calling to their home^[22]. The most effective approach to promoting programmes among men, however, is by word of mouth and they are more likely to attend when a recommendation is received from a trusted source.^[213] It should be noted that when using written promotional material (e.g. local newspapers), the message should:^[213]

- clearly identify what will be gained by attending the programme;
- use 'doing' words or 'action' words;
- emphasise that there will be an opportunity to hear other men's ideas when promoting group programmes.

In order to engage men, the community development programme itself must appeal to them. Community workers may have to be quite innovative to identify an appropriate 'hook' that will appeal to their male target group. For example, fathers might be more willing to attend a programme that supported them in their role as a father for the good of their children rather than themselves. Men are also more likely to seek and accept support when experiencing a transition or a crisis in their lives, such as during a marital separation. Programmes should therefore be targeted at men in crisis and should emphasise that involvement in the programme will allow men to learn from the situations of other men.^[213]



10.2.2 Nature of work done within communities

The nature of community work currently being done with men is quite varied. Many successful initiatives show that while many community-based workers may feel that 'men are hard work' (Phase 1 of the consultation process), once safety is created, men are willing participants in both task-orientated and personal development work. For example, the Men's Development Network (MDN) engages in a wide range of developmental work with marginalised men that is predominantly centred on personal and community development. Examples of programmes being run by the MDN include (i) the Men's Development Project ; (ii) the Men's Education Project; (iii) the Men's Development Health Programme; and (iv) Domestic Violence Intervention Programme for Male Perpetrators.^[418] Through these programmes, men are supported to build social networks and social capital, and are thereby supported to build confidence, self-esteem and self-worth and can go on to achieve their full potential as men. Face-to-face counselling and telephone support is also provided on an individual basis. Men are also supported to develop better physical and emotional health and to engage with appropriate services that meet their needs. This is predominantly achieved via the Men's Development Health Programme and by hosting national men's health events.

The North Leitrim Men's Group^[22] adopts a slightly different approach, by working with men primarily through a community employment scheme, which comprises the three distinct elements of organic vegetable production, community projects and social and health development. Men are provided with opportunities to develop new hands-on skills that will support them to return to work and become involved in their communities. This approach to community development is more task-orientated, which, for some men, is preferable to discussing issues such as health or self-esteem. More recently, the Group opened a drop-in facility, which provides men with a place to met and socialise with each other.

Outreach work is also used by community groups that work with men.^[22, 217, 418] This approach is particularly relevant for some men who tend to be reluctant to access existing services and to 'mobilise' themselves.

10.2.3 Working exclusively with men

Barriers to male participation in generic community-based programmes vary.^[427] Many men, for example, associate community projects with 'women's groups' and therefore do not consider them as something they could attend. Some men view the issues being addressed through community development work as 'women's business' and therefore do not see that they even have a need to attend. Other men, who feel that they would like to attend, fear being the only man among a group of women and therefore do not attend. (Conversely, if a man is aware of other men being involved in a community group, he is more likely to attend.) Yet other men are reluctant to seek support anywhere, let alone in their community.

By bringing men together in their community, they can be facilitated to both receive support and to reciprocate support to other men. This allows them to preserve their

status as a man, both by avoiding indebtedness and by demonstrating competence. Therefore, the provision of community-based programmes or services exclusively for men removes many of the barriers and, indeed, gives many of them 'permission' to participate. Working exclusively with men also offers an opportunity to explore the impact that their gender has on their lives. Through a personal development approach that examines the impact of male gendering on health, the Men's Development Network supports men to achieve their full potential – as men.^[418]

10.3 Facilitating community development work with men

The process of empowering a community to take control over its health is both slow and complex and, in order to effectively support a community, a long-term commitment is required. Targeted funding (3-5 years) should be made available for those working with vulnerable men in our society in order to develop evidence of good practice and to ensure the sustainability of gains made. This funding will not only allow for the continuation and expansion of existing work, but it will also encourage others to become involved in the area of men's health. Community workers themselves should also be supported to engage and work with men through the provision of specific training (*see Chapter 7, Section 7.1*). Support should also be available to community workers to improve their capacity to access funding from Government departments and agencies.

To date, there is no national organisation that has been funded to represent all those working in the area of men's health within communities. The absence of such an organisation has resulted in a lack of:

- coordination of the work being done with men on the ground (e.g. networking and evaluation);
- support for those working with men in communities (e.g. financial and professional);
- growth in the area of community development for men's health;
- a partnership approach to community development work for men between community, voluntary and statutory sectors (e.g. developing and delivering training);
- representation for men within communities in the national arena to inform public policy.

An appropriate national organisation should be tasked with supporting community groups to access funding, education and training, and with informing public policy on the health needs of men at national level. It should be noted that the Men's Development Network currently fulfils a number of these functions at national level. However, to date, there has been no dedicated funding to support any organisation in this role.



10.4 Conclusions and Recommendations

- Many men in Ireland experience social isolation and disadvantage on a daily basis. These men currently have the worst health profiles of any other category of men in our society and are most likely to die prematurely. The re-integration of these men into community and social networks is essential in terms of improving their health. By empowering these men to take control of their lives, they may ultimately be able to change the circumstances that contribute to their disadvantage.
- National health policies across a number of areas have consistently recognised the value for health of developing social capital within communities.^[49, 55, 57, 131, 136, 227]
- Funding should be targeted at vulnerable men throughout the lifecycle, as advocated in the National Action Plan for Social Inclusion (NAPinclusion 2007-2016).^[50]
- Traditionally, men have tended not to engage in community development projects or to mobilise themselves collectively to improve their health. And yet, there is evidence that men do engage in certain community projects and that they are willing participants in both task-orientated and personal development work. There is also evidence that men need to be targeted exclusively and that the nature of the project may differ considerably to that preferred by women.
- Community workers must be adequately resourced and supported, both financially and professionally, to work with men in a safe environment.
- An organisation should be funded to support community groups to access funding, education and training, and that would contribute to the informing of public policy on the health needs of men at national level.

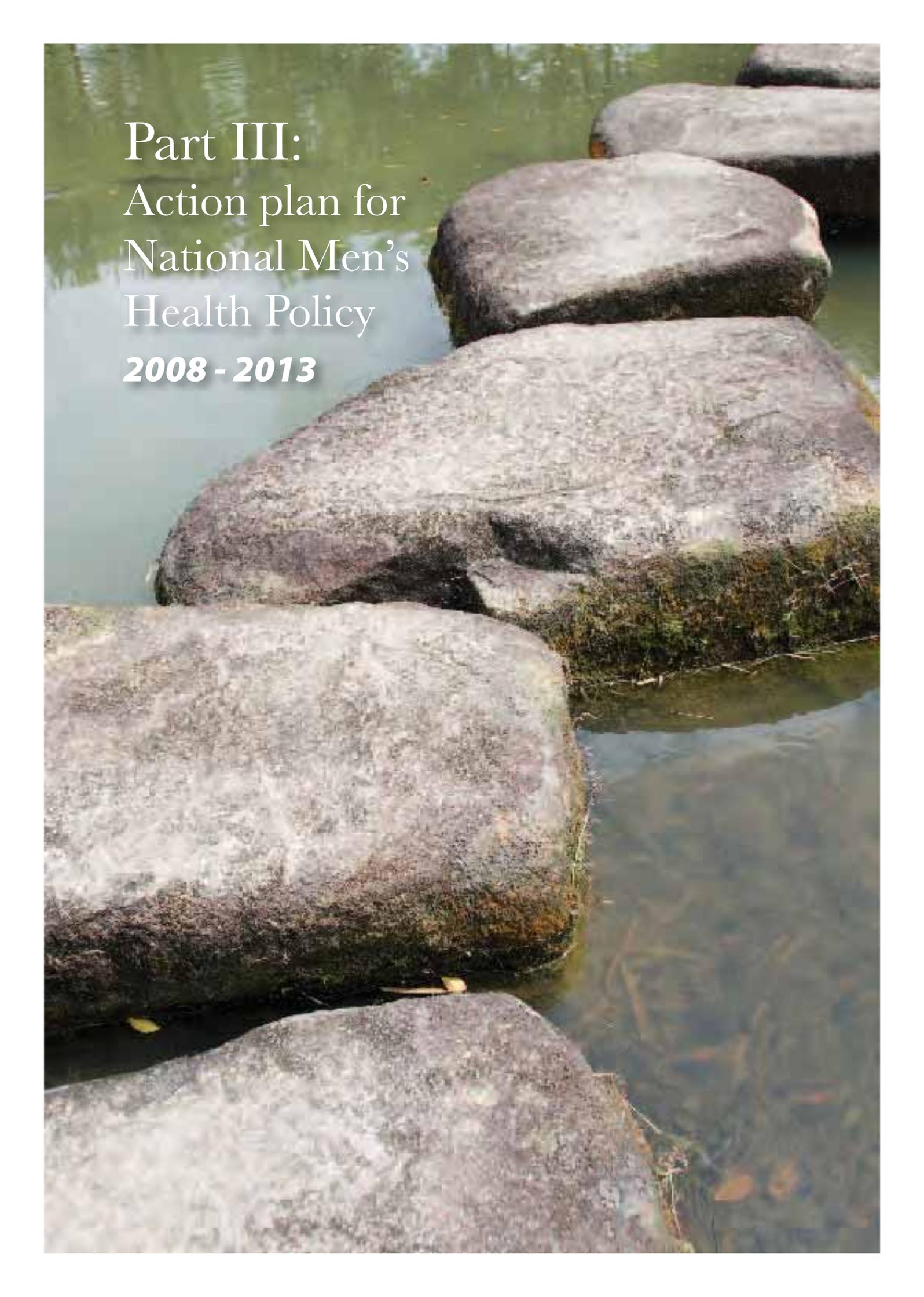
In order to improve the quality of life and health outcomes of those men most in need in our society and with due consideration to the issues raised throughout the consultation process and the weight of evidence from the literature, the following recommendations are made:

STRATEGIC AIM

SA10 Build social capital within communities for men.

RECOMMENDATIONS		Lead Agency
R10.1	Develop mechanisms and structures to support community work for men who experience disadvantage.	Dept. of Community, Rural and Gaeltacht Affairs Dept. of Enterprise, Trade & Employment HSE
R10.2	<ul style="list-style-type: none"> • Name disadvantaged men as a vulnerable group to be supported through available funding streams under the National Action Plan for Social Inclusion (NAPinclusion 2007-2016).^[49] 	All relevant Government depts.
R10.3	<ul style="list-style-type: none"> • Modify the current gender-proofing mechanisms to be inclusive of vulnerable men in our society, in accordance with international best practice.^[34, 35] 	All relevant Government depts.
R10.4	Incorporate a health agenda into all community development work for men in consultation with the men in the community.	All relevant Government depts.

See Actions A10.1 – A10.4 (1-8) in Part III: Action Plan



Part III:
Action plan for
National Men's
Health Policy

2008 - 2013

This Action Plan gives guidance and structures for the implementation of the Recommendations contained within this policy document

RECOMMENDATIONS (R) and ACTIONS (A)

STRENGTHENING PUBLIC POLICY ON MEN'S HEALTH		LEAD AGENCY
R5.1.1	Oversee the implementation of the policy at an interdepartmental level and monitor and evaluate policy outcomes on an ongoing basis.	Dept. of Health and Children HSE
A5.1.1	<ol style="list-style-type: none"> 1. Make provisions for appropriate mechanisms to monitor and evaluate the policy at both a departmental and interdepartmental level, under the aegis of the Inter-Departmental Group. 2. Develop a joint research agenda on men's health. 3. Maintain an explicit focus within men's health policy on men who are disadvantaged or marginalised. 4. Develop a framework for gender-mainstreaming men's health across all Government departments that is based on current international models of best practice^[34, 35] and that is consistent with the development of a National Equality Strategy Framework^[50]. 	<p>Dept. of Health and Children Other relevant Government departments</p> <p>Dept. of Health and Children HSE</p> <p>Dept. of Health and Children</p> <p>Dept. of Health and Children HSE Equality Authority Other relevant Government departments</p>
R5.1.2	Establish appropriate structures and secure resources to support the implementation of the policy.	Dept. of Health and Children HSE Other relevant Government departments
A5.1.2	<ol style="list-style-type: none"> 5. Appoint a National Implementation Group to oversee the implementation of the policy, giving due consideration to the following (see <i>Figure 5.1</i>): <ul style="list-style-type: none"> • The development of appropriate structures at both national and regional level to support the implementation of the Men's Health Action Plan. • Establishing strong networks and partnerships that integrate men's health within existing organisations in the statutory, community and voluntary sectors. • The development of clear, time-framed performance indicators and health outcomes for men's health. 	HSE

R5.2.1	Establish a Centre for Research and Development in Men's Health.	Dept. of Health and Children
A5.2.1	<p>1. Support the establishment for a Centre for Research and Development in Men's Health, in partnership with an academic Institution, with consideration to be given to the following:</p> <ul style="list-style-type: none"> • Develop a National Men's Health Research Framework and Network within the context of the existing National Population Health Research Framework. • Actively compete for other research funding, including that outlined through the National Population Health Research Framework. • Establish baseline measures across different aspects of men's health that can be monitored to evaluate changes in men's health status over time. • Broaden the research base and increase the level of post-graduate research on men's health. • Promote more multidisciplinary approaches to research on men's health. • Develop appropriate filtering mechanisms to disseminate research findings. • Liaise with other academic institutions to promote an increased focus on men's health in relevant undergraduate and post-graduate courses. • Develop and maintain links with international research on men's health. 	Dept. of Health and Children
R5.2.2	Ensure that research continues to underpin the implementation and evaluation of the policy.	Dept. of Health and Children HSE
A5.2.2	<p>2. Review on an ongoing basis the implications of research findings (both national and international) for both policy and practice.</p> <p>3. The proposed Centre for Research and Development in Men's Health will support practitioners with the ongoing evaluation of men's health initiatives on the ground.</p>	<p>HSE Dept. of Health and Children HSE Proposed Centre for R&D in Men's Health</p>

PROMOTING MEN'S HEALTH – MARKETING, INFORMATION AND PROGRAMMES		
R6.1	Promote a holistic and positive focus on men's health that supports men to take greater ownership of their own health.	HSE Other relevant Government departments
A6.1	<ol style="list-style-type: none"> 1. Develop an overall Communications, Social Marketing and Advocacy Plan for men's health that is integrated into the overall HSE Plan and that maintains a clear focus on men's health through national and local campaigns. 2. Develop and disseminate guidelines for best practice in relation to appropriate and inappropriate portrayals of men and masculinity. 3. Advocate for the use of appropriate complaints procedures to challenge negative stereotypes of men in advertising, public broadcasting and the popular press. 	HSE National Implementation Group Equality Authority Broadcasting Commission of Ireland Advertising Standards Authority
R6.2	Devise gender-competent health information and disseminate it through media that are appropriate for men.	HSE Other relevant Government departments
A6.2	<ol style="list-style-type: none"> 4. Pilot a national men's health helpline. 5. Provide a national men's health website for men, including links with existing reputable websites and helplines. 6. Engage with the providers of existing helplines and websites to include a specific focus on men's health. 7. Provide health information to men through existing services and settings. 8. Use best practice guidelines in the design of gender-competent health promotion literature. 	HSE HSE HSE HSE HSE

R6.3	<ul style="list-style-type: none"> • Fully implement existing Government policies^[57, 95, 131-140] that target the health and risk behaviours of men in Ireland through health promotion initiatives. Ensure that their implementation adopts a gendered approach. 	<p>HSE Other relevant Government departments</p>
A6.3	<ol style="list-style-type: none"> 9. Pilot and evaluate health promotion programmes to target specific health-related behaviours and ensure that these programmes account for the gendered nature of that behaviour. 10. Offer capacity-building programmes for those men who are not yet ready to engage in health promotion initiatives. 11. Target health promotion programmes at subpopulations of men, particularly at young men and those in SEGs 5 and 6, with an emphasis on raising awareness of both the generic and male-specific risks associated with health-related behaviours. 12. Consult with men and those working with men in the community, voluntary and statutory sectors in the design of health promotion programmes targeting men. 13. Support men to become involved in the delivery of health promotion programmes targeting men. 	<p>HSE Other relevant Government departments HSE Other relevant Government departments HSE Other relevant Government departments HSE Other relevant Government departments HSE Other relevant Government departments</p>
R6.4	<p>Review the adequacy of existing legislation that is in place to deter risk-taking behaviour among men.</p>	<p>Dept. of Justice, Equality and Law Reform Dept. of Transport Dept. of Health and Children HSE</p>
A6.4	<p>14. Improve the enforcement of legislative measures, particularly in relation to speeding, drinking driving, use of seat belts in cars, underage drinking and smoking.</p>	<p>An Garda Síochána Road Safety Authority HSE</p>

PROMOTING GENDER-COMPETENCY IN THE DELIVERY OF HEALTH AND SOCIAL SERVICES		
R7.1	<p>Develop specialised academic programmes on men's health and integrate modules on gender and men's health into the training syllabi of all health and allied health courses.</p>	<p>Institutes of Technology Ireland Irish Universities Association Third-level institutions Relevant professional bodies</p>
A7.1	<ol style="list-style-type: none"> 1. Use existing academic structures to expand and develop specialised academic programmes and research in men's health (and 'men's studies' in the wider context of health), from Certificate to Masters/PhD level. 2. Provide a clear focus on gender and men's health in all undergraduate, post-graduate and professional development programmes for health and allied health professionals. 	<p>Institutes of Technology Ireland Irish Universities Association Third-level institutions Relevant professional bodies</p> <p>Institutes of Technology Ireland Irish Universities Association Third-level institutions Relevant professional bodies</p>
R7.2	<p>Develop training protocols and training courses on men's health that are tailored to the needs of those working in the health and allied health professions, and that offer a range of innovative methodologies.</p>	<p>HSE</p>
A7.2	<ol style="list-style-type: none"> 3. Develop training protocols and short training courses in the area of men's health, targeting existing service providers in the health, allied health and community sectors. 4. Develop men's health training protocols and modules for delivery through existing community education and community development programmes. 5. Ensure that training opportunities are provided for men to become facilitators of men's groups, using experiential methodologies. 6. Develop models of peer training to enable men to support other men to manage their health. 	<p>HSE</p> <p>HSE Community Development Organisations</p> <p>HSE Community Development Organisations</p> <p>HSE Community Development Organisations</p>

R7.3	Promote strategies and initiatives to increase men's participation in education and caring professions, and in community work.	HSE Dept. of Education and Science Teaching Council
A7.3	<ul style="list-style-type: none"> 7. Fully implement existing recommendations^[224, 225] to increase the number of men entering the education and social care professions. 8. Commission research to identify strategies and initiatives to increase the number of men entering other caring and allied health professions. 	Dept. of Education and Science Teaching Council Dept. of Health and Children HSE Dept. of Health and Children HSE

BUILDING GENDER-COMPETENT HEALTH SERVICES WITH A FOCUS ON PREVENTATIVE HEALTH

R8.1	Develop specific initiatives that enable men to access health services promptly, particularly for conditions that pose a serious threat to their health. Specific provisions should be made for marginalised subgroups of men (e.g. Traveller men, ethnic minority men, disabled men, isolated rural men).	HSE Irish College of General Practitioners
A8.1	<ol style="list-style-type: none"> 1. Develop specific health education initiatives that enable men to make more informed decisions about seeking help in a timely fashion for health conditions that pose a serious threat to their health. 2. Improve men's access to primary care services by creating more 'male-friendly' environments within those services. 3. Consider mechanisms for tackling the cost of primary care services for non-GMS holders. 4. Clearly advertise the eligibility criteria for GMS entitlement. 	HSE HSE HSE HSE

	<p>5. Support complementary models of healthcare to men that offer easy access, opportunistic health checks and a more holistic model of healthcare.</p> <p>6. Pilot methods of managing primary care databases to identify indicators of health disadvantage (e.g. men who are living alone, long-term non-attenders).</p> <p>7. Develop systems at primary care level to monitor and track the delivery to and uptake of services by men who are not in long-term relationships.</p> <p>8. Ensure that primary care services are accessible to people with disabilities, in accordance with the Disability Act 2005.</p>	<p>HSE</p> <p>HSE</p> <p>HSE</p> <p>HSE</p>
R8.2	Develop an increased focus on gender-competent cancer preventative measures and implement existing guidelines for cancer screening services.	<p>HSE</p> <p>Dept. of Health and Children</p>
A8.2	<p>9. Adopt an increased focus on cancer preventative measures for men, paying particular attention to:</p> <ul style="list-style-type: none"> • Further research on patient delay in presenting with cancer symptoms and how and why this varies according to gender. • Greater emphasis on symptom recognition as a component of health improvement campaigns. • An increased focus on cancer prevention programmes that take an outreach approach to engaging with men. <p>• 10. Implement existing guidelines^[264] for the development of a national colorectal cancer (CRC) screening programme in Ireland.</p> <p>11. Continue to monitor the outcomes of ongoing randomised control trials to establish the efficacy of prostate cancer screenings at a general population level.</p>	<p>HSE</p> <p>Dept. of Health and Children</p> <p>Dept. of Health and Children</p>

R8.3	<ul style="list-style-type: none"> • Implement the recommendations of the Expert Group on Mental Health Policy^[136] and the National Strategy for Action on Suicide Prevention^[131], with a clear focus on the gendered nature of mental health. 	<p>HSE Other relevant Government depts.</p>
A8.3	<p>12. Provide gender-competent community-based mental health services that facilitate early intervention and that provide a range of treatment options.</p> <p>13. Support joint programmes between primary care services, addiction services and community-based mental health services.</p> <p>14. Develop a gendered approach to de-stigmatising depression that enables men to seek help more readily and to know where to seek help.</p> <p>15. Conduct research to establish the extent (if any) to which depression is under-diagnosed among men.</p> <ul style="list-style-type: none"> • 16. Prioritise the implementation of Actions 20.1–20.3 in the Reach Out Strategy^[131] to address the issue of suicide in young men. 	<p>HSE Other relevant Government depts.</p> <p>HSE/ Other relevant Government depts.</p>
R8.4	<p>Ensure that there is a clear focus on the provision of gender-competent sexual health services and programmes for men.</p>	<p>HSE</p>
A8.4	<p>17. Ensure that a gendered approach is adopted in the development and implementation of a national sexual health strategy, paying particular attention to the following:</p> <ul style="list-style-type: none"> • The promotion of more positive associations between sexuality and masculinity. • Increasing men's awareness of existing sexual health services and challenging existing perceptions that sexual health services are primarily for women. • The provision of more outreach sexual health services to target men in different settings. • The provision of more confidential and anonymous sources of sexual health information for men. 	<p>HSE</p>

	<ul style="list-style-type: none"> • The development of sexual health surveillance systems to track men's use of sexual health services. • The development of services that are more inclusive of and sensitive to men's needs in the context of crisis pregnancy. <p>18. Ensure that a gendered approach is adopted in the implementation of the HIV and AIDS Education and Prevention Plan.^[432]</p>	HSE
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DEVELOPING SUPPORTIVE ENVIRONMENTS FOR HEALTH: THE HOME

R9.1.1	Target the home as a setting for enabling men to take greater responsibility for their own health.	HSE
A9.1.1	<ol style="list-style-type: none"> 1. Include as the focal point of all men's health initiatives men taking increased responsibility for their own health. 2. Conduct further research to identify ways of enabling men to take increased responsibility for their own health (e.g. through examining the role of women). 	HSE HSE
R9.1.2	Develop explicit and gender-competent father-inclusive policies and practices within all health and social services, and as an integral part of social inclusion.	HSE Other relevant Government depts.
A9.1.2	<ol style="list-style-type: none"> 3. Pilot a range of initiatives in relation to father-inclusive practices that are based on national^[293] and international^[291, 292] models of best practice, which can be evaluated within an Irish context. 4. Consider the provision of statutory paternity leave, with pay to new fathers. 5. Make appropriate provisions for increased uptake of existing parental leave by fathers. 	HSE Other relevant Government depts. Dept. of Justice, Equality and Law Reform Dept. of Justice, Equality and Law Reform

	<p>6. Provide an increased focus on the needs of separated/divorced and lone fathers, as part of the Family and Community Services Resource Centres Programme.^[302]</p> <p>7. Continue to monitor current practices relating to the access entitlements of single fathers to their children within the context of existing[299] and future reports into the workings of the family law courts.</p> <p>8. Commission further research to establish greater insights into the experiences and needs of lone and separated/divorced fathers in Ireland.</p>	<p>HSE</p> <p>Other relevant Government depts.</p> <p>Dept. of Social and Family Affairs</p> <p>Dept. of Justice, Equality and Law Reform</p> <p>HSE</p>
R9.1.3	Develop a National Carer's Strategy[50] that can provide increased support for men in their role as carers.	<p>HSE</p> <p>Dept. of Social and Family Affairs</p> <p>Dept. of Community, Rural and Gaeltacht Affairs</p>
A9.1.3	<p>9. Consider the recommendations from existing Carer reports^[291, 292] in the development of a National Carer's Strategy^[50], paying particular attention to:</p> <ul style="list-style-type: none"> • Promoting awareness of the particular needs of men as carers in training for service providers. • Developing networks of male carers and strengthening networks between male carers and other community groups. 	<p>Dept. of Social and Family Affairs</p> <p>HSE</p>
R9.1.4	Provide a range of measures to address sub-standard living conditions among men, within the context of <i>Delivering Homes, Sustaining Communities</i>^[306], that are sensitive to the needs of poorer men living alone.	<p>Dept. of the Environment, Heritage and Local Government</p> <p>Dept. of Social and Family Affairs</p>
A9.1.4	10. Conduct a survey of housing and living conditions of people living alone, with a particular focus on establishing the extent of poverty and sub-standard housing conditions of men living alone.	<p>Dept. of the Environment, Heritage and Local Government</p>

	<p>11. Use the findings from this research to make appropriate provisions under affordable and social housing schemes.</p> <p>12. Provide improved and targeted information to support and encourage men who live alone to access existing social supports.</p>	<p>Dept. of the Environment, Heritage and Local Government</p> <p>Dept. of Social and Family Affairs HSE</p>
R9.1.5	Increase support measures for male perpetrators of domestic violence.	HSE Dept. of Justice, Equality and Law Reform COSC
A9.1.5	<p>13. Provide increased intervention programmes for male perpetrators of domestic violence.</p> <p>14. Research the impact that intervention programmes have on reducing cycles of violent behaviour and recidivism, and on improving the health of male perpetrators.</p>	<p>HSE Dept. of Justice, Equality and Law Reform COSC</p> <p>HSE Dept. of Justice, Equality and Law Reform COSC</p>
R9.1.6	Increase support measures for male victims of domestic violence.	HSE Dept. of Justice, Equality and Law Reform COSC
A9.1.6	<p>15. Provide increased training and awareness-raising to all service providers who deal with male victims of domestic violence.</p> <p>16. Provide improved access to information, support services and counselling services for male victims of domestic violence.</p> <p>17. Provide increased family-based interventions that recognise domestic violence both as a relationship issue and as an issue that affects children.</p>	<p>HSE COSC</p> <p>HSE COSC</p> <p>HSE COSC</p>

DEVELOPING SUPPORTIVE ENVIRONMENTS FOR HEALTH: SCHOOLS AND COLLEGES

R9.2.1	Provide a clear and prominent focus on the development of positive and healthy masculinities among boys through both policy and practice within schools.	Dept. of Education and Science
A9.2.1	<ol style="list-style-type: none"> 1. Provide a visible and integrated focus on boys and men's health within primary and post-primary school curricula (e.g. PE, SPHE, EM, RSE, Biology). 2. Implement the recommendations of the CPA report⁽³²⁰⁾ and provide increased professional support services for teachers in the delivery of SPHE, RSE, EM and other personal development programmes to boys and young men. 3. Support the full implementation of SPHE in all schools, and in particular in all-boys schools. 4. Involve more men in the delivery and ongoing evaluation of SPHE programmes, both locally and nationally, and in particular in all-boys schools. 5. Develop post-graduate modules for SPHE teachers that include a focus on gender issues and that can be built into the core professional training of teachers and offered to qualified teachers as part of in-service training. 6. Implement a revised EM programme on a pilot basis, in consultation with all relevant stakeholders. 7. Use creative subjects, such as art and drama, as media for boys to express their feelings. 	<p>Dept. of Education and Science National Council for Curriculum and Assessment</p> <p>Dept. of Education and Science</p> <p>Dept. of Education and Science HSE</p> <p>Dept. of Education and Science</p> <p>Dept. of Education and Science</p>
R9.2.2	Establish within an Irish context if particular learning styles and teaching practices should be considered as key elements in addressing the educational needs of boys.	Dept. of Education and Science
A9.2.2	8. Build on existing research to establish if particular learning styles and teaching practices should be considered in addressing the educational needs of boys.	Dept. of Education and Science

	<p>9. Provide opportunities for mentoring to be used as a resource within schools to support boys to reflect on their understanding of masculine roles, beliefs and values.</p>	Dept. of Education and Science
R9.2.3	<p>Establish improved links between the home and school that enable fathers to have an increased involvement at all levels of a child's education.</p>	Dept. of Education and Science
A9.2.3	<p>10. Request schools to make provisions in the planning of a school calendar of events for the inclusion of fathers (2 days per year).</p> <p>11. Work with schools and parenting programmes to promote and increase fathers' involvement in their children's schoolwork and homework, particularly at primary school level.</p> <p>12. Support the expansion of the Home School Community Liaison (HSL) Scheme, with a view to developing closer cooperation between parents, teachers and the wider community.</p>	<p>Dept. of Education and Science</p> <p>Dept. of Education and Science</p> <p>Dept. of Education and Science</p>
R9.2.4	<p>Reduce the rate of drop-out of boys from secondary school and expand the number of places offered through second-chance education initiatives.</p>	<p>Dept. of Education and Science</p> <p>Other relevant Government depts.</p>
A9.2.4	<p>13. Implement in full the proposed actions in the DEIS action plan.</p> <p>14. Conduct research to establish the factors leading to the higher drop-out rate of boys from school within an Irish context.</p> <p>15. Develop guidelines for best practice and implement initiatives to reduce the drop-out rate of boys from school.</p>	<p>Dept. of Education and Science</p> <p>Dept. of Education and Science</p> <p>Dept. of Education and Science</p>
R9.2.5	<p>Develop best practice guidelines on policy approaches to reduce school bullying and violence (within the context of health and education partnerships associated with SPHE and the Health Promoting School).</p>	<p>Dept. of Education and Science</p> <p>HSE</p>

A9.2.5	<p>16. Document models of best practice as to how bullying is effectively prevented/managed, in the context of the 'bullyer' and the 'bullied'.</p> <p>17. Ensure that the prevention of school bullying is a recognised area of work within SPHE and the Health Promoting School model.</p>	<p>Dept. of Education and Science HSE</p> <p>Dept. of Education and Science HSE</p>
R9.2.6	<p>Implement the recommendations from the CLÁN Survey and develop the health promoting college model in a way that is informed by gender analysis.</p>	<p>Institutes of Technology Ireland Irish Universities Association Third-level institutions HSE</p>
A9.2.6	<p>18. Resource and implement initiatives targeting mental health promotion among male college students, including the development of peer education models.</p> <p>19. Evaluate the effectiveness of college alcohol policies, with a view to reducing alcohol-related harm among male college students.</p> <p>20. Pilot peer sex education programmes among male college students that promote greater responsibility for their own sexual health.</p> <p>21. Promote specific strategies within the college setting that challenge popular assertions of young men being invulnerable and invincible.</p>	<p>Institutes of Technology Ireland Irish Universities Association Third-level institutions HSE</p>

DEVELOPING SUPPORTIVE ENVIRONMENTS FOR HEALTH: THE WORKPLACE		
R9.3.1	<p>Adopt a more targeted and gender-specific approach to the development of health promotion initiatives in the workplace.</p>	<p>Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE</p>
A9.3.1	<ol style="list-style-type: none"> 1. Use the Construction Workers' Health Trust as a model from which to expand work-site health initiatives that target, in particular, male-dominated, SEG 4-6 workplaces. 2. Strengthen the monitoring and auditing of all data that relate to productivity and men's health. 3. Promote men's health to employers as a productivity issue. 	<p>Dept. of Enterprise, Trade and Employment HSE</p> <p>Dept. of Enterprise, Trade and Employment Health and Safety Authority</p> <p>Dept. of Enterprise, Trade and Employment Health and Safety Authority</p>
R9.3.2	<p>Promote and encourage family-friendly policies in both the public and private sectors that enable men to exercise greater choice in the making of decisions regarding work-life balance.</p>	<p>Department of Enterprise, Trade and Employment Employment</p>
A9.3.2	<ol style="list-style-type: none"> 4. Support increased availability of family-friendly initiatives within the workplace (e.g. flexitime, working from home). 5. Support an increased uptake of family-friendly work initiatives among male workers and promote and highlight the availability of all statutory and non-statutory measures that are currently available to support workers who wish to avail of such initiatives. 6. Conduct national campaigns to promote and endorse work-life balance initiatives to both employers and employees. 7. Provide increased childcare and crèche facilities in the workplace. 	<p>National Framework Committee for Work-Life Balance</p>
R9.3.3	<p>Implement the Health and Safety Strategy Statement 2007-2009^[361] and work in partnership with the HSE and other relevant organisations to create increased opportunities for the promotion of men's health in the workplace.</p>	<p>Health and Safety Authority HSE</p>

<p>A9.3.3</p>	<p>8. Implement in full the Health and Safety Authority's <i>Strategy Statement 2007-2009</i>.^[B61]</p> <p>9. Provide assistance to the HSE and other relevant organisations (e.g. Irish Heart Foundation, Irish Cancer Society) in the promotion of men's health in the workplace, including:</p> <ul style="list-style-type: none"> • the development of workplace health promotion campaigns with a focus on men's health; • promoting initiatives to enable men to take increased responsibility for their own health (e.g. skin protection in construction sector, manual handling training in retail sector); • promoting an increased focus on men's health research in the workplace; • developing evidence-based fact sheets on men's health based on efficacy of work site health projects. 	<p>HSE Health and Safety Authority Other relevant organisations</p>
<p>R9.3.4</p>	<p>Develop tracking systems at primary care level to monitor more closely the health of the long-term unemployed, those engaged in transient work and non-voluntary early retirees.</p>	<p>HSE</p>
<p>A9.3.4</p>	<p>10. Ensure that there is close liaison between primary care services and community organisations to track the health status of long-term unemployed men and those men engaged in transient work.</p> <p>11. Provide an increased focus on preparation for retirement for men and ensure that such initiatives are tailored to the needs of different populations of men.</p> <p>12. Provide increased support for phased retirement for men.</p> <p>13. Create opportunities for men to use their skills and experience after they retire as mentors within schools and supporting community work.</p>	<p>HSE HSE HSE HSE HSE Dept. of Education and Science</p>

R9.3.5	Ensure that there is an increased focus on the prevention and management of stress in the workplace.	Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE
A9.3.5	<p>14. Implement increased support measures for the prevention and management of workplace stress.</p> <p>15. Develop increased peer support mechanisms for the management of stress in the workplace.</p> <p>16. Increase the availability and ease of access to counselling services in the workplace.</p>	<p>Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE</p> <p>Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE</p> <p>Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE</p>
R9.3.6	Implement the recommendations of the 2005 Report of the Expert Advisory Group on Bullying^[376] and the Code of Practice for employers and employees on the prevention and resolution of bullying in the workplace^[378].	Employers & Unions Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE
A9.3.6	17. Monitor the implementation of the 2005 Report of the Expert Advisory Group on Bullying ^[376] and the Code of Practice for employers and employees on the prevention and resolution of bullying in the workplace ^[378] .	Employers & Unions Dept. of Enterprise, Trade and Employment Health and Safety Authority HSE
DEVELOPING SUPPORTIVE ENVIRONMENTS FOR HEALTH: SOCIAL SPACES		
R9.4.1	Provide increased investment in the development of facilities for sport and recreation for all men and safe social spaces for young people.	Dept. of Arts, Sport and Tourism Irish Sports Council

A9.4.1	<ol style="list-style-type: none"> 1. Increase the provision of funding for community-based social health projects for young people. 2. Increase the provision of funding from the Sports Capital Programme and from local authorities for the provision of recreational and sporting facilities. 3. Pilot alternative recreational activities (e.g. skateboarding parks, cycle lanes, walkways) across urban and rural settings. 4. Pilot recreation programmes for men and in particular target men in their mid- to late-30s who are most inclined to retire from sport. 5. Provide incentives to commercial investors to provide safe and affordable social alternatives to young people (e.g. matched funding for youth cafés). 	<p>Dept. of Community, Rural and Gaeltacht Affairs Dept. of Education and Science HSE</p> <p>Dept. of Arts, Sport and Tourism Local Authorities</p> <p>Local Authorities</p> <p>Irish Sports Council HSE</p> <p>HSE City/County Development Boards</p>
R9.4.2	<p>Ensure that young men are fully represented within existing structures at local and national level that give a representative voice to youth.</p>	<p>Office of the Minister for Children and Youth Affairs</p>
A9.4.2	<p>6. Ensure that there is equal participation by young people in Comhairle nÓg and Dáil na nÓg along the 9 grounds of equality (including gender).</p>	<p>Office of the Minister for Children and Youth Affairs</p>
R9.4.3	<p>Consult with and involve young men in the development of policies, services and programmes designed to meet their needs.</p>	<p>Office of the Minister for Children and Youth Affairs</p>
A9.4.3	<p>7. Appoint youth representatives from Comhairle na nÓg to sit on steering committees of community projects that are relevant to them.</p>	<p>Local Authorities City/County Development Boards Dept. of Education and Science</p>

STRENGTHENING COMMUNITY ACTION TO SUPPORT MEN'S HEALTH		
R10.1	Develop mechanisms and structures to support community work for men who experience disadvantage.	Dept. of Community, Rural and Gaeltacht Affairs Dept of Enterprise, Trade and Employment HSE
A10.1	<p>1. Establish a national agency to represent all those working in the area of men's health within communities, paying particular attention to the following:</p> <ul style="list-style-type: none"> • Coordinate the work being done with men on the ground (e.g. networking and support for and dissemination of evaluation). • Support those working with men in communities (e.g. financial and professional). • Expand the area of community development for men's health. • Ensure a partnership approach to community development work for men between community, voluntary and statutory sectors (e.g. developing and delivering training). • Represent men within communities in the national arena to inform public policy. 	HSE
R10.2	Name disadvantaged men as a vulnerable group to be supported through available funding streams under the National Action Plan for Social Inclusion (NAPinclusion 2007-2016). ^[49]	Cabinet Committee on Social Inclusion
A10.2	<p>2. Ensure that vulnerable men are included in the allocation of funding within all relevant Government departments and agencies.</p> <p>3. Support those working with vulnerable men in communities to improve their capacity to access funding.</p> <p>4. Continue to provide medium multi-annual funding to community-based work to ensure sustainability and stability of the work being done.</p> <p>5. Ensure that independent evaluations of all community work are conducted, with a view to using that evaluation as a means of developing work in the future.</p>	<p>All relevant Government depts.</p> <p>All relevant Government depts.</p> <p>All relevant Government depts.</p> <p>All relevant Government depts.</p>

	6. Support those working with vulnerable men in communities to evaluate the work that they do and disseminate those findings.	All relevant Government depts.
R10.3	Modify the current gender-proofing mechanisms to be inclusive of vulnerable men in our society, in accordance with international best practice. ^[34, 35]	All relevant Government depts.
A10.3	7. Develop expertise in gender-proofing in all Government departments and agencies to ensure that it becomes standard practice.	All relevant Government depts.
R10.4	Incorporate a health agenda into all community development work for men in consultation with the men in the community.	All relevant Government depts.
A10.4	8. Support the inclusion of health as a core element of the criteria for funding men's community development work.	All relevant Government depts.

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Appendix 1: Membership of Steering Committee Men's Health Policy



Mr Chris Fitzgerald	Department of Health & Children (Chair)	Replaced by: Mr Brian Mullen (Chair)
Mr Shay McGovern	Department of Health & Children	Mr Robbie Breen
Ms Biddy O'Neill	Health Service Executive	
Mr Owen Metcalfe	Institute of Public Health	
Ms Maureen Mulvihill	Irish Heart Foundation	
Ms Helen Corrigan	Irish Cancer Society	Ms Elaine Glynn/ Ms Norma Cronin
Mr Tony Fitzpatrick	Irish Nurses Organisation	
Prof. Tom O'Dowd	Department of Community & Health in General Practice, Trinity College Centre for Health Sciences	
Mr David Simpson	Men's Health Forum in Ireland	Mr Finian Murray
Mr Michael Sullivan	Department of Social & Family Affairs	Mr Heber McMahon/ Ms Ann-Marie O'Connor Mr Seamus McLoughlin
Mr Alan Wall	Department of Education & Science	
Mr Brendan Ingoldsby	Department of Health & Children	
Mr Brian Neeson	Health Service Executive	
Ms Tara Coogan	Equality Authority	
Mr Paul Howard	Department of Health & Children	
Mr Alan O'Neill	Men's Development Network	Mr Lorcan Brennan
Mr Jack Thompson	Department of Enterprise, Trade & Employment	
Mr Brendan McInerney	Department of Agriculture & Food	
Mr Dermot Kilgallon	Department of Justice, Equality & Law Reform	Mr Tony Flynn
Dr Jim Kiely	Department of Health & Children	
Dr Brian Gaffney	Health Promotion Agency, Northern Ireland	
Mr Kieran Sludds	Health & Safety Authority	
Mr John Breen	Department of Health, SPSS, Northern Ireland	
Dr Declan Bedford	Health Service Executive	
Dr Noel Richardson	Institute of Technology Carlow (Author)	
Dr Paula Carroll	Waterford Institute of Technology (Author)	



Drafting Committee:

Mr Brian Mullen	Department of Health & Children (Chair)
Mr Robbie Breen	Department of Health & Children
Dr Declan Bedford	Health Service Executive
Mr Brian Neeson	Health Service Executive
Ms Bidy O’Niell	Health Service Executive
Mr Owen Metcalfe	Institute of Public Health
Prof Tom O’Dowd	Department of Community & Health in General Practice, Trinity College Centre for Health Sciences
Mr Lorcan Brennan	Men’s Development Network
Dr Noel Richardson	Institute of Technology Carlow (Author)
Dr Paula Carroll	Waterford Institute of Technology (Author)

Secretariat:

Ms Frances Keegan	Department of Health & Children
Ms Eileen Ryan	Department of Health & Children
Dr Noel Richardson	Institute of Technology Carlow (Author)
Dr Paula Carroll	Waterford Institute of Technology (Author)

Replaced by:

Ms Deirdre Mahony/
Ms Marian Beakley
Ms Sheila Kulkarni

Appendix 2: Areas in need of further research in men's health

Social marketing

A social marketing campaign that challenges contemporary stereotypes of men and masculinity *and* promotes a more positive and holistic image of men's health should be developed and evaluated. In accordance with good practice, this campaign should be supported by local and national events and education programmes (see *Chapter 6, Section 6.1*).

Health information

Health information specific to men should be developed, piloted and evaluated. Information should cover all the relevant health topics, such as diet and physical activity, and medical conditions, such as colorectal cancer. There is also a need to develop and evaluate general health information that challenges men to consider their health and supports men to seek medical advice early. Media through which to disseminate health information appropriately and effectively to men should also be explored and evaluated (see *Chapter 6, Section 6.2*).

Health promotion programmes

Health promotion programmes that support men to modify risky lifestyle behaviours should be developed and piloted. Priority should be given to targeting young men and vulnerable groups of men in our society, such as marginalised men and those in SEGs 5 and 6 (see *Chapter 6, Section 6.3*).

Men's health training

Evaluation should be undertaken to assess the effectiveness of training in men's health that is targeted at different service providers and that takes account of best practice in the delivery of healthcare programmes to different populations of men. There needs to be a particular focus on evaluating the effectiveness of brief intervention type training with a focus on men's health that is developed and delivered to GPs and practice nurses in the primary care setting (see *Chapter 7, Section 7.1*).

Mobile health units

There is a need for further evaluation of mobile health units (such as those provided by the Construction Workers' Health Trust), with a view to measuring equity of access, sustainability and follow-up (see *Chapter 8, Section 8.1*).

Men and cancer

There is a need for a systematic review of existing evidence in relation to men and cancer (see *Chapter 8, Section 8.2*). There is also a need for further research:

- to establish why some patients delay presenting with cancer symptoms and how and why this varies according to gender;
- to investigate the psycho-social aspects of cancer diagnosis and treatment, and whether interventions aimed at providing greater support for men would be useful.





Men taking increased responsibility for their own health

There is a need for research to identify ways of enabling men to take increased responsibility for their own health, including an examination of the role of women in this regard (see Chapter 9, Section 9.1.1).

Fathers

There is a need to pilot and evaluate a range of initiatives in relation to father-inclusive practices that are based on national and international models of best practice and that can form the basis of increasing the evidence-base of father-inclusive best practice within Ireland. There is also a need to commission further research to establish greater insights into the experiences and needs of lone and separated/divorced fathers in Ireland (see Chapter 9, Section 9.1.2).

Living conditions of men living alone

There is a need to survey the housing and living conditions of men living alone (see Chapter 9, Section 9.1.4).

Domestic violence

There is a need to research the impact that intervention programmes have on reducing cycles of violent behaviour and recidivism, and on improving the health of male perpetrators (see Chapter 9, Section 9.1.6).

Gender differences in learning and development

There is a need to build on existing research to establish if particular learning styles and teaching practices should be considered in addressing the educational needs of boys in Ireland (see Chapter 9, Section 9.2.2).

Early drop-out rates for boys from second-level school

There is a need to conduct research to establish the factors leading to the higher drop-out rate of boys from school within an Irish context (see Chapter 9, Section 9.2.4).

Bullying in schools

There is a need to conduct further research to establish models of best practice as to how bullying is effectively prevented/managed in the context of the 'bullyer' and the 'bullied' (see Chapter 9, Section 9.2.5).

College men's health

There is a need to monitor the implementation of the recommendations from the CLÁN Survey and evaluate the effectiveness of alcohol policies in third-level colleges, with a view to reducing alcohol-related harm among male students (see Chapter 9, Section 9.2.6).

Productivity and men's health

There is a need to strengthen the monitoring and auditing of all data that relate to productivity and men's health (see Chapter 9, Section 9.3.1).

Family-friendly work practices

There is a need to conduct research to establish the level of awareness among male workers of statutory and non-statutory measures that are currently available with regard to family-friendly work initiatives (see *Chapter 9, Section 9.3.2*).

Health and safety

There is a need to promote an increased focus on men's health research in the workplace that pertains to all aspects of health and safety (see *Chapter 9, Section 9.3.3*).

Social spaces for young people

An evaluation should be conducted on the level at which young men access existing youth services, with a view to supporting more young men to avail of such services in their communities. The involvement of young men in the development of new services and social spaces for young people, as outlined in the National Recreation Policy, should also be monitored (see *Chapter 9, Section 9.4.1*).

Supporting men to become more physically active

Pilot programmes should be developed by Local Sports Partnerships, in consultation with men in communities, that support men to become more physically active. Such programmes may involve the provision of local recreation and/or leisure facilities (see *Chapter 9, Section 9.4.2*).

Building social capital among disadvantaged communities of men

Community development projects that target disadvantaged men in our society should be piloted, with a view to building social capital among those men and empowering them to have control over their own health and their lives (see *Chapter 10*).

