

# **MEN'S HEALTH ACTION PLAN**

**Sláinte na bhFear  
Plean Gníomhaíochta**

**2004 - 2009**



North  
Eastern  
Health  
Board

Bord  
Slainte  
An Oir  
Thuaiscirt

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## **Preface**

In 2001 the North Eastern Health Board set out to ascertain the views of men in relation to their health and well being. The findings from this research were published in *Men Talking*. This was followed in 2002 by a Men's Health Consultation Day where men and women from many backgrounds and from statutory and voluntary organisations addressed men's health issues. As a result of this day, a Men's Health Consultative Committee was set up to develop a men's health strategy for the region. This action plan is the fruit of their work.

Healthcare agencies working alone cannot address all the societal, economic and environmental factors that impinge on men's health. The objectives of this action plan can only be achieved by building on our existing partnerships and developing new and sustainable partnerships in both the statutory and voluntary sectors of our community. The multidisciplinary and multi-agency nature of the Men's Health Consultative Committee reflects this partnership approach and the need of the whole of society and not just the health services to address the many and varied factors which concern men's health.

I wish to thank all the members of the Men's Health Consultative Committee for their work in preparing this action plan and in particular I wish to thank Finian Murray, Men's Health Development Officer for his tremendous work in taking men's health from the publication of *Men Talking* to the development of this action plan.



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Paul Robinson  
Chief Executive Officer

*The Men's Health Consultative Committee prepared this document*

## **Men's Health Consultative Committee**

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### ***Management Team Sponsor:***

Geoff Day, North Eastern Health Board

## Terms of Reference

The Men's Health Consultative Committee will advise the Chief Executive Officer through the agreed reporting relationships with the Regional Services Programme on aspects of Men's Health ensuring that:

- Men are consulted at local level regarding their health needs
- The health needs of men are identified and planned in an integrated, equitable and comprehensive way.
- Services for men are appropriate, responsive to their needs, accessible when required, and delivered in a manner that respects their privacy, dignity and individuality.
- Gaps in service provision are identified and that there is effective co-ordination of the services maximising the use of existing resources
- Partnership is promoted where possible between the NEHB and community groups
- A draft Action Plan for Men's Health to be prepared by the end of 2003 to address men's health issues across the region, adopting a consumer orientated approach and reflecting the issues that emerged in the "Men Talking" report and the report of the "Men's Health Consultation Day"
- Information, reports and proposals for submission to the Department of Health and Children are provided from time to time as appropriate

## **Introduction**

*A Health Strategy for the People of the North East* (2003) identifies ‘better health for everyone’ as one of its high level goals. There is certainly room for improvement in men’s health. Irish men die on average nearly six years younger than Irish women and have higher death rates at all ages, and for all leading causes of death. The mortality pattern for males in the North Eastern Health Board (NEHB) region is similar to the national profile, with the majority of deaths caused by diseases of the circulatory system (43%), cancers (23%), respiratory disease (14%) and injury and poisoning (7%). The national health strategy, *Quality and Fairness, A Health System for You* (2001), informs us that men experience more accidents than women during sporting activities and in the workplace; they are more likely to engage in risk behaviours such as speeding, drink driving and not wearing seatbelts. The highest rate of deaths from road traffic accidents is in males aged 20-24 years. Men have less healthy diets than females, are more likely to be overweight or obese, drink more alcohol and are more likely to become involved with substance misuse. Men are also more likely to experience considerable mental health problems. Of particular concern in recent years has been the increase in the number of young male suicides. Men see health as ‘important but not urgent’. Current research suggests that men take few preventive health measures and are less willing than women to seek medical help.

Some welcome men’s health initiatives have taken place in recent years. The first World Congress on men’s health was held in Vienna in 2001. Other important initiatives include the launch of the International Society for Men’s Health, the European Men’s Health Forum and the Men’s Health Forum in Ireland. The consultation process for the development of a national plan for Ireland on men’s health commenced in January 2004.

In the NEHB, the Department of Public Health conducted qualitative research where men in the region were consulted about their health needs and their priorities for improvements. The report, entitled *Men Talking* (2001) identified the following:

- Men equate health with physical well being, with their emotional health given less priority
- Men perceive risky behaviour e.g. speeding and alcohol consumption, as part of being male and difficult to change
- Men tend to be less proactive about looking after their own health, responding to ill health rather than health promotion
- There are vulnerable groups of men who require more focused support

The main finding of the research is that masculinity rules men's decision-making processes and behaviour. Further consultation with men took place at a Men's Health Consultation Day in November 2002. This consultation day was held to elicit views from interested parties on ways to address issues concerning men's health. The conference provided a networking forum and offered the opportunity for men to voice the needs of men in the NEHB area and how these needs could best be addressed. The main findings from that day, as outlined in the *Men's Health Consultation Day Report* (2003) are as follows:

- There still exists a lack of information on available services, eligibility and providing health information literature. Suggestions for men taking responsibility for their health include targeting men where they are.
- Delegates felt that there is a need for services to be made men-friendly at the point of contact with more emphasis on male issues.
- The need for the development of a men's health strategy acknowledging that men's health needs are different for younger men, men in their middle years, older men and rural men.
- There exists a lack of funding (and information on funding) for community initiatives that promote men's health.

The main recommendation was for the establishment of a Men's Health Consultative Committee to develop a men's health strategy for the region. This committee was established in July 2003.

## **Action Plan Development**

### **Objectives**

- To involve stakeholders in planning and producing an action plan for improving men's health
- To create an infrastructure to support and empower all stakeholders
- To create an environment and a structure more conducive to promoting men's health
- To strengthen partnership

### **Methods**

A rapid action plan development model was adopted whereby The Men's Health Consultative Committee developed the Action Plan ensuring that stakeholders were involved and participated in all stages.

### **Aims of the Action Plan**

- To develop awareness among men of relevant health issues
- To advocate the development of services which are men friendly
- To disseminate information on men's health
- To reduce current male mortality and morbidity rates

### **Principles**

The principles underpinning this Action Plan are aligned to those of the national health strategy *Quality and Fairness, A Health System for You*:

- People-centredness
- Quality
- Equity and Fairness
- Accountability and Governance
- Partnership and valuing communities

With the additional principles of:

- Planning for real
- Inclusivity

The strategy is further underpinned by the following:

### **National**

Building Healthier Heart: The Cardiovascular Health Strategy 1999-2004

National Health Promotion Strategy 2000-2005

National Cancer Strategy 1996

Strategic Task Force on Alcohol - Interim Report 2002

### **Regional**

A Health Strategy for the People of the North-East 2003

The NEHB Public Health Department 2001 report “Men Talking”.

Men’s Health Consultation Day Report 2002

NEHB Health Status Report 2000.

EROS: A Suicide Prevention Strategy 2002

This Action Plan requires a variety of organisations and individuals to become involved in promoting men’s health and emphasises co-ordination of resources and appropriate services at all levels - state, regional, community and the individual. The Men’s Health Consultative Committee, established in July 2003, will continue to set the agenda for service change and development, which focus on the needs of men in the NEHB region. As such, it is critically important to locate and construct future research and service initiatives in community, work and other settings where men feel at ease, and where those men most in need can be targeted.

### **Definitions**

Men as a group have not pushed for attention to be drawn to men’s health. Whilst men have been the predominant players in the decision-making process affecting health research and health service policy and provision, men themselves have not argued, lobbied or campaigned in the same way that women have, for improvements to their health at a group or individual level. Banks (2003) even suggests that ‘men are more likely to look after their cars than their own bodies!’

The World Health Organisation defines health in broad and holistic terms, recognising that health is a 'complete state of physical, mental, spiritual and social well-being, and not merely the absence of disease or infirmity'; and 'a resource for everyday life'. Health is associated with 'family security' amongst men, compared to 'happiness', 'a comfortable life' and 'pleasure' among women.

There is an absence of explicit definitions of men's health, and the concept has tended to be constructed by a contrast with women's health. It is vital, however, that men's health does not become defined as a narrow set of sex-specific conditions, and that the broader determinants of health are taken into account. In other words, the concept should also incorporate the way that men perceive themselves and live as masculine within a specific culture. Connell et al (1998) tell us that there has been a tendency in the literature to focus on the 'health' issues of 'men's health', with comparatively less focus on 'men', or more specifically men as gendered beings. There is also a lack of a clear distinction between 'sex' and 'gender' in much of the literature on men's health.

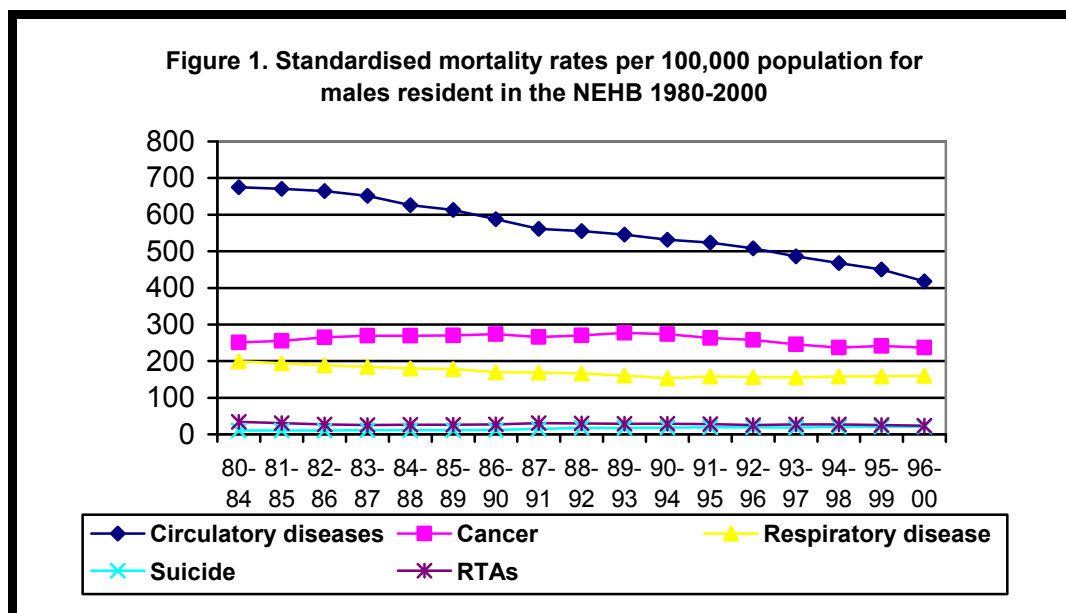
*Sex relates to biology, the dimorphic division of male and female, gender in contrast refers to the cultural meanings that are attributed to those biological differences, gender in other words is socially constructed (Stakelum, A. and Boland, J., 2001)*

There is therefore a need to consider men within the context of their gender, in a way that identifies the links as well as the margins of difference between men's health and women's health issues. What it is 'to be a man' in Ireland is indeed an important and necessary question if we are to seek to understand how Irish men actively construct behaviours and attitudes which ultimately determine their health status. Just as we accept that women are not to blame for feminine health problems, we need to realise that masculine health problems are to be solved, not judged. There are many factors along with gender that affect men's health and that need specific action targeted at men (and boys) in order to help to get the most out of life by way of social, emotional and physical health. These factors include socio-economic status, marital status, family status, race, sexual orientation, age, disability, religion and membership of an ethnic group.

## Men's Health Statistics

The population in the NEHB region has been growing continuously since the health boards were established in 1971. The population in the region has risen from just less than 250, 000 in 1971 to 344,965 in 2002. The rise in population in more recent years, from 1996 to 2002 has been most dramatic with a rise of 12.7%. The rise in the population in the NEHB over this latter period was higher than in any other board region and far higher than the 8% rise seen in the overall population in the country. The number of males living in the region at Census 2002 was 174,043.

The standardised mortality rate for males in the NEHB has fallen from 1,314 per 100,000 population in 1980 to 915 per 100,000 in 2001. The main contributor to this fall has been a significant fall in deaths from circulatory diseases. Figure 1 outlines the mortality rates for males in the NEHB for the main causes of death. As seen in the figure there has been a substantial drop in the mortality rate from circulatory diseases with little change in the other rates. The rates for males in the NEHB are similar to the national rates.

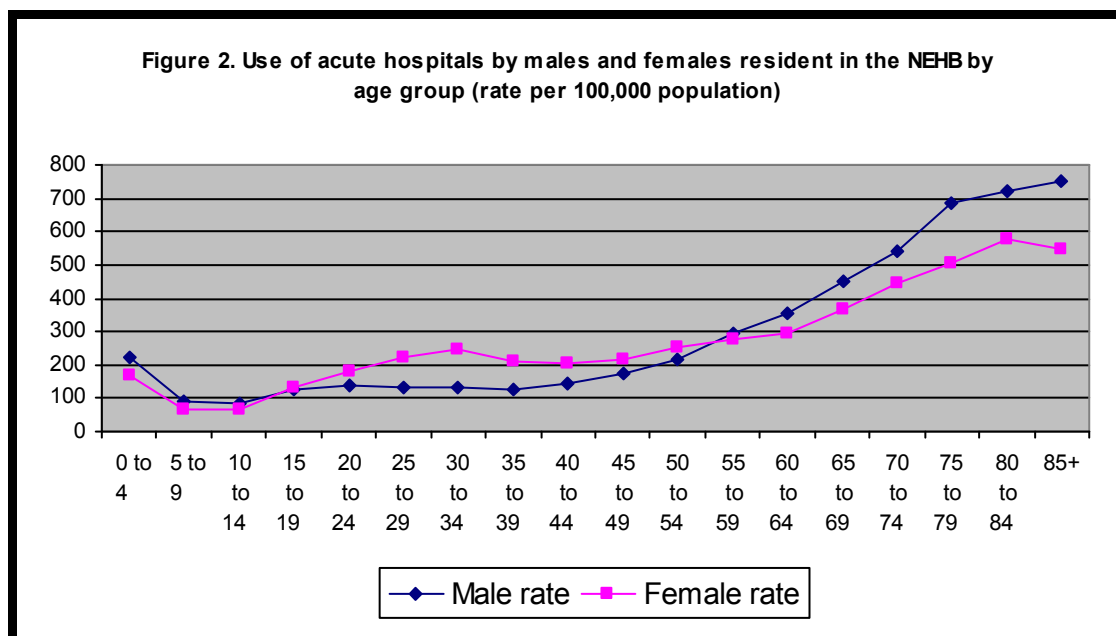


\*RTAs = Road traffic accidents

Life expectancy for males in Ireland is 73.0 years compared to 78.5 years for females.

Data on life expectancy are not broken down by health board area. Males in Ireland have the 4<sup>th</sup> lowest life expectancy of males in the European Union (EU) at age 40 and the lowest at age 65.

Figure 2 outlines how males have a lower usage of acute hospitals from ages 15 to 54. Thereafter, males have significantly higher rates for admission to acute hospitals.



## Action Plan

There are many different approaches in developing strategies. In the development of this strategy, a multidisciplinary and multi-agency group drawn from the North Eastern Health Board region involved in the area of men's health agreed to formulate a strategic response. In light of male mortality and morbidity rates, as already outlined, the consultative process collapsed the myriad of issues into seven main areas:

- **Area 1 Cardiovascular disease**
- **Area 2 Cancer**
- **Area 3 Respiratory disease**
- **Area 4 Accidents**
- **Area 5 Mental health**
- **Area 6 Sexual health**
- **Area 7 Uptake of health services**
- **Area 8 Research/Education**

## **Action Area One – Cardiovascular disease**

### **Rationale**

Cardiovascular or circulatory disease (CHD) is the single biggest cause of death in Ireland. It kills more men in the Western World than any other disease. The widening gap in life expectancy between Irish men and the average for the EU is caused by higher death rates, particularly from cardiovascular disease, in Ireland compared to the EU.

It accounts for more than a third of all deaths of men aged between 45 and 65 years. In Ireland and the United Kingdom (UK), nearly half of all men die from heart disease and related conditions such as stroke. Men's death rates from ischaemic heart disease (IHD) and stroke rise more quickly with age than women. In fact, 35% of premature deaths in men are from IHD.

In addition to the higher mortality rates, IHD places a very considerable burden on the acute hospital system. For example, in Ireland in 2001 there were 15,542 discharges for males where IHD was a diagnosis on discharge. The largest number of discharges was in men in the under 65 age group, followed by men aged 65 to 74 years. Persons resident in the NEHB have the highest discharge rates from hospital with a diagnosis of IHD when compared to persons living elsewhere in the country.

The main risk factors for heart disease are: being male, smoking, a family history of heart disease, high blood pressure, high cholesterol, being overstressed, eating a diet high in saturated fats, being overweight and leading a sedentary lifestyle. Testosterone has also been linked with higher blood pressure, raising the risk of heart disease and with damping down the immune system.

### Area One - Cardiovascular Disease

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>i) Develop awareness among men of IHD and related conditions like stroke.</b></p> <p><i>(Quality &amp; Fairness, actions 5, 19)</i></p>	Health Promotion Department, Men's Health Development Officer NEHB	Irish Heart Foundation, Department of Health and Children, Department of Public Health, cardiac rehab co-ordinators NEHB	The adult male population	Targeted dissemination of information on IHD in line with Health Promotion Department's overall marketing/communication strategy	Ongoing	<p>Improved lifestyles</p> <p>Reduction in the age standardised rate of IHD and strokes admissions to hospitals</p> <p>Reduced mortality</p>	Existing resources

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>ii)</b> The prevention of cigarette smoking</p> <p><i>(Quality &amp; Fairness, action 5)</i></p>	<p>Health Promotion Department NEHB</p>	<p>Environmental health officers, cardiac rehab co-ordinators, acute hospital smoking cessation officers NEHB, employers, colleges, sporting organisations etc.</p>	<p>The general public, employers, sport organisations</p>	<p>Smoking cessation clinics will continue to be provided and expanded across a range of setting and subpopulation groups</p> <p>The Health Promotion Department will support the Men’s Health Officer in maximising the uptake of men attending these clinics</p> <p>“No smoking” policies will continue to be provided to all sporting organisations within the region. Guidelines and support in implementation of same will also be provided</p>	<p>Dec. 2005</p>	<p>A reduction in the number of young males starting to smoke</p> <p>A reduction in the number of males smoking</p>	<p>Additional resources</p>

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>iii)</b> Increase physical activity levels of men.</p> <p><i>(Quality &amp; Fairness, action 5)</i></p>	Health Promotion Department NEHB	Cardiac rehab co-ordinators NEHB, local sports partnerships, employers, third level education colleges	The adult male population	<p>(a) Current linkages with all sporting organisations particularly G.A.A. and soccer clubs will continue to be maintained and consolidated</p> <p>(b) A range of physical activity programmes i.e. Right Weight to Fitness, Go for Life, Path, Best Foot Forward, Games for Life, Walk for Healthy Leadership training (etc) will continue to be provided across settings and population subgroups</p> <p>In conjunction with C.A.W.T. (Co-operation &amp; Working Together) prioritise physical activity initiatives in workplace programmes and where possible in these settings give focus to men's needs</p>	Ongoing  2005	An increase in the number of men engaging in regular physical activity	<p>(a) Existing resources</p> <p>(b) Additional resources</p>

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>iv)(a)</b> To promote a reduction of alcohol consumption among men</p> <p><b>(b)</b> Early identification and intervention of alcohol related problems among men</p> <p><i>(Quality &amp; Fairness, action 5)</i></p>	<p>Health Promotion Department NEHB</p>	<p>Department of Public Health, Mental Health Services, Primary Care Services, acute services NEHB, the media, Irish National Alliance on Action on Alcohol, sporting organisations, workplaces, voluntary agencies</p>	<p>Men</p>	<p>To support the implementation of the recommendations of the <i>Strategic Task Force on Alcohol</i></p> <p>Deliver training to all relevant health professionals and brief intervention on alcohol misuse</p>	<p>End of 2005</p>	<p>Reduction in alcohol consumption, unsafe drinking habits and related harm</p>	<p>Additional resources needed to implement report recommendations</p>

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
v) Secondary prevention in primary care and acute hospitals  <i>(Quality &amp; Fairness, action 53)</i>	Primary Care Cardiovascular Facilitator NEHB	Cardiac rehab co-ordinators, physiotherapists, acute hospital services NEHB, allied health professionals, ICGP, Irish Heart Foundation	Men with IHD (e.g. cardiovascular disease)	Cardiac rehab programmes  Heartwatch  DiabetesWatch  To support GPs and practice staff to work more pro-actively around men's issues	Ongoing – to be reviewed annually	Risk factor reduction  Increased functional capacity and empowerment to maintain lifestyle changes	Resources in place for current number of participating GPs  Cardiac rehab departments already in place  New funding required for further development



## **Action Area Two – Cancer**

### **Rationale**

Cancer is still regarded by the public as an especially threatening disease and one, which to some extent is still a taboo subject (Calman and Hine, 1995). It is one of the main causes of morbidity and mortality from a global perspective. In Ireland, there is a one in three chance of developing cancer by age 74 years. Data is available on cancer incidence and deaths from *National Cancer Registry Ireland (N.C.R.I.)*. The data used in the following paragraphs are from the N.C.R.I. report *Cancer in Ireland, 1994-1998*. The primary non-gender specific cancers affecting Irish males include: lung cancer, colon cancer, rectum and anus cancer, bladder cancer and skin cancer. With reference to lung cancer, there were on average 972 new cases in males per year in Ireland from 1994-98 with on average 971 deaths over the period in males from lung cancer. Lung cancer is the most common cause of cancer deaths in males.

In relation to colon cancer, from 1994 to 1998 there were on average 572 new cases of colon cancer in males per year, with on average 370 deaths per year. There were on average in males in Ireland 410 new cases of cancer of the rectum and anus per year from 1994-98, with on average 145 deaths. Concerning bladder cancer, there were on average 328 cases per year with 112 deaths on average per year. In relation to malignant melanoma (the most serious form of skin cancer) there were on average 140 new cases per year in males from 1994-98 with on average 28 deaths per year.

### **Male specific cancers**

Testicular cancer is primarily a disease of young men, the average age at diagnosis is 32 years (much younger than for most cancers). In Ireland from 1994 to 1998, there were on average 89 new cases with on average seven deaths per year. It is the most common cancer affecting young men. More men get prostate cancer in Ireland than any other cancer. Prostate disease is common and may present either as benign enlargement of the prostate gland or as cancer. In Ireland there were on average 1,150 new cases of prostate cancer diagnosed over the period 1994-98 with on average 513 deaths. Early detection is still the key to fighting this disease before it has spread.

### Area Two – Cancer

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p>i) Develop awareness about cancer among men through the implementation of best practice initiatives</p> <p><i>(Quality &amp; Fairness, actions 5, 15)</i></p>	Health Promotion Department NEHB	Department of Health and Children, Department of Public Health, Men's Health Development Officer, environmental health officers, acute hospital services NEHB, primary health care professionals, Office of Tobacco Control, Irish Cancer Society, Irish Thoracic Society, ASH Ireland	The adult male population	<p>Targeted dissemination of information on cancer in line with Health Promotion Department's overall marketing/communication strategy</p> <p>The development of a training and education programme on men's cancers</p>	2004 - 2007	<p>Increased awareness of prevention and early detection of cancer among men</p> <p>Earlier referral for curative surgical treatment</p>	<p>Existing resources</p> <p>Additional resources required for improved administrative and specialist resources such as X-Ray and Lung CT to allow rapid access for early referrals to specialist</p>

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>ii)</b> Provide training for health professionals and health care workers</p> <p><i>(Quality &amp; Fairness, action 69)</i></p>	Men's Health Development Officer NEHB	Training Department, Health Promotion Department, acute hospital services, community services NEHB, primary healthcare professionals	All relevant Health Board staff, GPs and other relevant primary health care workers	The development of a programme to specifically enhance detection capacity and response amongst health professionals for cancers affecting men (lung, prostate, colon, testicular etc.)	2004 -2005	Improved service provision in the early detection of cancer for men	Existing resources
<p><b>iii)</b> Provide awareness programmes in relation to the prevention and early detection of skin cancer amongst outdoor workers</p> <p><i>(Quality &amp; Fairness, action 5)</i></p>	Health Promotion Department NEHB	Men's Health Development Officer, Department of Public Health NEHB, IFA, construction industry, Irish Cancer Society, allied health professionals	Farmers, construction workers, gardeners etc.	Evaluate the current <i>Sun Safety and Farmers</i> campaign	2004	Develop appropriate response to the evaluation	

<b>Objective</b>	<b>Lead Agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated outcome</b>	<b>Resource implications</b>
<p><b>iv) Further development of urology services</b></p> <p><i>(Quality &amp; Fairness, action 84)</i></p>	Acute hospital services	Management Team NEHB	Male patients in need of service	Develop a comprehensive urology service in the NEHB region	2007	Improved urology services for men	Additional resources
<p><b>v) To develop measures to enhance the awareness of the benefits of continence management</b></p>	Physiotherapy departments NEHB	Continence advisors/nurses, community services NEHB	Men post-prostatectomy or bowel surgery for cancer, with continence problems	<p>Network with men's groups regarding physiotherapy service</p> <p>Increase awareness of service available to referrers e.g. consultants, GPs</p> <p>Increase awareness among men in NEHB region regarding service</p> <p>Provide treatment to men with continence problems</p>	2005	Improved continence support services for men post-specific surgery	Additional resources

<b>Objective</b>	<b>Lead Agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated outcome</b>	<b>Resource implications</b>
vi) Delivery of cancer awareness peer training to men's groups  <i>(Quality &amp; Fairness, action 5)</i>	Health Promotion Department NEHB	Men's Health Development Officer, acute hospital services NEHB, primary healthcare professionals, Irish Cancer Society	Men's groups	Delivery of awareness programme on the prevention and early detection of cancer affecting men	On-going	Increased awareness of prevention and early detection of men's cancers	Existing resources

## **Action Area Three – Respiratory diseases**

### **Rationale**

Death rates from respiratory disease in Ireland are over twice the EU average. Ireland has the highest death rate from respiratory disease in Western Europe with the disease killing one in five people here. Between 1989-1998, over half of all deaths from respiratory diseases on the island of Ireland were due to pneumonia (McEvoy, 2004). Along with heart disease and cancer, lung diseases are the third major cause of death and morbidity. The most commonly reported long-term illnesses in young men are conditions of the respiratory system. It is one of the most common reasons for men to visit their GP. Drug prescription rates for respiratory disease are among the highest compared with other conditions.

There is a co-relation between respiratory diseases and occupational class. Social inequalities cause a higher proportion of deaths in respiratory disease than in any other organ system. The directly standardised mortality rate for respiratory diseases is over 200% higher in the lowest occupational class. Homelessness, poor housing/damp housing and household overcrowding are likely to lead to increased amounts of respiratory infection with an increasing risk of mortality (McEvoy, 2004). A need currently exists for a process aimed at improving care for men with lung diseases including asthma, chronic obstructive pulmonary disease, lung cancer, tuberculosis, cystic fibrosis, occupational lung disease, lung fibrosis and other disorders.

### **COPD / Pulmonary Rehabilitation / Early COPD Discharge Programmes**

Chronic obstructive pulmonary disease (COPD) is the most common chronic respiratory disease in Ireland today. There is an increasing disease prevalence with an estimated 110,000 patients attending hospital clinics annually and a substantial use of hospital bed-days are due to this condition nationally. It is one of the significant diseases peaking in winter, leading to hospital overcrowding and is most prevalent in older patients, either current or ex-smokers, with a lower occupational class preponderance. Earlier diagnosis, lifestyle changes (smoking cessation and pulmonary rehabilitation) and specialist treatment reduce the healthcare burden on both patients and acute hospital services (GOLD Guidelines, 2003). Pulmonary rehabilitation

improves both patient quality of life and functional capacity, while reducing hospital readmission rates and has been shown to be cost efficient. Targeted discharge services can achieve earlier home discharge from acute hospitals in up to 30% of patients with acute COPD. This reduces the average length of stay per patient from circa eight days to three days with substantial reduction of overall costs and hospital bed usage without increased readmission or mortality (Costello, Beaumont Hospital, Dublin 2003).

### **Obstructive Sleep Apnoea**

Obstructive sleep apnoea (OSA) is an increasingly recognised condition with estimates between one and four percent of the adult population. Those affected are predominately male with a characteristic pattern of being overweight and snoring. Males presenting with OSA are often first referred due to socially troublesome snoring and daytime sleepiness. Co-morbid diseases such as hypertension, diabetes and heart disease are often diagnosed on initial screening (Kiely, 2000). It is becoming more prevalent with increasing levels of obesity but it has been clearly shown to be an additional risk factor for cardiovascular disease and stroke, independent of obesity. This condition has been shown to cause premature death mainly from increased levels of coronary heart disease and stroke, though treatment can reduce or delay these adverse events. Road traffic and work related accidents are also increased in persons with this condition due to the excessive levels of daytime sleepiness that characterises this condition. This daytime sleepiness results in significant impairment of quality of life of both patient and their partner (Kiely, 1997) though effective therapy is available which is cost effective (Kiely, 1999). A need exists for the local resourcing for diagnostic and treatment facilities of this condition in addition to raising awareness of this condition among GPs and undiagnosed affected persons. Current facilities do not meet this need.

### Area Three – Respiratory Diseases

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>i) Develop awareness about early signs and symptoms of chronic obstructive pulmonary disease (COPD) among men for earlier intervention</b></p> <p><i>(Quality &amp; Fairness, action 5)</i></p>	Respiratory Physician NEHB	Health Promotion Department, Respiratory Specialist Nurse, Pulmonary Function Laboratory staff NEHB, primary care professionals	The adult male COPD population	<p>Targeted dissemination of information on COPD in line with Health Promotion Department's overall marketing/communication strategy</p> <p>Support the legislation concerning smoking</p> <p>The development of a training and education programme on COPD in men</p> <p>Training of practice nurses to facilitate GP based COPD measurements</p>	2007	<p>Increased spirometric testing for diagnosis of early COPD according to worldwide GOLD standards</p> <p>Earlier diagnosis and intervention</p> <p>Reduced admission rates and reduced rates in male morbidity / mortality</p>	<p>Additional resources for:</p> <p>Respiratory Specialist Nurse recruitment</p> <p>Dissemination of GOLD guidelines to GPs</p> <p>Increased capacity in hospital pulmonary services to treat increased primary care referrals earlier in the course of disease</p>

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p>ii) Development of pulmonary rehabilitation service for COPD patients</p> <p><i>(Quality &amp; Fairness, actions 5, 84)</i></p>	ACEO Acute Hospital Services NEHB	Pulmonary Physician, physiotherapy departments, acute hospitals, Specialist Respiratory Nurse, Nutritionists NEHB, primary care professionals, Irish Thoracic Society	The adult male COPD population	<p>Pulmonary rehabilitation programmes</p> <p>Post acute hospital admission with COPD</p> <p>Treatment and rehabilitation of men with pulmonary problems</p>	2008	<p>Enhanced quality of life following treatment</p> <p>Reduced readmission rates to acute hospitals</p> <p>Risk factor reduction</p> <p>Increased functional capacity</p> <p>Empowered to make lifestyle changes</p>	<p>Additional resources for employment of Respiratory Rehabilitation Physiotherapist and Specialist Respiratory Nurse with administration support for service</p> <p>Co-share cardiovascular rehabilitation facilities</p>

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p>iii) Development of a screening, diagnostic and treatment service for patients with obstructive sleep apnoea (OSA) and related conditions</p> <p><i>(Quality &amp; Fairness, action 84)</i></p>	ACEO acute hospital services NEHB	Pulmonary Physician, pulmonary laboratory technicians, Specialist Respiratory Nurse, Men's Health Development Officer NEHB, Department of Health and Children, Irish Thoracic Society	The adult male OSA population, obese snorers	Adequately trained pulmonary laboratory technical staff and Respiratory Specialist nurse	2004 - 2007	<p>Improved diagnosis and earlier treatment</p> <p>Reduced co-morbidity and mortality</p> <p>Enhanced quality of life following treatment</p> <p>Reduced risk of road traffic and work related accidents</p> <p>Increased patient functional capacity</p>	<p>Additional resources for increased diagnostic equipment (<i>partially achieved</i>)</p> <p>Treatment Equipment (<i>in progress</i>)</p> <p>Adequate staffing to deliver service (<i>partially achieved</i>)</p>

## **Action Area Four– Accidents**

### **Rationale**

Men generally have more accidents than women. In the NEHB region in 2001, 43 persons died as a result of motor vehicle accidents, of whom 27 (63%) were males; 30 died as a result of falls, 20 (67%) of whom were males; six died as a result of fire, all of whom were males; five drowned, three (60%) of whom were males. In 2002 of those killed in Ireland as a result of fire, 70% were males who lived alone without a working smoke alarm.

*The National Health and Lifestyle Surveys* demonstrated that 17% of male respondents in the NEHB region indicated having had an injury which interfered with their daily activities within the past two years. Males in the NEHB were more likely to suffer a non-fatal injury than females. Twenty-six percent of the accidents occurred in the home/garden, 17% involved car/bike and 16% occurred at work. The surveys showed that the main treatment of injuries was carried out by the Accident and Emergency (A&E) services. In the NEHB region, 31% of injuries as a result of accidents were treated at the A&E department in a local hospital, 31% were treated by GPs and 24% were treated by the individual themselves. At a national level, 47% attended an A&E Department, 36% attended their GP and only 15% treated the injury themselves.

Purser (2001) reported an association of high levels of risk taking behaviour with alcohol consumption amongst men. These included taking drugs they would not otherwise have taken, engaging in unprotected sexual intercourse, becoming involved in an argument or fight, or drink driving. Injury on the road is a leading cause of death for young men, and young men's road accident rates are spectacularly higher than those of other groups. Young men aged 17 to 25 years are involved in four times as many serious speed-related casualties as young women (Connell, 2000). Young men die on the road at a rate four times that of young women, and kill on the roads at an even higher ratio.

*For men it would seem that there is an age gradient to risk-taking – the older they get the less likely they are to admit risk-taking. This was particularly so with speeding. The greatest motivator to risk reduction is not health promotion, but legislation (Stakelum, A. and Boland, J., 2001: 33).*

Men suffer greater injuries due to contact sports than women. In some respects, sport, as well as being a health promoting activity, can also be a major threat to men's health. For example, body-contact sports, such as boxing and football involve ritualised combat and often physical injury. Connell (2000) tells us that the process of commercialisation has included in the domain of 'sport' certain activities, notably car and motorcycle racing, which actually have no physical benefits at all. On the contrary, certain practices are glamorised e.g. speeding and aggressive driving; practices directly implicated in road deaths and injuries among men.

Men are also more likely to be killed in workplace accidents. The traditional male role of provider places men at much greater risk of being injured or dying prematurely from occupational accidents. Farmers as an occupational group, represent a particularly high-risk category in terms of accidents, injury and health problems in the workplace.



### Area Four – Accidents

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>i)</b> Campaign for road accident prevention among men</p> <p><i>(Quality &amp; Fairness, actions 5, 10)</i></p>	Health Promotion Department NEHB, C.A.W.T.	National Roads Authority, National Safety Council, An Garda Siochana, Department of Environment, Society of Irish Motor Industry, Co. Councils, Department of Public Health NEHB	The male population	<p>Collate and analyse available data for R.T.A.'s</p> <p>Disseminate information on accident prevention</p> <p>Analyse existing road laws and rules</p> <p>Develop range of initiatives focused on identified target groups</p> <p>Lobby and advocate for change</p>	Spring 2005	Reduction in male accidents mortality & morbidity rates	Existing resources
<p><b>ii)</b> Continue to work with other agencies to increase signage on the road about speed limits</p> <p><i>(Quality &amp; Fairness, action 10)</i></p>	Health Promotion Department NEHB	Department of the Environment, National Roads Authority, National Safety Council, County Councils, Department of Public Health NEHB	Motorists & pedestrians	<p>Develop partnerships with relevant organisations</p> <p>Support the European Charter on Road Safety campaign</p>	2007	Reduction in the number of road fatalities and injuries	Existing resources

<b>Objective</b>	<b>Lead Agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated outcome</b>	<b>Resource implications</b>
<b>iii)</b> Policy development related to alcohol consumption and misuse  <i>(Quality &amp; Fairness, action 5)</i>	Public Health Department NEHB	Health Promotion Department, acute hospital services NEHB	General public, young males	Progress recommendations of <i>Strategic Task Force on Alcohol</i>	2006	Reduction in number of alcohol related accidents among men	Existing resources
<b>iv)</b> Support the Health and Safety Authority's <i>National Prevention Strategy for Occupational Health</i>  <i>(Quality &amp; Fairness, action 10)</i>	Health Promotion Department NEHB	Department of Public Health, Occupational Department, Health & Safety Department NEHB, employers, VEC's, voluntary sector, Health & Safety Authority	The workplace	Enhance relationships with other sectors i.e. voluntary, private, workplace  Provide accident prevention courses for groups	2006	Reduced numbers of workplace accidents	Additional resources

## **Action Area Five – Mental Health**

### **Rationale**

Mental health is far more than the absence of mental illness and has to do with many aspects of life including how we feel about ourselves/others and how we are able to meet the demands of life. Courtenay (2000) argues that whilst women are encouraged to be knowledgeable about their bodies, to recognise and acknowledge susceptibility to illness, and to freely express their emotions, the gender pattern for men is very different. The social construction of gender is quite evident in relation to the socialisation of the male. Many young boys are still brought up to believe that they must be tough and strong and behave as if they were indestructible. Boys are still discouraged from crying if they fall and injure themselves. From an early age they are told that they are not supposed to cry and that they have to ‘be strong soldiers’ (Stakelum, A. and Boland, J., 2001).

As a result, the young male learns to be stoical and suppress feelings and eventually fails to recognise the bodily symptoms that indicate he is heading for trouble (Condren, 2002). This is not just confined to boys. Men also conceal vulnerability, are stoic and independent, and may turn to unhealthy behaviours and indeed risk behaviours, that are culturally defined as masculine, to ‘prove’ their masculinity to themselves and others. Self-care practices on the other hand have become culturally defined as ‘feminine’ (Richardson, 2002).

Men are less likely than women to report concerns relating to mental or emotional problems. Suicide is the most frequent cause of death in 15 – 34 year olds. In 2002, there were 454 suicides in Ireland, of which 80% were male. In the NEHB region there were 34 deaths by suicide in 2002, of which 27 (79%) were male. International studies show that young unemployed men up to 25 years of age are especially vulnerable to suicide. High alcohol consumption, marital breakdown and isolation from traditional family supports such as the extended family are also factors leading to an increased incidence of young male suicides. The relationship between masculinities and men’s mental health, and how this impacts at a service delivery level, may have particular relevance in tackling the issue of suicide in Ireland.

Some men seem to feel that self-revelation of personal difficulties is tantamount to an admission of failure of their masculinity or manhood. In relation to suicide, the NEHB has recently drawn up a regional suicide prevention strategy called EROS.

Stress can be an emotionally upsetting experience but men tend to feel more constrained in expressing their emotions. It is the pressure exerted by masculinity to conceal emotional vulnerability that results in men being more susceptible to stress than women. Many of the following situations are likely to cause stress, especially if several occur at the same time namely, living alone, family conflicts, loss of friendship/separation, money worries, low pay, bullying, being subject to prejudice/abuse, work overload, not enough to do at work, shift and night work and unemployment. Prolonged stress can cause physical and/or emotional problems such as anxiety, increased heart rate and blood pressure, abuse of alcohol, tobacco, drugs and depression.

Although we cannot eliminate stress, we can learn how to recognise and cope with it more effectively. Often we cannot change a situation but we do have the power to change our reaction to it.

### Area Five – Mental Health

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>i) Campaign for mental health promotion among men</b></p> <p><i>(Quality &amp; Fairness, action 25)</i></p>	Health Promotion Department NEHB	Education, media, Mental Health Ireland, voluntary and sporting organisations, Workplace, Mental Health Services NEHB	The male population	Enhance mental health literacy amongst men in line with EROS	Spring 2005	Increased awareness of mental health issues for men	Existing resources
<p><b>ii) Early risk assessment by healthcare providers</b></p> <p><i>(Quality &amp; Fairness, action 76)</i></p>	Primary Care Services, Mental Health Services NEHB	Health Promotion Department, Department of Public Health NEHB, primary care health professionals	All appropriate health board staff, GPs and other relevant primary health care workers	Identify needs and gaps  Develop appropriate training programmes and protocols	2005	Early identification and intervention in mental health problems	Additional resources

Objective	Lead agent	Partners	Target	Actions	Timescale	Anticipated outcomes	Resource implications
iii) Advocate the importance of the environment i.e. access to recreation facilities to be developed in conjunction with new housing developments	Community & Regional Services NEHB	Men's Health Consultative Committee, Health Promotion Department, Department of Public Health NEHB, local sports partnerships	Local authorities and the general public, county development boards, partnerships, sporting organisations	Continue advocacy role	Ongoing – to be reviewed annually	Greater availability of recreational facilities	Existing resources
iv) Increase advocacy and action at community and regional level in light of increasing levels of alcohol consumption and related harm among men  <i>(Quality &amp; Fairness, action 5)</i>	Health Promotion Department NEHB	Primary Care Services, Department of Public Health, acute services NEHB, Department of Health and Children, community advocacy groups, the media, sporting organisations, An Garda Siochana	All relevant agencies; the Dáil, Garda Síochána, licensing authorities, the judiciary, advertising, sporting organisations, insurance corporations, health services and education, parent groups, workplace	Establishment of alcohol advisory group	2004	More effective public health interventions to tackle alcohol issue	Existing resources

<b>Objective</b>	<b>Lead agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated outcomes</b>	<b>Resource implications</b>
<p>v) To build ongoing sustained programmes to raise self-esteem, self-efficacy and self-competency among men.</p> <p><i>(Quality &amp; Fairness, actions 5, 25)</i></p>	Men's Health Development Officer, Health Promotion Department NEHB	Men's Health Consultative Committee, education, voluntary sector, sporting organisations	Men's groups and all service managers	<p>Continue implementation of EROS including awareness training, support and information dissemination</p> <p>Enhance linkages with all relevant men's groups</p>	Ongoing – to be reviewed annually	Increased coping capacity in men	Existing resources

## Action Area Six – Sexual Health

### Rationale

One of the objectives of the National Health Promotion Strategy 2000 – 2005 is

*“To promote sexual health and safer sexual practices amongst the population”*

Sexual health is defined by many organisations and professionals in lots of different ways. Some of those definitions are:

*“(Sexual health is)... the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love.”*

*“(Sexual health involves).... A capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic.”*

*“(Sexual health involves)... freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relation ships.”*

*“(Sexual health involves)... freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive function.”*

(WHO, 1975: Langfeldt and Porter, 1986)

Traditionally, most people and organisations, relate sexual health to reproductive health. This is manifested mainly by the provision of family planning services. However, increasingly it is becoming imperative that sexual health is far greater than this. The promotion of safer sexual practices, responsibilities for sexual practices and greater understanding of consequences are all important, as are the provision of services in relation to family planning for men, protective services to reduce sexually transmitted infections, psychosexual health clinics and provision of men specific clinics.

### Area Six – Sexual Health

Objective	Lead agent	Partners	Target	Actions	Timescale	Anticipated outcomes	Resource implications
<p>To develop a comprehensive sexual health strategy</p> <p><i>(Quality &amp; Fairness, actions 16,19,28)</i></p>	Men`s Health Development Officer NEHB	Health Promotion Department, Department of Public Health, Primary Care Services NEHB, Men`s Health Consultative Committee, Crisis Pregnancy Agency (C.P.A.), Irish Family Planning Association (I.F.P.A.)	Identified by the strategy	<p>Set up a committee</p> <p>Agree terms of reference</p> <p>Develop the strategy</p> <p>Agree action plans</p> <p>Submit for funding</p>	2005	<p>Better understanding of sexual health</p> <p>Safer sexual practices</p> <p>Provision of services</p> <p>A strategy</p>	Additional resources towards the development of the strategy



## Action Area Seven – Uptake of Health Services

### Rationale

Research shows that men know more about a woman's cycle than they do about their own body. As one commentator puts it 'some men don't know their epididymis from their elbow!' (Armstrong, 1999). Men are less likely to see their doctor than women and are generally less likely to be thought to need medical services, yet by any objective criteria they experience worse health. Any strategy to improve men's health must increase men's use of primary healthcare services.

The *Men Talking* report clearly highlighted the fact that men are slow to seek help. Screening for example does not appear to be actively sought:

*“The last check up I had was the school medical ...and I didn't go since”*  
*“Unless I had a reason to go, I certainly would not go for a check up”*

Men are also slow to seek help in times of illness. The main barriers are sociocultural and institutional. The sociocultural barriers refer to the way males, through their upbringing, place a high priority on work and providing for others and a low priority on self-care. In addition it refers to the macho principle, which equates illness with weakness. Men are afraid of losing control and being considered weak:

*“Well me father, God be good to him never went to the doctor in his life, or me grandfather, and I won't do it...”*

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

While there is a certain convenience at a policy, research or conceptual level in labelling 'men's health and 'women's health', this segregation tends to give rise to a focus on the margins of difference between men and women, and may indeed invite conflict and rivalry. The pursuit of men's health agenda must not be at the expense of women's or children's health.

In addition, there is increasing evidence to suggest that choosing to access health services is based not just on need, but on how a given service is perceived, and on the value that patients' place on the service (Humphreys et al, 1997). Since men attend GPs less frequently than women, it is not surprising that the services provided by most practices are geared towards women. Courtenay (1998) cites a number of studies which confirm that men take much less physician time than women do in their health visits, receiving less information with fewer and briefer explanations. While there would appear to be a strong consensus in the literature that men are unwilling or less able (than women) to access health services (Griffiths, 1996), there is also evidence that many men feel marginalised by the health services. For example, in the *Men Talking* report there were few complaints regarding the hospital sector. However, when they did emerge, they generally revolved around what men described as the female bias that surrounded doctor-patient communication. This was particularly true for fathers who felt demeaned by a system that was perceived to reinforce the societal notion that mothers are always 'the better carers'. In the same report, fear also emerged as a reason why many men fail to access the health services.

Women have traditionally played a vital role in positively influencing men's health. It has been estimated that 40% of male consultations are at the prompting of a female (McEvoy, 2004). Baker (2002) suggests that the time has come to look beyond initiatives directed at improving men's health via women. Such an approach does not encourage men to take greater responsibility for their own health; places an additional burden on women; is based on traditional and outdated views of women's and men's roles; and fails to cater for a high proportion of men who are not in relationships with women.

*Men Talking* highlighted that men are not a homogeneous group. There are vulnerable groups of men who require more focused support. The groups identified with specific needs include, male Travellers, gay men, male victims of domestic violence, male farmers, rural bachelors, men with disabilities, male asylum seekers and refugees.

Current research indicates that men in the lowest social classes have a life expectancy of almost five years less than men in the highest social classes and have worse health in all years and for all the major conditions.

The NEHB is committed to developing services, which respond to men's health and which address some of the key determinants that prevent and restrict men from accessing health services in a preventative and health promoting way.

### Area Seven – Uptake of Health Services

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated Outcome	Resource implications
<p><b>i)</b> To make health service more men friendly</p> <p><i>(Quality &amp; Fairness, action 51, 53)</i></p>	Men's Health Development Officer NEHB	All health care service providers	All relevant health board staff, GPs and other relevant primary health care workers	Commence discussion concerning times of services, attitudes of health professionals and facilities	2004	More men-friendly health services	Existing resources
<p><b>ii)</b> To provide training for health professionals and healthcare workers on men's health issues</p> <p><i>(Quality &amp; Fairness, action 69)</i></p>	Men's Health Development Officer NEHB	Training Department, Health Promotion Department NEHB, AMEN	Health care workers interested in men's health	Development of a training programme to deliver to NEHB staff	2004	Greater awareness of men's health among health professionals	Existing resources

<b>Objective</b>	<b>Lead Agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated Outcome</b>	<b>Resource implications</b>
<b>iii)</b> To reduce inequalities in service provision for men.  <i>(Quality &amp; Fairness, action 19)</i>	Men's Health Development Officer NEHB	Managers of the health services	All appropriate health board staff, GPs and other relevant primary care workers	Encourage health professionals to increase clinical appointments and follow-ups to men where there is a gender imbalance in current uptake	2005	Increasing number of men availing of timely health care	Existing resources
<b>iv)</b> To support GPs and practice staff to work more pro-actively around men's health issues  <i>(Quality &amp; Fairness, actions 69, 77)</i>	Primary Care Services NEHB	Men's Health Development Officer NEHB, primary care professionals	GP practices	Make presentation on men's health at GP meetings to include topics such as screening, obesity and sedentary lifestyles etc.	2005	Increased numbers of men accessing primary care services	Existing resources

<b>Objective</b>	<b>Lead Agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated Outcome</b>	<b>Resource implications</b>
<p>v) To establish men's health networks</p> <p><i>(Quality &amp; Fairness, action 15)</i></p>	Men's Health Development Officer NEHB	Men's Health Consultative Committee	All appropriate NEHB staff, GPs and other relevant primary health care workers, voluntary, community and statutory groups and members of the public	To establish men's health networks	2005	Established support network	Existing resources
<p>vi) To set up crisis pregnancy men's health support group</p> <p><i>(Quality &amp; Fairness, actions 16, 28)</i></p>	Men's Health Development Officer NEHB	Men's Health Development Officer, Health Promotion Department, NEHB	Young men	To set up a group	2005	To provide a more supportive role for men	Additional resources

<b>Objective</b>	<b>Lead Agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated Outcome</b>	<b>Resource implications</b>
<b>vii)</b> To emphasise men's issues in policy development  <i>(Quality &amp; Fairness, actions 15,34, 70)</i>	Department of Public Health NEHB	Health Promotion Department, Men's Health Development Officer NEHB, men's advocacy groups	NEHB managers	To revisit existing policies and identify areas where men's issues could be re-addressed	2004	Health policy more oriented to men's health needs	Existing resources
<b>viii)</b> To develop services which respond to the needs of vulnerable men.  <i>(Quality &amp; Fairness, actions 19,20,21,22,23,34, 54)</i>	Managers of the health services	Men's Health Development Officer, Traveller Health Care Unit, disability services NEHB, Outcomer's Dundalk, Treskele, AMEN, Parental Equality, I.F.A.	NEHB managers	Focus primarily on the groups of men who are considered to be particularly vulnerable namely: male Travellers, gay and bi-sexual men, male victims of domestic violence, male farmers, rural bachelors, men with disabilities and male asylum seekers/refugees	2004	Increased health status of vulnerable groups	Existing resources

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated Outcome	Resource implications
<p>ix) To develop projects specifically targeting older men</p> <p><i>(Quality &amp; Fairness, actions 26, 54)</i></p>	Men's Health Development Officer NEHB	Elderly services co-ordinators, Health Promotion Department NEHB, voluntary sector (e.g. Older Men's Organisation, Third Age etc.)	Older men	Awareness campaign aimed specifically at older men	2004 - 2005	Increased life expectancy and quality of life for older men	Existing resources
<p>x) To set up a project for gay men similar to the Gay Men's Health Projects in Dublin and Cork.</p> <p><i>(Quality &amp; Fairness, actions 16, 19, 54)</i></p>	Primary Care Services NEHB	Department of Health & Children, Men's Health Development Officer NEHB, Dundalk Outcomers	Gay and bi-sexual men in the north east region	Research the gay community's access to existing services and recommendations to improve and build on them	2005	Higher health status for gay and bi-sexual men  Increased access to services	Additional resources

<b>Objective</b>	<b>Lead Agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated Outcome</b>	<b>Resource implications</b>
<b>xi) To develop Wellman Clinics across the region</b>  <i>(Quality &amp; Fairness, actions 15, 76)</i>	Men's Health Development Officer, Primary Care Services NEHB	Department of Public Health, Health Promotion Department, GP unit, acute hospital services NEHB, GPs	18 - 55 year old men in the general population	Support a number of GPs to set-up the service on a pilot basis	2004	Men routinely attending GP for wellness check	Additional resources



## **Action Area Eight – Education and Research**

### **Rationale**

The traditional model of health has become known as the biomedical model. However, a new model is emerging, the sociocultural model, which emphasises the influences of cultural practices, social conditions, emotions, environment and personal beliefs on health. It requires an approach to health that probes much deeper than the simplistic and reductionist definition of men's health as a set of sex-specific biomedical conditions.

There is now a growing awareness of the need to start from an understanding of men, and the implications of men's practices and behaviours on their health. This means putting 'the men into men's health', and not trying to separate or isolate men's health from all of the other aspects of men's lives.

In recognition of this, the Action Plan takes this opportunity to address broader social and personal issues that affect men today by including this section on education and research, reflecting a holistic approach to men's health.

### Area Eight – Education and Research

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>i)</b> To develop a Higher Diploma/ Masters in Men's Health programme</p> <p><i>(Quality &amp; Fairness, actions 5, 69)</i></p>	Royal College of Surgeons, Health Promotion Department NEHB	Department of Health & Children, Men's Health Development Officer NEHB	Healthcare workers who wish to study men's health as part of their professional development	<p>Commence with meeting between the college and the NEHB</p> <p>Develop modules</p> <p>Deliver programme</p>	Autumn 2005	<p>Healthcare workers with a greater understanding of the issues affecting men</p> <p>Improved service delivery</p>	Additional resources
<p><b>ii)</b> To develop a men's health course in Dundalk Institute of Technology (DKIT)</p> <p><i>(Quality &amp; Fairness, actions 5, 69)</i></p>	Dundalk Institute of Technology, Men's Health Development Officer, NEHB	Health Promotion Department, Department of Public Health, NEHB, Parental Equality, Amen, Simon Community	Adults, students, men's development groups, community organisations, healthcare professionals	To carry out a feasibility study	2005	Better understanding of the issues relating to men's health within community/ men's groups	Additional resources

Objective	Lead Agent	Partners	Target	Actions	Timescale	Anticipated outcome	Resource implications
<p><b>iii)</b> To establish men's health courses as part of the VEC's adult education programme</p> <p><i>(Quality &amp; Fairness, actions 5, 69)</i></p>	Men's Health Development Officer NEHB, VEC's	NEHB, community and voluntary sector	Adult population interested in night course on men's health	<p>Establish relationship with VEC's</p> <p>Draw up contract to develop course programme</p> <p>Pilot a course in Co. Meath VEC</p> <p>Make relevant changes and roll out the programme to other VEC's</p>	2005	<p>Communities better informed</p> <p>Increased uptake of health services by men</p>	Additional resources
<p><b>iv)</b> To commission research on men's perception and use of health services</p> <p><i>(Quality &amp; Fairness, action 73)</i></p>	Department of Public Health NEHB	Primary Care Services, Men's Health Development Officer, GP unit NEHB, community and voluntary sector	Adult male population	Set-up a meeting for interested parties to explore the idea further	2005	<p>Greater awareness of services</p> <p>Increased uptake of services by men in the region</p>	Additional resources

<b>Objective</b>	<b>Lead Agent</b>	<b>Partners</b>	<b>Target</b>	<b>Actions</b>	<b>Timescale</b>	<b>Anticipated outcome</b>	<b>Resource implications</b>
<p>v) To establish an annual men's health awareness month for the region</p> <p><i>(Quality &amp; Fairness, action 5, 69)</i></p>	Men's Health Consultative Committee	Health Promotion Department NEHB, statutory and voluntary organisations	Adult male population	Set-up a meeting for interested parties to explore the idea further	2005	Men's health month established as integral part of annual calendar of events in health promotion	Existing resources

## **Summary**

This action plan has been developed using a partnership approach between the NEHB and other statutory and community organisations. For men to reach their full health potential there is a need for a wide range of agencies and community organisations to address the needs and support initiatives. The health service, or indeed any other agency or group working alone, will not be sufficient to effect the required changes to improve and sustain the gains in men's health that can be achieved by a multi-agency, multidisciplinary and cross community approach.

The action plan has eight action areas which include the main causes of mortality: cardiovascular disease, cancer, respiratory disease and accidents. The high level of mental illness in our community is reflected in actions aimed at promoting positive mental health, addressing the high levels of alcohol consumption and developing programmes to raise self-esteem and self-competency among men.

Sexual health has become an increasingly important issue in recent years and extremely important from a men's health perspective. It is an area that has not received sufficient attention or funding to develop the appropriate services. Actions to deal with specific sexual health matters are not dealt with in this action plan. However, one of the actions is to develop a comprehensive sexual health strategy.

A key action area is that of increasing the utilisation of health services by men. Men are slow to use health services. The actions planned include amongst others, initiatives to make health facilities more "men friendly", providing training to health care workers on men's issues and establishing men's networks.

The final action area targets research and education. If we are to achieve our objectives, it is necessary to continually research and develop our knowledge in regard not alone to men's health issues, but also to the social context they live in, their emotions, beliefs and behaviours. Actions outlined include the development of a Masters degree in men's health.

It is hoped that this action plan will act as a catalyst for change. Each action has been designated a lead agent to take responsibility for the action. Some of the planned actions can be delivered using existing resources and these can be addressed in future service plans. Indeed a number of actions have already commenced. However, there is a need for additional resources in many of the actions. This action plan can now be used as a tool to attract the required additional funding.

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