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GENDERED PERSPECTIVES OF MEN'S HEALTH AND HELP SEEKING: IMPLICATIONS FOR PUBLIC HEALTH AND HEALTH PROMOTION

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ABSTRACT

Men have a shorter life expectancy than women and have higher death rates. Despite this, men have limited contact with GPs, are reluctant primary care users and often seek help late in the course of an illness compared to women. While research has elicited men's attitudes towards their health and accessing health services, it has not determined the factors that men take into account when assessing their own health status; the criteria men use to decide whether or not to seek formal health care; or the factors that inform men's perception of what constitutes an acceptable threshold for seeking help. Therefore, this research set out to explore these aspects of men's health. A qualitative approach was undertaken incorporating semi-structured interviews (n=18 males), two three focus groups with males (n=26) and two focus groups with females (n=20). Potential research participants were sourced from urban and rural locations throughout Ireland via purposive/snowball sampling. The principle of theoretical saturation was applied. The focus groups and interviews were recorded, transcribed and then analysed using thematic analysis. Men's attitudes and behaviours towards health seeking were complex. Health consciousness increased with age, as did willingness to access health and preventive health services. Health was primarily assessed by physical fitness and absence of disease/illness. Perceived severity of the symptom was the primary trigger to attend the GP although others included persistent symptoms, prompting by a significant other, a direct/indirect health crisis and the media. Men experienced structural, psychological and social barriers to help seeking. Such factors must be taken into consideration when developing health services and health promotion programmes for men.

Keywords: Men's health, Help seeking, Masculinity, Gender, Health promotion, Health services, Men, Male.

Contribution/ Originality

This study documents men's attitudes and practices towards help seeking from both male and female perspectives. It outlines the factors that men consider when assessing their health; the criteria used to decide to seek healthcare; and the factors that inform perceptions of what constitutes an acceptable threshold for seeking help.

1. INTRODUCTION

Despite having a key role in the functioning of health service policy and provision, men have not argued, lobbied or campaigned in the same way that women have for improvements to men's health at an individual or collective level [1]. Resultantly, there has been a deficit at a strategic level in the area of the promotion of men's health [1]. However, real differences exist in mortality among men and women [1, 2].

According to the World Health Organisation [3] life expectancy rates in Ireland (where this study was conducted, for example) in 2011 were 79 years for males and 83 years for females. Gender differences in mortality and life expectancy are evident in most countries [4]. For example in Latvia the difference in 2011 between male and female life expectancy was nine years (69 vs. 78), in the United States, the male disadvantage is also evident (76 vs. 81) with a difference of six years [3].

Men are more likely to die from circulatory diseases, malignant neoplasms, injury and accidents than women [5]. On the other hand, men have slightly better self-reported health and report less chronic illness than women [6]. There are a number of reasons for gendered differences in life expectancy. These include biological differences between men and women [2, 7-9] and also cultural and behavioural differences linked to different social expectations of men and women, including gendered use of and access to the health services [2, 7, 10-12].

Given these gender differences there is need to consider gender when discussing men's health research, policies, plans, and service delivery [1, 13-17]. This is also the case for the development of public health initiatives and health promotion policies, which are more likely to be effective if gender is considered [18]. In terms of health promotion, more careful consideration of gender needs to be employed in promoting responsibility help seeking amongst the population. For males, health gain and help seeking are influenced by many factors including social constructs of masculinity.

Improving men's access to primary care services in settings such as the community and workplace and also the promptness with which they seek help, is a key policy issue [17]. Men's health is under-researched from a clinical and health promotion perspective. Therefore, this study set out to understand and interpret the lived experiences of a sample of Irish men and to elicit the factors that influenced their decisions to seek professional help for health-related issues.

2. METHODS

A qualitative research design was adopted for the study. Several authors have noted the absence of qualitative research in men's health research [19, 20]. This study was concerned with

understanding men's help seeking in more depth and as such it was deemed that a qualitative study would be most appropriate, using focus groups and semi-structured interviews to address the deficit in terms of qualitative research in the field. Qualitative approaches such as interviews are particularly well suited to exploring the complexity of men's subjective lives [21].

2.1. Sampling Procedures

Purposive sampling was employed to ensure diversity in age range, occupational status and socioeconomic backgrounds. Similar to the approach adopted by O'Brien, et al. [22] men anticipated to have had 'everyday' or unremarkable experiences of masculinity and health, and men anticipated to have had 'epiphanies' prompting reflection on masculinity and health, were targeted for both data collection methods.

Snowball sampling was employed and this is a process whereby participants were recruited via third parties (friends, colleagues and partners) who had been informed about the research as this is a particularly effective method for researching about health or illness experiences with men [23]. Interviews and focus groups were held until theoretical saturation was reached [24, 25].

2.2. Sample

Data were collected via eighteen semi-structured interviews with a national sample of male participants from six different geographical counties in the Republic of Ireland (see Table 1).
Three focus groups were conducted with male participants nationally, with a further sample of twenty six males (see Table 2). Two focus groups were conducted with female participants comprising a sample of 20 females (see Table 3).

2.3. Data Collection

An interview guide and focus group guide (i.e. schedules of question themes) were compiled and piloted after an extensive review of literature in the field.

Interviews and focus groups were conducted at times and locations convenient to participants [26]. Interviews lasted approximately 40 minutes, while focus groups lasted between 60 and 90 minutes.

2.4. Data Analysis

All discussions were audio-taped, transcribed verbatim and analysed using thematic analysis [27]. Preliminary data analysis was completed following each interview/focus group through a process of iterative reading and identification of emerging themes. This was conducted to inform data collection, develop and refine questions, explore new avenues, and look for negative or deviant cases [28]. Further analysis was completed after all participants had been interviewed and focus groups had taken place.

Firstly, the data were analysed separately in order to answer aspects of the research question. Secondly, the data from the focus groups were triangulated with the data from the interviews and overall comparisons made to provide further understanding. The main themes

were identified and further sub-themes were developed inductively. Comparisons and contrasts within the data were made [29]. Data analysis was conducted by both a male and female researcher in order to eliminate any biases, including gender.

2.5. Ethical Approval

Ethical approval was granted by the University of Limerick College of Education Research Ethics Committee. In addition, the guidelines prescribed by the Declaration of Helsinki [30] were used to inform ethical practice throughout the study.

3. RESULTS

3.1. General Health Perceptions

General health awareness among men and the general population was perceived by participants to have improved. Comments that illustrated this perspective included:

> *…do you know that attitude has changed? …Younger people now are more conscious, more health conscious, you know (James: Focus Group 1; 1388-1392).*
>
> *But they're better educated too now like and people are more open-minded and talk more. (Maurice: Focus Group 1; 1388-1392).*

This increased awareness was attributed in part to greater information being made available, through the media for example.

> *…there's certainly more information out there…there's more, people are pushing information at you more often, you seen it on the television and through the state agencies …that would…incentivise you to go to your GP for a general check-up…. at least you might have a better awareness of what the symptoms would be…that might be causing something…so, you know, that's no harm anyway… (Tom 39, 6:676-689).*

Participants, however, generally had limited knowledge of the types of conditions that can affect male health and the associated risk factors and symptoms. Female participants were of the opinion that knowledge of health does not come naturally to men and that in fact it was driven by wives/partners.

> *Sure at the end of the day, no matter whether you're man, woman or child, you took what your mammy told you to take, didn't you? And men continue to take what the women… tell them to take or do … (Caroline: Focus group 4; 1735-1739)*

Men indicated that health did not form part of men's everyday discourse.

> *It's not an issue. It's not something that's not going to come up unless you're ill…or unless one of you, you know, one of the party are ill, if friends are sick or whatever. Am, yeah you talk about it.* (Ray 42, 18:634-637).

Health was primarily assessed by men as physical fitness and absence of disease/illness.

> *Mmm, am…I suppose firstly off the top of my head like, being healthy is just the opposite to being sick like, as in, I would see being healthy as anyone who doesn't have serious illness like…a serious disease. (Adrian 26, 12: 54-58).*

Being healthy means I suppose being active and being able to go out and…participate in sport and…have a life [laughs]! (Gordon 63, 14:27-30).

Health consciousness and perception of vulnerability increased with age, as did willingness to access health and preventive health services. For example Liam (aged 20) admitted that he never thought about health and believed that this would be normal for people his age. His perspective was that health issues did not affect people in their twenties and maybe people in their late twenties might be more conscious of it when they start to settle down. He believed that something would have to challenge his health status before he would really start thinking about his health; he suggested a visit to the doctor might prompt this if there was something wrong. In contrast Tom (aged 39) admitted to being more conscious of his health as he approached 40 as he believed he was of an age where he was susceptible to conditions such as heart disease or cancer. He disclosed feeling 'mortal' since his sister's recent breast cancer diagnosis. Up to that point he would not have 'bothered too much' about his health, but now indicated that he was more aware of health issues generally.

Michael (aged 58) admitted to becoming more conscious of his health in his fifties. He attributed this to an increasing awareness of the conditions that people can experience mid-life, also to the fact that his father had a heart attack early in life and because his wife suffered a heart attack when he was in his fifties.

Male and female participants were resolute in their opinion that men were reluctant to seek help and would only do so when they have no choice in the matter. Instead of seeking help men were seen to deny weakness, ensure symptoms, become self-reliant and wait for the body to heal itself.

If a thing was plaguing a fella too much like, he might mention it then alright like, he'd be worried then but like my idea of going to the doctor is you'd weather the storm until you'd think you'd can't weather it and then you'd go on for relief…and I'd be no different I suppose than most fellas. (Maurice, Focus group 1; 1542-1547)

Help seeking was only perceived as legitimate if one was ill and additionally a certain threshold would have to be reached. While females could see the detrimental impact that delayed help seeking could have on illnesses and witnessed men suffering as a result, men accepted it as a part of the traditional male gender script.

3.2. Barriers to Help Seeking

Men experienced structural, psychological and social barriers to help seeking. Many were deterred from accessing health services by systematic barriers including cost, time (wasting their own and the GPs – linked to the need to have a tangible illness, and waiting in the surgery) and female GPs.

In situations where the perceived severity of the illness was great, however, concerns about systematic barriers diminished. There was a mixed reaction to cost, perhaps reflective of the varying social backgrounds of participants. Psychological/personal barriers to help seeking such as perceived vulnerability, fear and denial, and a macho rejection of help seeking or adopting

preventative health behaviours were observed in male and female participants' accounts. The following interaction illustrates how the conversation centered on men's fears:

Vincent: Fearful.

Patrick: The unknown, that's right.

Vincent: Fearful of the unknown.

Patrick: I think that's what it is, we'd hate to be told we have a problem or an unnatural thing like that.

Patrick: We've our heads in the sand that way.

(Focus Group 3; 1280-1287).

Females also reiterated this perspective:

Anne: I wonder is it something to do too they don't want, the fear of what they'd be told…

Sheila: That could be it yeah.

Anne: …you know, is there an element of that with them as well. That they're afraid, afraid if I go in and I've an ache here or there I'll be told all of a sudden, oh god.

Mary: They're afraid to start going.

(Focus Group 4; 970-974).

This fear centered on being diagnosed with a terminal illness and ultimately death, although being told of the presence of any illness was feared.

Men's fears were associated by women with a loss of independence also. Females, however, felt that such fears could be assuaged if men were more engaged with health issues in terms of awareness of conditions and proactive in asking questions. Fear diminished with age in many cases as men became more concerned with reassurance.

For some males, particularly younger ones, embarrassment/shyness was perceived a deterrent to seeking help, especially for 'those kind of problems'.

Rory: Yeah, I mean, it would, I suppose we're going to the same doctor with years and years so yeah if I had to go I'd go to him…but I would still be uncomfortable going like…

Conor: Yeah.

Rory: …do you know?

Facilitator: And why do you think that is?

Rory: I suppose, I don't know, it's just, 'tis something you kind of wouldn't be used to showing off to anyone you know? Bar the boss woman! [all laugh]…I just think of it that way. I mean it's very, very private but I know it's a doctor and we need to break down those barriers a bit I suppose…

(Focus Group 5; 1069-1086).

For others embarrassment was not an issue and the benefits of being diagnosed early outweighed the risk of potential embarrassment. Men generally stated that they had good relationships with their GPs and that they would talk to them about any issue. Females argued, however that men probably did not have good relationships with their GPs as they were just not there often enough.

They also disclosed that men do not have the language to explain how they are feeling to a GP and they don't ask questions or seek information either. This was acknowledged by some male participants.

Social norms of masculinity as barriers to help seeking were evident, albeit implicitly, throughout the entire narratives. While women challenged such stereotypical norms, men accepted them.

3.3. Prompts to Help Seeking

Perceived severity of the symptom was the primary trigger to attend the GP although persistent symptoms and prompting by a significant other were also important. These were used to legitimise their help seeking. Serious in this case, was defined in the context of '*if panadol (over the counter medicine) doesn't work'*, an unusual pain and a severe pain. For many participants, the perception that a symptom was indicative of a condition such as cancer or heart disease was a trigger to attend. Persistent symptoms where one would have to endure symptoms for a reasonable amount of time beforehand thus preserving masculinity to some extent. Others triggers included the prompting of females who also played a role in identifying illness. Female participants, however, divulged that their involvement in prompting men to seek help had limited effectiveness and was a painstaking process.

If you nag long enough they will go (Aisling: Focus Group 2; 792).

The experiencing of symptoms similar to that experienced by a friend/relative, reaching a certain age (for many this was fifty), other milestones such as parenthood and media campaigns also impacted on willingness to seek help when ill and also preventive help. Some men required a tangible problem before they sought help. Younger participants and also females divulged that they (men) would only be prompted to attend the GP if they required a medical certificate to take time off work or a medical examination for a driver's license.

3.4. Overall Perceptions of Help Seeking

Health did not form part of everyday discourse for men. It was acknowledged that women were able to express themselves much better and that men prefer to *'bottle it'*. Men were generally quite skeptical about speaking to others about their health for confidentiality and legitimacy reasons.

The majority stated that they would talk to their wife/partner/girlfriend and their GP, with mothers and a close friend less frequently mentioned. Females suggested that men were even reluctant to speak with them on issues that were particularly personal. Some men disclosed that they might delay confiding in their wives/mothers because it might worry them but also they might be too pushy and thus felt they lacked supportive structures.

There was evidence of non-compliance with medical advice among both female and male narratives. The rationale for this non-compliance was that taking medication regularly would result in it losing its effectiveness when really needed. Male participants openly acknowledged

that women were better to look after themselves than men in terms of seeking help and preventive health measures.

> *No, no. But they can cope, with what's, like they can make, make, they can make more things available to their minds than men… Like a woman could have the same problems as me, the very exact same problems as me, or think they'd have the same problems as me right?...But they could, they could cope better with the situation than I would…And I found that even through experience...* (*Henry:* Focus group 3; 1144-1154)

This was also the case for coping with health issues. Men stated that while women could cope effectively when faced with challenges, including illness and conditions such as stress, men themselves could not and therefore dwelt on their problems. This stance was confirmed by female participants.

In contrast to the picture of the strong male who 'suffers in silence' and defies seeking help, men often resisted this role in privacy of their own homes. While some male participants alluded to such disparities between public and private behaviours, females directly accounted for it. Females admitted that men made bad patients, they dwelt on their problems, they were fatalistic and they were *'moody'*, *'moany'* and '*whingy'* when confronted with illness.

> *Aine: I find that when a woman gets sick like she thinks she is well able to battle it…I think that men when they do get sick…*
>
> *Ina: They get nervous.*
>
> *Aine: …they get nervous and they can't handle it you know?*
>
> *Helen: When a woman gets sick they have to get up and …*
>
> *Aine: Keep going like.*
>
> *Helen: … they have to get up and get on with it don't they?*
>
> *Una: Yeah.*
>
> *Frances: They think you have to tend to them hand and foot, don't they?*
>
> *Una: Yeah that's right.*
>
> *Facilitator: So women cope better.*
>
> *Una: They do yeah.*
>
> *Helen: I think women are stronger than men anyway.*
>
> *Aine: They are yeah.*
>
> *Facilitator: And when you say stronger like you mean*
>
> *Helen: Emotionally I think and mentally I think*
>
> *(Focus Group 2; 403-421).*

Men were also seen to demand sympathy. Such accounts reveal the strain placed on men to live up to stereotypical norms. Some men, however, felt that women were worse to attend to GP than they themselves were and in certain cases it was the males who actually prompted females to attend the GP.

Mental health and sexual health were two areas which posed particular challenges to men in terms of non-disclosure and help seeking.

3.5. Preventive Health Measures

Men who participated in health checks did so for various reasons, including perceived susceptibility to a condition, the benefit of early diagnosis and treatment if a condition was present and also reassurance and peace of mind that one did not have any illness.

> *Yeah that's right, I think, there's, it's probably human nature. Most guys I think don't want to know or will never want to know but like today like, if you're to judge like by what some doctors have said, it's a, the blood test…the blood test today tells so much…and they'll tell you that you're in an age of prevention…rather than anything else, more so than ten years ago…So it's vital for people to know, whether they want to know or not like, it's vital today. And the blood test will…so we're told anyway, will tell most stories about getting complaints or whatever like.* (Toby: Focus Group 3;1342-1357)

Men who did not partake of health checks did not because they did not want to know if there was something wrong with them.

> *No, I mean you bring the car to the garage for servicing…you don't do it with yourself* (Larry 44, 9:184-186).

Men who undertook routine check-ups were not completely aware of all they entailed, although they generally cited, cholesterol, blood pressure and, in the case of older participants, the PSA (Prostate specific antigen) test. Many men stated that they leave the decision up to the GP although some recognised that they should know what tests were being carried out on their behalf. Self-directed routine preventative behaviours were not commonly employed by men. In all instances of prostate screening, it was the PSA test that was used by and participants were unaware of the reliability issues surrounding this test.

4. DISCUSSION

The participants in the study illuminated male perspectives on health and help seeking. The data obtained here was used to increase insight into a social phenomenon rather than assume representativeness [31] and as such this paper does not seek to generalise but rather to increase insight into men's perception of their health help seeking. In recent years there has been increasing attention to men's health issues [17, 32-34]. Men's health poses a number of challenges for health service provision, in particular for public health and health promotion. Men are reluctant users of health services and delay seeking help when experiencing symptoms of illness [1]. Accessing preventive health services poses similar challenges [35].

For the men in this study, health was understood primarily as the absence of pain or illness; the ability to do things; and as the product of health-related behaviours, including fitness. Emotional and mental wellbeing and happiness featured little. The participants discussed their own health status on the basis of the presence/absence of pain or illness and physical fitness and they did not consider their mental health at all in their discussion.

This may be linked to the argument that men must have a tangible illness or that an illness must manifest itself physically and thereby impact on fitness levels before seeking help [1, 11, 35-37]. The men in the study did not consider family history in relation to their health stating it

would only be of relevance when illness is experienced. This indicates lack of awareness of the importance of genetic predisposition for disease aetiology but it may also be attributable to avoidance due to the pressure to manifest strength and lack of vulnerability.

As men progress through life health consciousness increases. While young men perceive themselves invulnerable to ill-health and do not associate current behaviours with long term risk, increased awareness of health and a greater propensity to seek preventive health services appeared to occur among the men in this study in their late thirties and forties as a result of 'settling down', becoming a father or a direct/indirect health crisis [38]. It is really only when the men in the study reached the age of fifty or over that their perspective towards their health really changed and they began to acknowledge susceptibility to conditions [39]. In many instances the media had raised awareness of certain issues such as prostate cancer which prompted men to attend for screening. Such transitions provide an opportunity to health (promotion) professionals to target men at various life stages.

While targeting middle-aged and/or older men with health promotion interventions may be more effective as they are more likely to be receptive and to act on such initiatives, there remains the challenge of promoting health to younger men who may not be receptive to such measures [40]. It is acutely necessary that such challenges are met nevertheless particularly as young men are a high risk group [17, 32].

The factors influencing participants in deciding whether or not to seek formal health care were complex and were influenced by a variety of factors. Participants had clear understandings of when help seeking was legitimate for them in terms of their health. Significant barriers for them were related to fear and to psychological/social norms of masculinity which dictate that men should be strong, resilient and stoic when confronted with illness ([40]; [41]). In situations where the perceived severity of the illness was great, however, concerns about structural, personal and social barriers diminished. Help seeking was only perceived as legitimate if one has a tangible illness and a certain threshold of pain and discomfort had been reached. Help seeking only occurred when there was severity and persistence of symptoms, and where help seeking became "the lesser of two evils." While there is a discrepancy among the literature as to whether men actually do delay seeking help more so than women [42, 43], participants here voiced reactive rather than proactive attitudes to help seeking and this has significant implications for health promotion and preventative strategies aimed at men.

Health was not an everyday discourse for the men in this study [1]. Their inability to articulate health concerns may be as a result of a number of factors, including level of knowledge/awareness of health issues [1, 44-49] and traditional perceptions of masculinity [50]. Sexual health and emotional health were topics that participants were especially reluctant to speak about and this is in keeping with international research [1, 17]. There is little doubt of the pressing need to build male health seeking capacity and health literacy in order to enable men to engage more effectively with their own health generally, with health services and preventative health promotion strategies aimed at increasing health amongst male populations. Men need to be supported to develop necessary awareness, knowledge and coping skills to allay fear in order to

encourage participation in preventive health measures. Men experience inner conflict and associated strain in their quest to comply with social norms of masculinity. While trying to live up to such expectations in public, men often resist this role in private [22, 50]. This aligns itself with men's acknowledgement of a lack of coping skills compared with women. Clearly there is a need to support men in dealing effectively with challenges they are presented with around help seeking.

The utility of men-only services has been questioned [51] however, information and services tailored to meet the needs of men are required [52] to reduce gender-based health inequalities.

Attitudes towards preventive health measures are changing, particularly amongst older men. Men who participated in health checks did so for various reasons, including perceived susceptibility to a condition, the benefit of early diagnosis and treatment if a condition was present and also reassurance and peace of mind that one did not have any illness. George and Fleming [53] established these factors also in relation to seeking preventive health services for cancer. Men who did not partake of health checks indicated that they did not because they did not want to know if there was something wrong with them.

Providing access to preventive checks in settings where men live and work is one such means to increase participation rates. There is need to think creatively so as to maximise opportunities for service providers to deliver service to men in ways that are less threatening, and in order to reach men who might not actively seek preventive services. In addition, men are often not fully aware of what screening entails for illness such as prostate cancer in terms of the tests undertaken, often leaving discussion of and decisions about screening to the initiation of their GP [54, 55].

It is imperative that GPs adopt a health promotion agenda in terms of prostate cancer by providing more detail to men about health checks and screening by demystifying the process for them. There is also urgent need to build capacity and awareness among men so that they actively seek such information rather than passively yield such decision to their health professionals.

Men need to be empowered to take responsibility of their health instead of abdicating control (knowingly or otherwise) to women and GPs. Women are currently seen as the gatekeepers of men's health as they assist men in interpreting symptoms and persuade them to seek help. Persuasion often is burdensome as women have to 'nag' men to attend the GP, force them to take medication and 'drag' information out of them due to their unwillingness to admit to health concerns. Women often collude with GPs behind men's backs, thereby presenting men as childlike and incompetent. Such activities, although done with the best of intentions by women, who feel they must resort to such practices, serve only to disempower men rather than ameliorate their engagement with the health services.

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Table-1. Profile of interview participants

No.	Pseudonym	Age	Occupation	Urban/Rural
1.	David	61	Retired	Rural
2.	John	21	Trainee apprentice carpenter	Rural
3.	Paul	33	Part-time office worker/Part-time student	Rural
4.	Michael	58	Electrical contractor	Rural
5.	Pat	32	Farmer	Rural
6.	Tom	39	Civil Servant	Urban
7.	Joe	58	Farmer	Rural
8.	Liam	20	Agricultural mechanic	Rural
9.	Larry	44	Council worker	Rural
10.	Owen	21	Apprentice carpenter	Urban
11.	Peter	26	Pensions administrator	Urban
12.	Adrian	26	IT Technical Support Analyst	Urban
13.	Stephen	21	Service Manager	Urban
14.	Gordon	63	Self-employed	Urban
15.	Frank	52	Delivery man (retired electrician)	Urban
16.	Eric	50	Mature student	Rural
17.	Brian	35	Bank official	Urban
18	Ray	42	Taxi driver	Urban

Table-2. Profile of Male Focus Group Participants

FG No.	Pseudonym	Age	Occupation	Urban/Rural
1.	Martin	56	Farmer	Rural
1.	Jack	48	Farmer	Rural
1.	Noel	71	Farmer (retired)	Rural
1.	Kevin	51	Farmer	Rural
1.	Maurice	72	Farmer	Rural
1.	Eamon	52	Farmer	Rural
1.	Patsy	45	Farmer	Rural
1.	James	54	School Teacher/Farmer	Rural
FG No.	**Pseudonym**	**Age**	**Occupation**	**Urban/Rural**
3.	Tommy	44	Taxi Driver	Urban
3.	Seamus	66	Not Given	Urban
3.	Harry	*ND	Not Given	Urban
3.	Henry	61	Not Given	Urban
3.	Justin	*ND	Not Given	Urban
3.	Patrick	*ND	Not Given	Urban
3.	Vincent	56	Not Given	Urban
3.	Ian	80	Not Given	Urban
3.	Shane	*ND	Not Given	Urban
3.	Toby	*ND	Not Given	Urban
3.	George	*ND	Not Given	Urban
FG No.	**Pseudonym**	**Age**	**Occupation**	**Urban/Rural**
5.	Ben	28	Construction worker	Rural
5.	Conor	32	Construction worker	Rural

5.	Des	40	Farmer	Rural
5.	Cathal	24	Financial Services	Rural
5.	Richie	30	Farmer	Rural
5.	Ken	41	Farmer	Rural
5.	Rory	38	Teacher	Rural

*ND denotes not disclosed

Table-3. Profile of Female Focus Group Participants

FG No.	Pseudonym	Age	Occupation	Urban/Rural
2.	Joanne	*ND	Homemaker/part time worker	Urban
2.	Aisling	*ND	Homemaker/part time worker	Urban
2.	Molly	*ND	Homemaker/part time worker	Urban
2.	Lisa	*ND	Homemaker/part time worker	Urban
2.	Una	*ND	Homemaker/part time worker	Urban
2.	Catherine	*ND	Homemaker/part time worker	Urban
2.	Orla	*ND	Homemaker/part time worker	Urban
2.	Vicky	*ND	Homemaker/part time worker	Urban
2.	Frances	*ND	Homemaker/part time worker	Urban
2.	Helen	*ND	Homemaker/part time worker	Urban
2.	Peggy	*ND	Homemaker/part time worker	Urban
2.	Rose	*ND	Homemaker/part time worker	Urban
2.	Ina	*ND	Homemaker/part time worker	Urban
FG No.	**Pseudonym**	**Age**	**Occupation**	**Urban/Rural**
4.	Sheila	*ND	Community Health worker	Rural
4.	Colette	*ND	Health services	Rural
4.	Caroline	*ND	Financial services	Rural
4.	Claire	*ND	Pharmacy technician	Rural
4.	Anne	*ND	Health services	Rural
4.	Mary	*ND	Accountant	Rural

*ND denotes not disclosed