MOVEMBER®

The Real Face of Men's Health Report Ireland

TECHNICAL METHODOLOGY NOTES

SECTION 1: HEALTHY MEN, HEALTHY WORLD SURVEY (CAREGIVERS OF MEN)

1. Objective:

Investigate how men's health issues affect their caregivers and society, aiming to foster awareness and support for program and service improvements. The focus was on understanding caregiver responsibilities and their emotional, physical, and social impacts.

2. Research Methodology:

- **Data Collection Period:** April 2025
- **Method:** 15-minute online survey via panel provider Dynata (https://www.dynata.com/)
- **Sample:** 804 informal caregivers, nationally representative by age.
- **Gender Split:** 32% male caregivers, 68% female caregivers, with diversity across health conditions and roles
- **Questionnaire:** Approximately 50 questions, with a focus on relevant caregiving experiences and impacts
- **Analysis:** Employing standard statistical tests (95% confidence) to discern trends and subgroup differences

3. Accuracy:

- **Sample Population:** Caregivers aged 18+
- **Error Margin:** ±4% at 95% confidence
- **Limitations:** Not a census; results may contain sampling error; data is preliminary and subject to revisions

4. Inclusion Criteria:

- **Caregiver Definition:** Any individual providing at least 3 hours/week of support to a man over 16 with a diagnosed or ongoing health condition
- **Health Condition Definition:** Experience or recent diagnosis/treatment (within last 12 months) of mental or physical health issues, excluding childhood or neurodevelopmental conditions
- **Key Activities:** Research, transportation, appointment management, emotional, physical, domestic support, communication, and advocacy roles

5. Further notes on definitions:

Defining carer.
A person of any gender who has an intimate, familial or platonic relationship with a man over the age of 16 who has received a diagnosis and/or receives regular or sporadic treatment for their health condition(s) (see below).
+
Someone who spends **at least (approximately) 3 hours per week** providing any type of care to that man.

'Care' includes: Researching the condition, treatments or support available, Transporting to healthcare appointments, Booking healthcare appointments, Attending healthcare appointments, Motivating them to engage with healthcare / treatments available, Emotional support, Worrying or ruminating on behalf of the man in your life, Physical care i.e., washing them, administering medicines, movement, Activities of daily living, Domestic support i.e. cooking, cleaning, shopping, beyond what would routinely undertake, Communicating with a support network on their behalf, Talk to them about their health and how they are coping / how to cope, Listen to their concerns (by phone, in messages, in-person)

Defining 'having a health condition'
To have a mental health condition and or a physical health condition.
'Having a condition' = a person who has had experience of and/or a diagnosis or treatment from a healthcare institution **in the last 12 months.**

A physical condition to include: Men's cancers, other cancers, diabetes, heart disease, stroke, COPD (other respiratory diseases), liver disease, kidney disease, sleep apnoea, infertility, erectile dysfunction, occupational injury or back injury. Option to define 'other'.

A mental health condition to include: Addiction or substance use issues, anxiety, phobias, PTSD and panic attacks, bipolar, depression, OCD, body dysmorphia or eating disorders. Option to define 'other'.

Conditions excluded = any childhood condition or condition from birth, neurodivergence (e.g., autism, ADHD), neurodegenerative diseases.

6. Survey Sections:

Section	Purpose	Number of Questions
Screener and introduction	Determine carer roles and relationships, screen in valid respondents and introduce survey and purpose	12
Carer impact	Exploring burdens related to type of care, condition of care recipient, life responsibilities, time, finances, etc	9

Section	Purpose	Number of Questions
Mental health deep dive	Explore emotional impact and wellbeing impact of performing care	5
Barriers and pain points	Identify challenges and pain points, structural barriers, critical moments where support is most needed from institutions	5
Positive aspects and enablers	Assess positive aspects of the journey such as sense of purpose and identity to challenge stereotypes	4
Conclusion and demographics	Final thoughts and demographics	**15**
Total Questions		50

SECTION 2: SUMMARY OF HEALTH ECONOMIC MODELLING ON THE COST OF ILL HEALTH

Conducted by Health Lumen, 2024.

1. Overview:

This study assessed the cost of men's ill health across six countries: Australia, Canada, Ireland, New Zealand, the United Kingdom, and the United States. The 2019 Global Burden of Disease study by the Institute of Health Metrics and Evaluation was used to identify the top five leading causes of years of life lost (YLL) in these countries (Table 1).[1]

[1] Global Burden of Disease Collaborative Network. Global Burden of Disease (GBD) IHME2021 [updated March 7 2023. Available from: https://ghdx.healthdata.org/series/global-burden-disease-gbd

Table 1: Top 5 Leading Causes of Years of Life Lost Per Country

Country of Interest	Leading Causes of YLL
Australia	COPD, CHD, lung cancer, stroke and suicide.
Canada	COPD, CHD, colorectal cancer, lung cancer, and suicide.
Ireland	COPD, CHD, colorectal cancer, lung cancer, and suicide.
New Zealand	COPD, CHD, lung cancer, stroke, and suicide.
United Kingdom	COPD, CHD, colorectal cancer, lung cancer, and suicide.
United States	COPD, CHD, colorectal cancer, lung cancer, and suicide.

Direct healthcare costs and indirect costs for the diseases of interest were also identified through a literature search. Official government sources were considered the most robust and accurate estimate of disease cost. If no official government sources were identified, costs from the published literature or grey literature sources were identified.

2. Health Economics:

National and per-patient costs were included in this analysis. Where national cost estimates were chosen, costs were divided by the estimated patient population from the cited cost year, to obtain per-patient costs. These costs, as well as any per-patient costs identified, were then multiplied by the projected estimate of the male patient population in 2023, to obtain male disease cost estimates. Costs were then converted to the country's local currency, and inflated using the CCEMG-EPPI purchasing power parity (PPP) tool from the cited cost year to 2023, using International Monetary Fund (IMF) 2022 data.[2] [3]

Preventable costs of disease were calculated by multiplying the estimated male cost in 2023 by the proportion of disease caused by mitigatable factors. Suicide and drug use disorder were assumed to be completely preventable. The proportion of avoidable coronary heart disease (CHD) costs was calculated by multiplying the cost of disease by the percentage of cases that are in men aged under 75 and then multiplying by the relevant percentage of disease that is found to be preventable. Male disease cost estimates were also used to estimate the cost per male of the diseases of interest. This was achieved by dividing the male disease cost estimates by the total estimated male population of the country of interest in 2023, taken from the United Nations, World Population Prospects 2022 data.[4]

Costs used in this study were estimated through various cost approaches across the published literature, and as such, costs between diseases are likely to be incomparable.

[2] Campbell & Cochrane Economics Methods Group (CCEMG), EPPI Centre. CCEMG - EPPI-Centre Cost Converter 2024 [updated January 2024. Available from: https://eppi.ioe.ac.uk/costconversion/.
[3] International Monetary Fund. World Economic Outlook: Countering the Cost-of-Living Crisis. Washington, DC; 2022 October,
[4] Department of Economic and Social Affairs. World Population Prospects 2022. United Nations. 2022 [Available from: https://population.un.org/wpp/.

SECTION 3: SUMMARY OF PREMATURE MORTALITY DATA ANALYSIS

1. Data Sources

The dataset utilised in this analysis derives from the following sources:

- **Life expectancy and healthy life years**: Data access by sex via the Eurostat
    - Life expectancy data accessed via the demo_mlexpec table (https://doi.org/10.2908/DEMO_MLEXPEC)
    - Healthy life years data accessed via the hlth_hlye table (https://doi.org/10.2908/HLTH_HLYE)
    - The most recent year of data available at time of access was used, this was 2023 for all countries except Luxembourg where 2022 was most recent.

- **Population projections**: Data access from the Central Statistics Office based on data from the 2022 census. All forecasting work was performed by the CSO.
- **Premature mortality data:** Obtained via the Central Statistics Office's PxStat Open Data Platform.
    - *Premature mortality by sex* accessed via the MORT02 table (https://data.cso.ie/table/MORT02) and accessed using the '75 years and over' in the 'age group' filter and the 'All causes of Death' in the 'cause of death' filter
    - *Cause of premature death by sex* accessed via the MORT02 table (https://data.cso.ie/table/MORT02) and accessed using the '75 years and over' in the 'age group' filter and the selected causes of death in the in the 'cause of death' filter. The causes of death were selected to avoid double counting due to overlapping definitions
        - "Infectious and parasitic diseases", "Neoplasms", "Diseases of the blood and blood-forming organs, immunological disorders", "Endocrine, nutritional and metabolic diseases", "Mental and behavioural disorders", "Diseases of the nervous system and the sense organs", "Diseases of the circulatory system", "Diseases of the respiratory system", "Diseases of the skin and subcutaneous tissue", "Diseases of the digestive system", "Diseases of the musculoskeletal system/connective tissue", "Diseases of the genitourinary system", "Complications of pregnancy, childbirth and puerperium", "Unknown and unspecified causes", "External causes of injury and poisoning"
        - An additional subgroup of the causes of death was accessed for the "External causes of injury and poisoning" which contained the causes:
            - "Transport accidents", "Accidental falls", "Accidental poisoning", "Suicide and intentional self harm", "Homicide/assault", "Event of undetermined intent"

- *Premature mortality by socioeconomic status* was accessed via the MIED04 table (https://data.cso.ie/table/MIED04)
    - This data was age-standardised as per method below
    - Cause of death data used the categories noted above
- Premature mortality by county was accessed via the MORT02 table (https://data.cso.ie/table/MORT02)
    - Cause of death data used the categories noted above

2. Location-Based and Ethnicity Designations

The data is organised across multiple geographical stratifications:

- **Total population:** National overview from 2015 to 2022
- **Socioeconomic status:** Deprivation quintile data are based on the Deprivation Index 2016 data via a linkage with Death Registration data with Census 2016
- **Counties: | 26 counties within Ireland with boundaries as defined by the CSO**

Classifications within tables

- **Sex:** Male and female
- **Age group:** ten-year age brackets (for the purpose of age standardisation)

3. Definitions and Descriptions

- **Data period:** For causes of premature mortality, the most recent data available Ireland as of 2023, where earliest data available was prior to that (primarily Luxembourg data via Eurostat) it is noted.
- **Data access:** data was accessible via the sources noted above.
- **Premature mortality:** Defined as deaths occurring before the age of 75.
- **Rates:** All rates are expressed as the number of deaths per 100,000 population, where 'population' is the population subtotal e.g. males or the specified ethnicity.
- **Age standardisation:**
    - Age standardisation allows for the comparison between groups (for example counties or deprivations quintiles) with different age structures, facilitating a more accurate comparison of mortality patterns without the impact of the variation in age structures.
    - All mortality rates are adjusted through age standardisation, which recalculates the rates to reflect a hypothetical population with a uniform age structure.
    - This process corrects for demographic differences and ensures that comparisons across locations are not confounded by varying age distributions.

- Age standardisation enhances the reliability of interpretations concerning true differences in mortality risks and trends.
- Where available, data age standardised by the CSO is reported, where that was not available it is noted in the data sources section
    - When that was the case the data was age standardised to the 2013 European Standard population.
    - When not done by CSO, the age standardisation was undertaken using the 'calculate_dsr' function from the package 'PHEindicatormethods' in R.

- **Limitations and considerations:**
    - Age-standardised rates may not precisely reflect the actual mortality experience within specific populations, but allow for more appropriate trend analysis and geographic comparison.
    - For purposes requiring actual counts, such as health service provisioning, non-age-standardised data may be more appropriate.

SECTION 4: DIFFERENCE IN DIFFERENCE ANALYSIS

The method used is called "difference-in-differences", a type of statistical analysis that helps identify whether a change (like a men's health policy) is associated with changes in outcomes, in this case premature mortality. A strength of this method is that by comparing with groups of people (in this case Irish men and women) living in the same location it can check for the presence and size of an effect, even when other large scale societal changes, like recessions, are occurring.

The method worked, in this instance, by comparing trends in men's premature deaths before and after a key time point (i.e. 2012) and the same trend in women's premature deaths. To check that the two groups are comparable a 'parallel trends assumption' is checked. For the current analysis the assumption was fulfilled for the 'before' period. If this parallel trend assumption was not fulfilled, then the results would not be valid.

The assumption that, in the absence of the policy, male and female trends would remain similar then allows us to estimate what the male PYLL would have looked like in a world where the policy was not introduced, often called a "counterfactual". The difference between the counterfactual and real world, CSO, data helps us understand the potential effect of something like the Men's Health Policy. It should be noted that this is result is observational and cannot be used to infer causality

SECTION 5: GP SURVEY ON MEN'S HEALTH

1. Objective

The purpose of the research was to understand the landscape of treating men's mental health, including male suicidality and suicide ideation through quantitative market research with General Practitioners (GPs) in Ireland.

The survey centred on three themes:

- Male patients' health – specifically mental health
- Experience and confidence with treating and engaging with ment's mental health and suicide
- Information and support services

2. Research Methodology:

- **Data Collection Period:** June 2025
- **Method:** 10-minute online survey via IPSOS B&A
- **Sample:** 80 GPs across Republic of Ireland.
    - **Gender of GPs:** 56% male, 44% female
    - **Regional distribution:** Connacht/Ulster: 21%, Dublin: 26%, Munster: 28%, Rest of Leinster: 25%
    - **Years in Practice:** Over 16 years: 43%, 15 years or less: 57%
- **Analysis:** Employing standard statistical tests (95% confidence) to discern trends and subgroup differences.

SECTION 6: PUBLIC SENTIMENT RESEARCH

1. Objective

The purpose of the research was to understand the public perception on the state of men's health in Ireland. Given the complex and emotive debates that a consideration of public attitudes on men's health will tap into, More in Common took a mixed-methods approach to this research project that combined quantitative and qualitative research.

2. Qualitative research exploring both current perceptions on men's health and masculinities and the public's assessment of broader government performance on this issue. Two focus groups were conducted - one in Cork South Central and one in Dublin.

3. Quantitative research

- **Data Collection Period:** June 2025
- **Method:** 10-minute online survey via More in Common
- **Sample:** 2,092 adults in Republic of Ireland aged over 18 years. Respondents were weighted according to age/sex interlocked, 2024 General Election vote, province, ethnicity, and education level.
- **Analysis:** Employing standard statistical tests (95% confidence) to discern trends and subgroup differences

For more information please contact advocacy@movember.com

End of Methodology Section