Getting Men to the Door

A Ministry of Health Men's Innovation Fund Project

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Executive Summary

During 2008, in recognition of the fact that men have worse health outcomes, experience more risk factors, and utilise health services less than women, the Ministry of Health established the 'Men's Health Innovation Fund' to support the development of community based men's health initiatives. Nelson Bays Primary Health (NBPH) expressed interest in this initiative and with C & M Associates (2006) Ltd made a successful application for funding. The application was endorsed by the Nelson Marlborough District Health Board.

The resulting 'Getting Men to the Door' project had a point of difference in that rather than focussing on men themselves it focussed on health and social agencies. While recognising that men are a diverse and often hard to reach group, this approach was based in the belief that agencies are often guided in their practice by commonly held, and largely negative, assumptions about men and what influences men's behavior. The project aimed to work with health/social service agencies who identified themselves as needing to build their capacity in better supporting men. The project was designed to assist them to reflect on their policies, strategies and procedures to enable them to be better placed to meet the needs of men.
To achieve this, and with assistance from the project team:

- there was an initial meeting of all interested agencies to outline the general aims of the project and to sign a Memorandum of Understanding with Nelson Bays Primary Health.
- each agency completed a self assessment on their capacity in both attracting and engaging with men.
- each agency developed a plan of action that they believed would result in improved support for men.
- progress on their plan of action was tracked and recorded as a case study.
- the experiences of each agency were collapsed into themes that identified commonalities between them.
- finally the agencies met together to share their experiences and future plans

Six agencies initially participated in this project (with one agency delegating involvement to one of their support groups). These worked in the areas of sexual health, family health, mental health, and physical health. The agencies themselves were very diverse in their size, staffing mix, position nationally, and whether their structure was public, private or trust. The six agencies were:

Independent Nursing Practice (Nelson) which provides a range of health services with a focus on youth, family and sexual health.

Whakatu Te Korowai Manaakitanga Trust (Te Korowai Trust) which provides health, social and economic support for all people and aims to create opportunities to improve the well-being of whānau.

Family Start which provides an early intervention, preventative, home-based service for families facing challenges in the areas of health, welfare or education.

Post Natal Depression Support Network which provides support for women suffering from post natal depression.

The New Hub which provides a holistic approach to youth development, regarding health as an essential ingredient in this mix.

The Cancer Society Nelson which provides a variety of services including health promotion and support services for people with cancer diagnosis. They put the project team in touch with the **Prostate Cancer Support Group.** This is a volunteer-based support group for men with prostate cancer. For the purposes of this report the input of this group is included as their experiences differed to the other groups.

Common themes, as listed below, were observed during the project.

- All agencies supported the aims underpinning the project (as described above).
- All agencies were aware they could and should provide a more effective service for men and were keen to do something about this situation.
- While the staff and management who were involved with the project believed the needs of men differed from those of women, they were unclear about the nature of these differences and how to respond to them. The fact that most agencies were generally staffed by women was an important point.
- Following a self assessment on their ability to attract and engage with men each agency developed, implemented and reviewed a plan that was appropriate to their resourcing and was consistent with the vision of their organisation (all agencies had up to $2000 available to assist in resourcing their plan).
- All but one agency[1] found the self assessment tool useful in raising their awareness of their current service and beginning a conversation about how best to meet the needs of male clients.
- Finally, all agencies reported their involvement in the project to be positive and worthwhile. They also believed they would be able to sustain the gains made with assistance from bodies such as NBPH.

While the project was limited in both size and scope it demonstrated that in order to address the poor health status of men, initiatives need to be focused more broadly than just on men themselves. The literature suggests that, for a variety of reasons, many agencies have difficulty both attracting and engaging with men. This project has demonstrated that, with assistance, the agencies in this project recognised this point and were willing and able to critically reflect on their practices and move to build their capacity in better supporting men. Whether or not these gains will be sustained would need later evaluation and this would need to be resourced. It is of interest that this group that targeted men specifically (the Cancer Society's Prostate Cancer Support Group) had endured, providing support for its members over a period of years. This group was primarily driven by a men's health champion. However, exploring this area more deeply was beyond the scope of this report.

This project has also demonstrated that NBPH, in collaboration with men's health advocates, has the ability to develop and coordinate initiatives aimed at assisting agencies in developing strategies to promote the health of their male clients as well as in facilitating networking between agencies. Using a process similar to that used in this project other PHOs, not currently engaged in the area of men's health, and with the assistance of men's health champions, should support similar initiatives. Given the results of this project, PHOs are ideally positioned to provide leadership in developing the foundation for a national network in promoting men's health.

[1] *The Post Natal Depression Support Network had always provided a service by women for women. The assessment tool assumed there was some contact with male clients.*

1. Introduction.

The Primary Health Care (PHC) Strategy was released in 2001 by the then Minister of Health the Honourable Annette King. This document built on the previously released New Zealand Health Strategy and the New Zealand Disability Strategy creating a framework through which the vision of PHC in New Zealand could be realised. The vision and key direction are detailed below.

The vision:

> *People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.*

The 6 key directions considered essential in achieving this vision were:

- *work with local communities and enrolled populations*
- *identify and remove health inequalities*
- *offer access to comprehensive services to improve, maintain and restore people's health*
- *co-ordinate care across service areas*
- *develop the primary health care workforce*
- *continuously improve quality using good information*

King, 2001, pvii.

While the areas above have always been of concern to some degree, The Strategy provided a clear framework that had previously been lacking. This visionary nature of the PHC Strategy is noted in the following statement.

> *The PHC Strategy (2001) paves the way for the successful future of the health system. It takes into account the complex nature of health, focuses on maintaining wellness, and considers the social and economic determinants that shape people's lives, health and well-being. Never before has a strategy been so focussed on community development, health promotion, and client empowerment.*

Macfie, 2006, p30.

1.1 Nelson Bays Primary Health.

Nelson Bays Primary Health is the local Primary Health Organisation (PHO) for the Nelson and Tasman region. PHOs were created through the PHC Strategy to implement and monitor the progress of the Strategy as well as to:

Work to reduce inequalities in population health by:

- *Supporting the development of cultural awareness and population health perspectives across the primary health care sector.*

- *Undertaking innovative initiatives to improve access to primary health care services.*
- *Developing collaborative relationships within and across the primary health care sector.*

Ministry of Health (n.d.).

It should be noted that Nelson Bays Primary Health (NBPH) has always taken a broad view of the nature of health, both in its definition as well as in the services it has developed relationships with. For example, NBPH currently houses the Strengthening Families Coordinator, who has a contract with the Ministry of Social Development as NBPH believes this more broad social approach to the consideration of health is entirely consistent with the PHC Strategy

1.2 The Men's Health Innovation Fund.

During 2007/8 the government announced its commitment to 'men's health' with this area becoming a new designation under the national health portfolio. During Men's Health Week, and following a period of extensive consultation with representatives from interested parties from throughout New Zealand, the Associate Minister of Health Damien O'Connor announced the provision of $3 million dollars over the following year to promote greater awareness of men's health. As the Minister said at the time, "It's no secret that Kiwi blokes can be reluctant patients. This new funding will go into programmes and initiatives aimed at encouraging men to be more aware of their health and access healthcare ... Men's health is a new delegation under the health portfolio and already we are making progress in this area. This funding is a start and shows that government is committed to improving access and raising awareness of men's health" (O'Connor, 2008).[2] A $300.000 Men's Health Innovations Fund was established as one part of this programme and was aimed at both supporting the development of initiatives to improve men's access to health care and to improve the effectiveness of health services for men.

NBPH expressed interest in the Fund and made application for funding in late 2008. The application was endorsed by the Nelson Marlborough District Health Board. There were several reasons for this interest.

- NBPH recognised the aims of the Fund as being entirely consistent with the vision of the PHC Strategy through the Fund's vision of reducing inequalities in population health by improving access to health for men, developing collaborative relationships within the local primary health care sector (including relevant social services) and supporting and developing the primary care workforce.
- NBPH believed that PHC development in the Nelson Tasman region is best driven by a range of factors including evidence based on researching the experiences of the PHC workforce and the consumers of PHC. In the past NBPH has commissioned several projects that have provided valuable information to guide the strategic development of the organisation.
- NBPH enjoyed the presence of champions for men's health within the organisation at governance, management and operational levels.

[2] *(Wilkins & Savoye, following a review of men's health policy in 11 countries observed that (in relation to New Zealand), "With the change of government in late 2008, and in the face of the then global economic recession, a review of all government expenditure was initiated. There is no longer any certainty about funding committed to men's health by the previous government that has not been spent or contracted. It appears there is no ongoing men's health policy work in the Ministry of Health at the time of writing" (2009. P49).*

The Ministry of Health received fifty three proposals for the Men's Health Innovation Fund. The proposals covered a wide range of approaches and, following an assessment process, funding for eleven proposals was approved. NBPH, in collaboration with C&M Associates (2006) Ltd., an external contractor, was one of the successful applicants.

2. The literature on Men's Health.

2.1 Introduction.

It should be noted that in this literature review men are considered as one group. Clearly men are not a unified group, differing in relation to areas such as ethnicity, age and sexual orientation. Further, disparities in health are notable within these subgroups. For example major differences in health outcomes are experienced by Māori men (Blakely, Fawcett, Hunt, & Wilson, 2006) and by those men most negatively affected by economic changes, the men Callister and Didham (2009) note as having little education and who are on the margins of employment and family life.

Interest in men's health has been gathering momentum over the past two decades, with most of the literature appearing in the past 10 years (Wilkins & Savoye, 2009). This situation is also reflected in a rise in the number of conferences, workshops, research projects, books and reports devoted to this topic both in New Zealand and internationally. The focus of this increasing awareness and concern is generally related to the statistics on men's health. Johnson, Huggard, & Goodyear-Smith summarise this situation when observing that "the emerging international literature on quality-adjusted life expectancy and disability adjusted life expectancy in developed countries indicates a persisting inequality of poorer lifetime health outcomes among men compared to women in the same community" (2008, p70). The authors point out that this pattern is also reflected in New Zealand.

Overall the figures relating to men's health, in comparison to that of women, make worrying reading. Both internationally and in New Zealand the health status of men is poorer in comparison to that of women and men's utilisation of health services falls short of that for women (Johnson, Huggard & Goodyear-Smith, 2008). Of particular concern is that in many cases, the early death of men is avoidable. Citing an international World Health Organisation study that focussed on six potentially avoidable causes of death (accidents, suicide malignant neoplasm, diseases of the circulatory system, homicide and chronic liver disease) Johnson, Huggard & Goodyear-Smith observed that deaths for men were over twice those for women.

While these figures are worrying, improvements in men's health (as well as in women's health) have been noted over the past two decades. These improvements are generally acknowledged as being due to success in the treatment of heart disease, a reduction in rates of smoking and lower mortality from accidents (Sandiford, 2009). However the gap between women's health and men's health remains and has proven difficult to reduce.

Concerns are also evident across age groups. Wilkins & Savoye (2009), drawing on a national survey of health and well being amongst male secondary school students observed higher levels of binge drinking, marijuana use, sexual activity and violence toward others among male students. While the authors did temper this finding with the comment that there has been a steady decline on most of these indicators since the first (2000) survey the figures were cited as still being of concern.

Taken overall, these points indicate that men are experiencing a significant challenge to their health. While the literature on men's health tends to focus on biophysical concerns (eg. cancers and cardiac conditions) the information we have on men's health also points to concerns over other areas of health and well being. For example, in relation to women, men

feature in higher rates of alcohol consumption at hazardous levels, suicide as well as in areas such areas as workplace and automobile accidents/deaths.

2.2 Common constructions of men and health.

It is well established that men are less likely than women to have a primary health care provider. In particular, they are less likely to attend a general practitioner (GP) and, if they do so, they generally present later than women (Neville, 2008), despite their being no evidence that they are healthier overall (Johnson, Huggard, & Goodyear-Smith, 2008). It has been suggested that this disparity may well be due to investigations and screening related to gynaecological and obstetrical conditions with women. However after conducting research in this area Santosh & Crampton, point out that "even after excluding gynaecological and obstetrical conditions. Determinants of GP consultation differed between the sexes" (2009, p263). This finding was confirmed by Jatrana & Crampton when they reported that "our results do not support the body of literature that suggests that women's excess in service use can largely be attributed to gynaecological and obstetrical conditions or that the female excess in visits is focussed in the childbearing years" (2009, p265).

There are a number of perspectives on why this situation exists. Men's poor understanding of health and how this affects the individual has been cited as a reason for late or non attendance in primary health care services (Neville, 2008; Wilkins & Savoye, 2009). For example Robertson, Douglas, Ludbrook, Reid, & van Teijlingen (2008) suggest that men have a very concrete view of their bodies and see health care more as a 'fix it' operation. For example, the attitude of 'if it ain't broke, don't fix it' leads to late or non-presentation for support. Conversely it has been observed that women are more interested in health related matters and are more aware of existing and potential health problems usually seeking assistance more readily because of this (Santosh & Crampton, 2009).

The socialisation of males, in particular the holding of a 'macho' approach to life, is also held as a barrier to men taking adequate responsibility for their health (Neville, 2008). Stoicism, independence and a reluctance to admit difficulty all contribute to poor or non-attendance in primary health care and social services. These attitudes are commonly associated with risk taking behavior; behavior that frequently has poor health outcomes. Risk taking can be understood as resulting from employment, recreational and lifestyle choices that are hazardous to the individual.

The following quotation summarises these points.

> *As in many other countries, the development and maintenance of masculine identities in Aotearoa/New Zealand is strongly associated with problematic social environments that support unhealthy beliefs and behaviours. For example local ideologies and practices mean that achieving the ideals of conventional masculinity requires an unwillingness to admit weakness or to accept help and a propensity towards risk-taking behaviour. The process of male socialisation and the sociocultural norms that underpin this process result in an adverse risk profile for men and subsequent poor health outcomes.*
>
> Wilkins & Savoye, 2009, p47.

Overall it is clear that males are experiencing significant challenges to their health status. What is less well understood are the causes of these disparities and what the best ways to address this situation may be.

2.3 Less common constructions of men and health.

Poor understanding of health matters, risk taking and male socialisation no doubt do influence males' attitudes and behaviors towards their health as well as the nature of their engagement with the health care system. These perspectives, dominant in the lay and professional literature, position men as being 'in deficit' and/or 'behaving badly' in relation to taking responsibility in matters of health. Of particular relevance to this project is the point that the dominance of these perspectives in society generally may well lead health professionals to take a narrow and largely negative view on men's health related attitudes and behaviors.

The perspective that men are reluctant to consider their health even to the point of ignoring it is challenged by several authors who draw on research evidence and professional experience. For example Morgan & Haar (2008) in a study exploring presentations to a New Zealand sexual health clinic found that men aged 20 years and older are at least as likely as women to present for support. Unfortunately this finding was not true for younger men. More recently Malcher suggested that men, in relation to attendance at general practice surgeries, "carefully self monitor their health while requiring their GPs to provide accurate information in a laidback and respectful manner. A key area identified by these men was the capacity of the GP to deal with their issues confidently and competently" (2009, p94). This finding, of the need for a forthright ('no nonsense') but respectful approach from GPs, was found by Mitchell & Chapman (2001a) who explored attitudes to health with focus groups of younger and older men.

McKinlay, Kljakovic, & McBain added to this theme. Following a project involving focus groups with male clients and staff from general practices, they found that the men in the project defined health differently to that of a disease or illness orientation, more as "a need for balance across their life; having effective relationships and a strong sense of self" (2009, p309). The authors concluded that "understanding how men view health and health care delivery can inform innovation in general practice care" (ibid).

These examples paint a different picture of men's attitude to their health and their ability to engage with others. Generally speaking, men do consider and care about their health (Mitchell & Horn, 2001; Johnson, Huggard, & Goodyear-Smith, 2008, The Cancer Society New Zealand, 2009). There is also evidence suggesting that much depends on the health care environment and the interactive processes involved. These perspectives in turn suggest that all is not what it should be in the manner in which health care agencies attract and engage with males.

2.4 The ability of agencies to effectively support males.

Various reports detail a number of barriers affecting agencies' ability to both attract and engage with men. These include but are not restricted to the following:

- The hours agencies are open do not work well for many men, especially those that are employed (Mitchell & Chapman, 2001b; McKinlay, Kljakovic, & McBain, 2009, McKinley, 2005).
- Women make up the greater number of staff in many organisations. In many cases they are the only staff present. This in turn leads to agencies being more focussed on the needs of women and children (Fletcher, 2008).
- Inappropriate targeting of interventions and/or the use of inappropriate communication strategies for men (Johnson, Field & Stephenson, 2006).

- A lack of evidence to support initiatives in men's health (McKinlay, Kljakovic, & McBain, 2009).
- Men appear to have a particular perception of health which may mean that they find it difficult to engage with the health services (McKinlay, Kljakovic, & McBain, 2009).
- A lack of undergraduate, postgraduate and inservice education focussed on the health of men, their support needs and on the context in which they live (Laws, 2005).
- Agency staff can reflect the dominant (negative) stereotypes held about men (McCarthy & Holliday, 2004; Fletcher, 2008).

In relation to the final point above when the nature of health care agencies and the values and attitudes they reflect are considered, the picture becomes more complex.

A research project with occupational health nurses utilised a design involving repeated focus groups. In the initial group, when asked about their experiences in supporting men, the nurses echoed the commonly held constructions regarding men and health, those of macho values and attitudes causing their male clients to have difficulty in expressing themselves and/or seeking help. Conversely, after a period of reflection on the initial discussion, they returned and talked of a complex dynamic between men, health assessment, and a perception of a threat to their employment and associated threats to their self image (Mitchell & Horn, 2006). This example suggests that the manner in which service providers practice may be guided by their personal assumptions about men and what influences their behavior. This in turn reflecting the negative societal assumptions about men and health which have previously been described.

2.5 Section summary.

Despite health policy in New Zealand having a strong focus on reducing inequities in health, there has never been a coordinated Men's Health policy. Men's health has always been considered as an indirect subset of other policy initiatives. Despite this situation there are occasional campaigns, for example 'International Men's Health Week', which are aimed at increasing awareness of issues related to the health of men, however support for these is minimal and scattered. The Ministry of Health's Men's Health Innovations Fund, from which this project results, was a welcome change to this situation.

While many consider a men's health policy to be unnecessary in that population based approaches and campaigns targeted at specific illnesses/conditions should be appropriate for all people, the evidence presented here strongly suggests this is not the case. Men's health is a complex and multifaceted topic, influenced by a range of social and historical factors. While most attention has been placed on biophysical nature of health and how men can be assisted, coerced or otherwise directed to alter their attitudes and behaviors towards their health, there are other areas that need attention as well. As Wilkins & Savoye (2009) observe, if the negative health outcomes experienced by men were present in any other section of the community the position would usually be that services were failing those people and that the health care systems involved with that population would need to examine their policies, practices and proceedures in order to more effectively service that particular community. The authors elaborate on this position below:

> *The idea that the problem lies with men themselves ... This may lead to the regrettable political view that it is up to men to change, not services. This is a fallacious argument that fails to acknowledge men's poorer health as the inequality that it is.*
>
> Wilkins & Savoye, 2009, p8.

It seems self evident that while men do need to take responsibility for their own health, equally agencies that seek to improve the health of men need to examine their practices in attracting and engaging with men.

3. The project design.

Access to appropriate health care services is pivotal to ensure men meet their health and sustained well-being needs. Contrary to initiatives that are positioned from the view of men taking more responsibility for their health, this project is focused on service provision in primary health care. In general terms, this project seeks to track the processes) five agencies follow as they attempt to build their capacity in better attracting and engaging with the male clients.

The World Health Organisation's (WHO) definition of health underpins the direction and scope of this project. This definition talks of health as being "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948). It is notable that this definition has retained its relevance and popularity internationally over six decades, this suggesting its credibility and robustness. The literature review is also underpinned by a belief that health and health care are strongly influenced by the values, attitudes and behaviors of the communities in which we live. These perspectives are fluid and are in turn influenced by subgroups within any particular community. All told, health is understood here as a dynamic, political and often contested field.

3.1 Aims.

While this project deliberately focuses on service provision in primary health care the participant base extends beyond this sector to include what are commonly understood as social services. This is in the understanding that, as previously mentioned, men's health should be considered in relation to biophysical, psychological, familial/social and developmental factors. Supporting this point, McKinley (2005) suggests that primary health care professionals need to work in and alongside the wider community in relation to men's health.

The project also focuses on a strengths based approach and is informed through action by agency workers at the coal face. Essentially the project is aimed at 'capturing' the wisdom of those at the coal face of service provision. This is in the belief that professional practice always occurs in dynamic and constantly evolving contexts. These contexts are unique and it is those that work within them that are best placed to appreciate and respond to the challenges and opportunities that are present. This project is designed to capture these insights from the participating agencies. In addition, the project should capture more general themes that may be common (or differ) across the agencies.

The project goal is to gain insight into what steps can be taken by health and social service agencies to better engage with, cater for, and provide services for men. The project aims to influence existing health and social services agencies' policies, strategies and procedures to enable them to be better placed to meet the needs of and provide services appropriate to men. As such it is a discrete project that will influence the functioning of the organisations involved but also may inform the wider health community should they choose to adapt their own work to better meet men's needs.

More specifically, a project that:

- Achieves sustained buy-in from at least five service agencies.
- Achieves discourse and action 'on the ground' among the participating agencies for the duration of the project.

- Achieves collaborative engagement across diverse agencies as well as with project and advisory team members.
- Provides information to support potential publication of guidelines/toolkit for similar organisations to use in their own self-assessment and development of their own action plans.
- Provides recommendations for direction of further research in this area.

The benefits should lead to:

- Improved access to participant agencies for local men and their whanau.
- Improved engagement with men and consequently their family/whānau by agencies, wider organisations and planners/strategists of health and social services.
- The evidence developing community being better informed of ways and approaches to engaging with men.

3.2 Ethical considerations.

The project goals and design were communicated through an Information Sheet (See Appendix #1)

As the project was considered of low/minimal (if any) risk to participants, no formal ethical approval process was entered. However issues to do with consent, anonymity, confidentiality of information and conflict of interest were identified and addressed.

Consent was assumed through representative(s) of each of the services attending a preliminary meeting/discussion and signing a Memorandum of Understanding (See Appendix #2).

All the involved services consented to having their name known providing they were able to view and verify the draft description and progress of their service for accuracy prior to the final report being completed.

3.3 The project design.

The project is informed by participatory action research (PAR) approaches. This approach to the generation of knowledge and understanding differs markedly from more traditional quantitative and deductive approaches. The design follows an inductive process where the reflexive and reflective nature of human actions and interactions are encouraged. This is in the belief that, with support, individuals and groups are able to critically examine their environment and develop creative and innovative solutions to issues that they experience. Furthermore, individuals/groups have the understandings and experience of the culture of their organisations and the community in which they exist. These understandings are essential to support effective change and, more importantly, to offer the best opportunity for sustained change (Denzin & Lincoln, 2005).

PAR approaches fit well with the aims of the project where it is planned that participants will explore opportunities that involve reflection and practical action aimed at organisational change The issues that are explored are experienced through the lives of the participants and the knowledge that is generated through the process of enquiry is located in the local organisational and community culture(s). PAR research provides a framework whereby

knowledge is generated from the coal face, not through the imposition of external theory or hypotheses.

PAR research generally involves defining an area or issue of interest with the participants moving through repeated cycles of planning, acting, observing and then reflecting on that particular stage of the process. Repeated cycles are aimed at the participants uncovering insights into the issue that were previously unknown (Hammersley, 2007).

The project is only informed by PAR research approaches as, due to time constraints, there was no opportunity to move through the process of repeated cycles. However, it was planned that the agencies would be able to:

- Assess and define their situation in relation to their ability to attract and engage with men[3] (An assessment tool was provided – See Appendix #3).
- Plan one cycle of strategies to effective positive change in this area
- Evaluate the strategy
- Plan for future cycles
- Meet together with other agency representatives to discuss their experiences

All agencies had up to $2000 available to assist in resourcing their plan.

The project team supported the agencies throughout this process with meetings at each of the stages detailed above. These meetings were digitally recorded. Another important aspect of the project design (and of PAR) is that, as well as addressing specific outcomes, the participants' engagement with the process results in changes in their awareness and understanding as the process unfolds. In effect, engagement with the process is an important outcome in itself.

Analysis involved two distinct areas. Firstly, each agency's progress was tracked and recorded as a case study. Secondly the experiences of each agency were collapsed into themes that described commonalities (and differences) experienced across agencies.

3.4 The participants

The selection of a range of health and social service agencies reflected the comprehensive definition of health and health care underpinning the project. While not commonly considered 'health care' agencies as such it was considered important, and entirely in keeping with this comprehensive definition, to include two agencies that would generally be considered as social services. A further aim was to include services that covered a range of areas affecting men and their health as well as those agencies that targeted specific age groups where possible. The project did not include general practices. While general practices are obviously central in the delivery of primary health care, they are a comparatively well researched group in relation to men's health. This project chose to explore the experiences of agencies that could be considered as supporting the community at a step before engagement with general practices.

The participating agencies are outlined below.

[3] *Returning to the point that the literature review regarded men as one homogenous group, it was anticipated that the participant organisations would define their male clients in a manner consistent with the organisational culture, values and practice. This was considered an important aspect of the project design.*

- **Independent Nursing Practice (Ltd).**

The Independent Nursing Practice is a private company. With a team of eleven staff (all women) the service has the very general aim of providing a range of health care services with a focus on collaboration, information sharing and supporting clients in the choices they make. More recently the service has specialised in family and sexual health. The majority of clients are in the 15-22 year old age group with around 12% being Māori. Only 3% of the clients are male. The service is committed to exploring the reasons for this and improving the mix of males in the service.

> *We are concerned that young men are not getting their sexual health care from anybody. Although we know that our service is primarily a women's service we take the view that women are not the only species on the planet. We want to live in a world where men and women have access to the same kinds of services.*
>
> The Director, Independent Nursing Practice, 2009.

- **Whakatu Te Korowai Manaakitanga Trust (Te Korowai Trust).**

Te Korowai Trust was established in 2001 as a 'not for profit' trust. The Trust provides health, social and economic support for all people and aims to work collaboratively to create opportunities to improve the well-being of whānau. With sixteen full and part time staff (all women) the services provided incorporate Māori values and practices and include free health services, support in the home and at work, support/information to reduce family violence and one on one mentoring for whānau support. The client base is predominantly from lower socio-economic groups with 70% being Māori. Women make up the majority of clients. The staff at Te Korowai Trust are aware the health needs of men differed from those of women and that, in many ways, they were compromised in terms of addressing these needs.

> *I knew there were gaps there but it wasn't until we entered into this process that we had a wakeup call to get out there [and do something]*
>
> Staff member, Te Korowai Trust, 2009.

- **The Post Natal Depression Support Network (Nelson)**

The service is staffed by one part time coordinator and a part time office administrator. The support workers are all volunteers. All the staff are women with the client base identified as female. Despite being small, the agency has sustained an effective service to its clients for several decades. While the agency functions independently there is a movement to developing a national coordinating body. The staff had recently attended a District Health Board workshop on 'Getting Men in the Door' and this had proved a catalyst for agreeing to take part in the project.

> *The workshop, it has given [us] permission, that the man actually does want to be spoken to. Even handing a card saying that I'm here if you want some more information. Asking him how he is. There definitely has been that shift. For me the workshop gave me the confidence to go ahead and do what I really knew was needed. It's more of a confidence thing I think, working at including guys.*

The Co-ordinator, Post Natal Support Network, 2009.

- **The New Hub.**

Established in 2002, the New Hub is one in the network of agencies supporting youth in Nelson. With a mix of around ten full and part time staff (mostly female), The New Hub has the general aim of adding value to young people's lives through working in partnership with them and through providing a safe and friendly environment for them to gather. The clients age between 11-20 years with around 40% being Māori. While not a health provider as such, the New Hub aims to provide a holistic approach to youth development, regarding health as an essential ingredient in this mix.

> *It's amazing the number of underlying health concerns that our [male youth] are experiencing ... We would be involved in any programme that is aimed at assisting young people to access services. We like to be involved in anything that we see as benefitting young people.*

The Manager, The New Hub, 2009.

- **Family Start (Nelson branch).**

Family Start is an organisation with a national profile, aimed at providing an early intervention, preventative, home-based service for families facing challenges in the areas of health, welfare or education. The Nelson branch, with a team of eleven staff (10 female and 1 male), addresses this aim through focussing on improved health, education and social outcomes for children through engaging parents in positive parenting activities. Clients (parents) range in age from 15-40 years. Family Start is aware of the difficulties they experience in attracting and engaging with fathers.

> *The support services aren't meeting the needs of [fathers]. We're missing finding a way of keeping the fathers connected. We've not done it well; we're still not doing it well. Looking into the future, from where I stand, we're going to continue to not do well. This gives us food for thought. Are we a bit blind? Are we giving fathers a choice or opportunity to [be involved]?*

Staff member, Family Start (Nelson), 2009

- **The Prostate Cancer Support group (affiliated with the Cancer Society Nelson).**

The Prostate Cancer Support Group is a volunteer-based support group for men with prostate cancer. For the purposes of this report the findings and input of this group was not included as it was an outlier to such an extent that their experiences and themes were not able to be correlated to the findings with the other groups. Despite this it was valuable having this group involved in the process as they were providing a service which other agencies had not developed in their organisations. This service had a distinct point of difference to the other groups that will be further discussed under 'Results'.

4. The results.

This section details the process and results from each of the participating agencies. In section five these individual cases will be collated and analysed according to commonalities.

4.1 Independent Nursing Practice.

4.1.1 Initial self assessment.

The Manager and three staff were involved in this assessment. Despite the low numbers of men presenting to the service, the staff felt they were able to acknowledge, respect and respond appropriately to the differences of male clients.

> *A lot of young women get socialised into medical services very early in their life (eg. For contraception needs) whereas men might not understand how things work and we explain that very matter-of-factly. Even a simple thing like understanding what to do with a prescription. We need to explain what it is and what you do with it.*

They also recognised the importance of positive images and avoiding stereotypes and generalisations.

> *We think we work really hard to avoid stereotypes and generalisations about such areas as men being violent or perpetrators of abuse.*
>
> *We don't think we are terrifically good in reaching out to men but we thought we were pretty good at recognising the differences in men. We think the promotional material available is pretty well dominated by positive images of men.*

Again, despite the low numbers of men using the service the staff also recognised that they have, in the past, made efforts in reaching out to males.

> *When we reflected on our involvement with men we thought that although men are 5% of our client base we have contact with men more than that. We ended up thinking "we do quite a lot." Most of that work is related to sexually transmitted diseases. We do see women, but every time we have a positive STI test, even if we don't see that young man ourselves we facilitate that young man accessing a service. We don't count them on the stats as we don't see them personally.*

While there were no programmes specific to men the service did attempt to attract males through their connections with school based health programmes. This relationship took the form of talks to students at local high schools that supplemented the health curriculum. Otherwise the staff felt comfortable in supporting and working with men, believing they offered the same degree of choice options that would be available to female clients. There had been efforts made in the past to obtain feedback and guidance from men as to how to improve the attractiveness of the service to men however the results of these initiatives had proven disappointing.

We had a focus group looking at a service for men. It gave us some ideas and we promoted a service but not many turned up.

Another initiative taken was to employ a male as part of the team but again the response to this proved disappointing.

Some years ago we had a male nurse. I felt decidedly [uneasy] about women talking to males about sensitive issues so we had a male and female nurse available. Over the year only one male requested the male nurse. We came to the conclusion that was a fairly homophobic response.

Other organisational factors also proved a disincentive for males to present for support.

Some of the barriers are related to the times we're open. Like men working out in the bush find it hard to see us whereas they can get to see a GP on the weekend or the sexual health service in the evening.

4.1.2 The plan.

With relationships already established at local high schools it was planned to conduct two focus groups with year twelve males to see if there was anything the Independent Nursing Practice could do that would enhance the students' access to the practice. In addition, the participants would be asked to complete a questionnaire related to their knowledge of health and the Independent Nursing Practice as well as their suggestions for future change/improvement.

In addition, all the men who attended the clinic over the months of September and October would be asked to complete a questionnaire

4.1.3 Action.

Two focus groups were held at two schools. There was a high degree of participation with twelve males attended one group and seventeen the other. Only four men completed the clinic based questionnaire.

4.1.4 Results.

While the limited number of respondents to the clinic base questionnaire was disappointing the responses in the focus groups was a different matter.

It was really interesting. What I was expecting was a detailed analysis of services, times available etc. We're not even at that level.

The focus groups went really well and I got some really useful information. Basically the young men haven't a clue about our service and about the service we provide. It blew me away how little they knew about us even though, at one of the schools, we run a clinic there once a week. I didn't get any information about the quality of our service ... we're a step back from that.

Despite working in the community, especially with youth, it was abundantly clear that the Independent Nursing Practice's assumptions about the preparedness of young men for health information needed re-evaluating.

> *It reinforced to me the importance of young people to have health information on an ongoing basis. Whatever the health curriculum is providing, it isn't enough as it only gives a snapshot at that time.*
>
> *Most of the boys in one group had extremely limited knowledge about STIs. The teacher was really shocked about the results.*

Some ideas regarding depth and method were suggested by the young men.

> *We have to start at a more basic level that I ever would have thought.*
>
> *I asked them what works. They'd really like to have a bus coming to the school. Raising awareness perhaps? Then... posters. They thought posters were the most useful way of disseminating information about the school. The posters had to be considered cool – posters young people had input in to.*
>
> *It was affirming that they liked school based services. They want information at school.*

4.1.5 The plan for 2010.

The following areas were identified.

- The development of health promotion posters aimed at young men. The focus groups emphasised that these needed to be 'cool'. By this was meant the imagery needed to be graphic, blunt and to the point. It is intended to achieve this by commissioning young men to develop the posters, perhaps through a competition.
- To disseminate the findings of the project to teachers, especially those working in the health curriculum, with the aim of raising awareness and the level of networking between the schools and Independent Nursing Practice.
- To build on the findings of the project through strengthening the relationship with the Sexual Health Promoter, Public Health Unit, Nelson Marlborough District Health Board. Discussions have already commenced.

4.1.6 Summary.

Despite their experience in the area of youth health, especially youth sexual health, the project has provided the opportunity for staff to raise their awareness of how young men regard their health and their health care needs and to receive suggestions about how these may be best met. It has resulted in Independent Nursing Practice reviewing and redirecting their approaches to this group as well as providing a vehicle to reenergise their enthusiasm for this work.

4.2 Te Korowai Trust.

4.2.1 Initial self assessment.

Several staff were involved in this assessment with the process proving productive. While the staff completing the assessment stated they were aware of differences in the needs of men in relation to their health, they also acknowledged difficulties in men's engagement with health agencies.

> *Men are more likely to shy away from seeking medical treatment, have a lack of willingness to adopt a healthier lifestyle. 'She'll be right mate' – that goes back through generations.*

While this comment reflected the perspective, dominant in the literature, of the distant, dismissive male, it was also recognised that in relation to family health when men were approached they added depth and perspective to the discussion.

> *The information the men provide [in family health] is quite helpful to me because mums tend to play things down a little.*

It was acknowledged that considerably more women than men were seen by the Trust. While no definitive figures were quoted it was estimated that around 20% of the clients were male. The self assessment process provided an opportunity for those present to reflect on this difference.

> *Men's health has been lagging for a long time so it's good to have something like this to bring it to a point where everybody can see that's what's happening.*
>
> *I knew there were gaps there but it wasn't until we entered into this process that we had a wakeup call to get out there [and do something].*
>
> *Most of my feedback comes from our female clients.*
>
> *Men don't want a woman doing these things. Do we speak the same lingo? We don't.*

As well as what were seen as deficiencies in the available support for males.

> *Women get a lot of help for their issues but men don't tend to. Trying to find pamphlets is hard.*

How this situation linked with Te Korowai Trust's vision of a culturally safe service was commented on.

> *When I talk about cultural safety it's not just about Māori, it's about younger people, older people, male/female; that sort of thing. It's all about the relationship.*
>
> *There's definitely room for improvement [in supporting men] and it's quite exciting thinking about how we can develop our service in a way that is*

> *acceptable to all. I'm looking forward to a year's time when men's health is part of the culture, just part of what we do.*

The main area of concern was the lack of male staff members and how this reflected poorly on a culturally safe service. However any remedy for this situation was viewed as being beyond the scope of the project.

4.2.2 The plan.

The plan involved two areas. Firstly, and consistent with Te Korowai Trust's vision of a service that is collaborative with its clients, a Hui was planned.

> *Holding a Hui so men can hear what [services] we have to offer, and to hear their comment and what they think. Just wanting a gauge of what's out there. What they think.*

The Hui was also to provide an opportunity to survey those males present about their healthcare experiences, needs and expectations.

In addition one staff member planned to attend a men's health night planned to be held in Nelson by a men's health promoter from the Public Health Unit, Nelson Marlborough District Health Board.

4.2.3 Results.

A Hui focussing on men's health was held. The Hui itself (with both men and women present) provided for considerable interaction between the attendees. This was described as honest, sharing and spiritual.

> *Some of the men were quite surprised at the amount of ill-health around. The stories that came out during the night. [It was] a very emotional Hui.*
>
> *A surprising result was the wahine support of their men – very touching. This was commented on by the wider staff group (other staff attended).*

Eighteen people attended. While this may be regarded as a poor turnout there were features of the Hui, including the survey/feedback form, which provided a very positive outcome and vision for the future.

> *The effort for that night was really worth it, I have to admit.*
>
> *Evaluations showed that meetings should continue. [It should] not just a 'one-off'. The ripple effect could be the key to getting the message out there. If these are the stories in one room, what stories are there out there?*

4.2.4 The plan for 2010.

It is planned to hold further Hui on men's health. The format is planned to be similar to the recently held Hui, following a collaborative and interactive process. Accessing men in other settings (eg. in workplaces) will be explored as well.

Secondly, Te Korowai Trust plans to build on the impetus provided by the project in bringing a range of organisations together, developing networks and collaborative relationships in relation to men's health.

> *Te Korowai Trust will] be working alongside other community organisations to build clear, realistic and attainable outcomes relating to Māori and non-Māori men's health issues.*
>
> Report, The Nelson Leader, 2009.

4.2.5 Summary.

While the staff and management at Te Korowai Trust supported the project overall, the responsibility for coordinating the project in an ongoing manner was delegated to one staff member. This staff member had a particular interest in men's health and is currently studying men's health at diploma level. It was clear that the process of the project design and the findings from the Hui have provided information to both improve service delivery to men and their whānau as well as encouragement to continue to develop networks with other organisations in the local community. The interest, enthusiasm and perceived need for these initiatives was encouraging to all involved.

4.3 Family Start.

4.3.1 Initial self assessment.

Two supervisors independently filled in the assessment tool as well as a group of three family/whanau workers. The exercise with the self-assessment tool prompted reflection and discussion on the topic of engaging with male clients. This conversation resulted in the development of topic areas for further consideration.

> *It was a good conversation. [We] came up with six main themes – policy, training, survey for fathers, survey with Family Start staff, resources within our site, networking with other agencies. Already, just by doing the self assessment, we're thinking about these things.*

A point of difference with the staffing mix at Family Start was that there was one staff member who was male. This added a further dimension to the discussions in terms of his participation in the project;

> *Initially I [the male employee] wondered if I should be involved with this as I might skew the results of how the agency saw itself. I see things differently to others.*

As well as in the clear identification of differences in professional practices and opportunities experienced by male staff.

> *If I'm working out there I know I communicate differently [to my female] clients] so I have to make an effort there ... I don't have to think about it with the dads. Is it visa versa for the female staff?*

With our referrals we have to take care about where we place [our male worker]. In 5 years there have been three complaints about male staff but from male clients. All when [the male staff member] had intervened regarding safety issues.

One father really came on board, after the initial shock of seeing a male family worker, he improved things. That family really went ahead in leaps and bounds. He asked if he could schedule the appointments so he could be there.

The staff were quick to acknowledge issues regarding their engagement with the men in their client families as well as some of the pressures that contributed to this situation.

Yes we acknowledge the differences in male and female clients but I don't think we are active in actually addressing these or exploring how we could do things differently.

This is creating an awareness of "I was actually advocating for the mum. The dad wasn't there. He may not have been living there." This gives us food for thought. Are we a bit blind? Are we giving [the men] a choice or opportunity to [talk]? They're all different. The ones who aren't assertive can be [disadvantaged].

One worker said "she [the mother] wants a female worker". I asked what the man wanted. She said "I didn't ask him". You are dealing with the mum mostly. You do slip into just listening to her.

We are very limited in our knowledge about resources or contact people for assisting us to work with males. With my solo dads I hit that place with them where I send them to the [men's centre] but what else do I do? What else is available? What else can I do?

Services were created by women for women and when they go out we see men struggling they say that's not their brief, it's just silly.

The situation was summarised by one staff member as:

If the services and support is meant to be tailored around the needs of the community there isn't a single area that men aren't involved in [in some manner]. The support services aren't meeting the needs of [men]. We're missing finding a way of keeping the fathers connected. We've not done it well; we're still not doing it well. Looking into the future, from where I stand, we're going to continue to not do well.

4.3.2 The plan.

A comprehensive plan was constructed, targeting several areas that were seen as key drivers in improving Family Start's service to male family members. Individual staff were allocated 'portfolios' addressing these areas. The key areas were:

Governance:

- Reviewing the current policies and procedures regarding staff recruitment to establish if gender is itemised as a specific consideration in staff replacement.

Staff training/education:

- Investigating training options to increase skill and knowledge specific to male issues.
- Attending an 'Engaging with men' workshop.
- Organising a presentation from the male staff member
- Organising fathers to come in to talk about their experience of parenting.
- Organising a presentation from staff on what they've found in terms of sources of support for men in the community.

Resource/capacity development:

- Developing a survey specific for male primary caregivers/fathers/partners.
- Developing a survey for Family Start employees to identify their current level of competency.
- Reviewing Family Start resources to ensure positive male images were depicted.
- Developing and collating a resource of options specific to males available in our community.

4.3.3 Results.

Governance:

- Current policies and procedures regarding staff recruitment were reviewed to establish if gender is itemised as a specific consideration in staff replacement.

> *We looked at our policies on recruiting males. They refer to reducing gaps but do not refer specifically to gender.*

Staff training/education:

- Staff training options to increase skill and knowledge specific to male issues were investigated.

> *An orientation folder for new staff was developed, plus a specific session engaging with fathers was organised.*

In addition, several staff members attended an 'Engaging with men' workshop organised by the Health Promotion Unit, Nelson Marlborough District Health Board.

Resource/capacity development:

- Male primary caregivers/fathers/partners were surveyed about their experiences and support needs.

> *We surveyed men. We've had 23 surveys back. Ten already participate [in our service], the others don't, and the reasons are around work and study. Some of the suggestions they gave us about increasing their participation*

were things like weekend visits, 'man games' and a male group. In relation to the preferred gender of the support person, only two said 'male', mostly they were 'no preference'.

- Family Start employees were surveyed to identify their current level of knowledge and ability in supporting male clients.

Of the staff surveys I collated about a third are saying they're not actively engaging with the men in the families they're working with.

The workers have identified the difficulties they've faced. They say males have different needs to their female clients and one of the things they wonder is if males are comfortable in working with the female worker.

Communication styles [differ]. Men are less likely to talk if their partner is there. The partner is likely to take over the conversation. Some men are scary. Female workers feel more comfortable with women.

- The Family Start resources (including the physical environment of the centre) were reviewed in relation to ensuring positive male images were depicted.

It was identified that there were no positive images of men in the office areas. This was quickly remedied.

- The availability of community resources specific to males were identified.

We've got together a good manual with a whole lot of resources for men as well as a list of agencies we can network with. Not just those agencies that say we work the same with everybody. Actually looking at how many men they have on their staff and things like that. As well as reporting back on how male friendly they are. Now we have a folder that covers all agencies that have services specifically for men.

4.3.4 The plan for 2010.

The plan is to continue to utilise the surveys of clients and staff to further develop the capacity of Family Start to support their male clients and to identify staff training needs.

4.3.5 Summary.

As with the other agencies participating in the project Family Start entered into it in an enthusiastic and positive manner. There was a distinct point of difference from the other agencies participating in the project in that Family Start are well resourced and at least six staff members were actively involved at all stages of the project. While other factors were involved this number of people gave the opportunity for a diversity of options to be explored.

It's been a start for us. It's got everybody thinking and talking. It's a good journey for us as a service. It's been interesting and not in a way we thought it would be. It's felt genuine.

4.4 The New Hub.

4.4.1 Initial self assessment.

All staff were involved in completing the initial self-assessment.

A point of difference to the other agencies participating in the project is that with The New Hub the majority of the clients are male. As previously mentioned, The New Hub was keen to better support their male clients as, although gender differences were acknowledged currently, it was not always possible to respond to them. In addition, The New Hub also wanted to better respond to the health issues many of their male clients were experiencing.

There was general acknowledgement of the differences between young men and young women and that there was a need to respond to these in a positive and focussed manner.

> *Mostly boys use this service (around 60%). It does vary. If you fill a room with boys, the girls leave – they're quite boisterous. Girls entertain themselves differently.*
>
> *We don't actively target males. We occasionally think about young men at times. We certainly think it would be good to have more men on the staff.*
>
> *The things we have on our activity programme are a bit girly so we would like to add more in there that is attractive to males.*
>
> *We recognise that males have something positive to contribute.*

As well as discussion about the impact the staff mix has on this situation.

> *All but one of the staff are women and [the female staff] have said that one of the biggest issues for them in working with males (and it's not a huge issue) is the fact that they're all women so there's not much choice for our male clients in this organisation.*

The self-assessment also prompted discussion about possible responses to gender differences.

> *We know that young men learn to be men by being around men.*
>
> *We've often talked about the place of a mentoring programme for males, a shed type concept for males. Older guys that have skills those young guys don't have these days. None of [my clients] have that.*

It was recognised that in order to effect change, support needed to be present throughout the organisation, especially at governance level.

> *We're a youth organisation and there are gender differences. It might be useful to talk about this at Board level. Developing or reviewing our policies would help us keep males at the forefront of our thinking.*

4.4.2 The plan

A plan was constructed that targeted three main areas, these being:

Governance:

- Looking at whether there should be a specific policy for male clients.
- Policy developed around young males initially being engaged with a male staff member when orientated to the facility.

Staff training/education:

- A staff meeting to look at training and development needs (based on the initial self-assessment).

> *Is there a way we could do things differently? Would they identify a way of working with boys that's different from working with girls?*

- With a greater focus on the health status of young males, training was needed around assessment and referral skills.

> *I don't want to be in the situation where a young guy is disclosing stuff to me and I don't have the skills to deal with it. I need to know where the backup is.*

Resource/capacity development:

- Identifying and resourcing a designated staff member to further develop and action the plan as well as working towards having a male on the floor at all times.

- Developing a welcome questionnaire to get some buy-in from new clients. This should incorporate a basic health check list (incl. Sexual health, alcohol and other drug use, smoking).

> *Developing an initial health check list will give us some idea of trends and issues facing our male clients. It's amazing the number of underlying health concerns that our clients are experiencing.*

- Introducing health care checks that are incorporated with activities (eg. Testing cardio-respiratory recovery levels through a game or exercise).

> *Just to give guys some ideas of how their bodies work through an activity.*

- Activities that involve taking young males away from the city environment to experience new activities in a different environment"

4.4.3 Results

It is of interest that in addition to developing a plan the staff felt that the process of self-assessment, reflection and discussion was a very positive outcome in itself.

Maybe the process here will be the [best] outcome, because we've considered the needs of male clients.

A male staff member has been resourced for the role of further developing and implementing the plan.

Already there's that increased awareness of men's health in the building. It's more about us starting our thinking about men's health. One of our staff members is quite fired up about it. He's thinking about this and will start networking now.

4.4.4 The plan for 2010

- Developing policy about how female staff should work with male clients.
- Developing support for young men through the health system.
- Developing an education programme for young men, teaching about their health.

At the simplest, just by developing a relationship with that young fella you identify health issues that they didn't know they had and the system hadn't picked up.

Mostly it's about steering young men through the systems that are available. Did they get to the appointment? Did they understand what was being said them? We're a link before GPs for example. We follow them through the system as well as we can.

Let's just drive this thing through and see if by the end of the year we can begin to see some results.

4.4.5 Summary

The New Hub is a vibrant and busy centre and, as with the other agencies, entered into the project enthusiastically. While focussing on supporting youth quite broadly the staff were clear that health was an integral aspect of their brief. The New Hub believes their plan to be realistic and sustainable.

I think our plan is sustainable if it becomes integrated with our usual processes. For example we will try and integrate the thinking about young men's health into all our current processes. It's got to start with policy, then to the staff and then to every young man that walks through the door. It's been a start for us.

4.5 Post Natal Depression Support Network.

4.5.1 Initial assessment

A significant point of difference exists between the Post Natal Depression (PND) Support Network and the other agencies participating in the project. This being that, although staff considered other family members, the support network had been developed by women for women.

> *To say that we weren't working with men at all is probably doing our service an injustice. It's not to say that our original workers 20 years ago didn't speak to men, I'm sure that wasn't the case, but it wasn't the primary focus of the support group.*

However, there was a growing recognition of the needs of the partners of the women they supported.

> *It's not like [the support workers] exclude the man if he is there. [For example] prior to attending a workshop on working with men I assumed the man didn't want to be involved, now I assume he does want to be involved unless he says otherwise. That gave [us] permission to approach the man.*

> *The way I view it personally is that it's a family issue, it's not just affecting the mother, it's affecting the whole family. While we're able to offer that support to the woman, and it's very much needed, so in one sense we are benefitting the family anyway but we could be doing a lot more to help the situation [if we support the partner as well].*

> *All our support workers work in the home and we need to remember that it is the family's home not just the woman's home.*

It was interesting that there was a strong appreciation the complexity of family health and the position of men in stressed families.

> *In my experience it would be difficult to argue that the partner is not seriously affected by a woman's post natal depression. The women themselves recognise that. It's a family thing. Children are affected [too].*

> *There are two issues. Firstly there's men supporting women with PND and that's part of our clients' recovery. Could we be supporting her more by involving the partner without compromising confidentiality on both parts? Or is the partner wanting that support but it's not there? Secondly men might want to approach our service and find out more about PND themselves, whether for themselves for their partner or themselves personally.*

> *We're here to support those with PND. There's debate about whether men can get PND. My view is that men no doubt can get depression postnatally. This is something I would like to acknowledge. That it's OK for the man to be feeling down at this time. We're not in a position to provide that one to*

one support for men but there are other services that do provide for this. It would be much better if we provided for referral to these services.

4.5.2 The Plan for 2010

The Post Natal Depression Support Network entered the project later than the other agencies. Because of this there has not been an opportunity to implement a plan. However this is planned to be implemented this year and covers a range of strategies.

The first is a brochure that is aimed at information for men.

> *[We are planning] a leaflet or brochure on PND in a male friendly format. It should contain information about people who can be contacted for support as well as practical things to help the family. It is the key to opening the door, an opportunity, a starting point. Given our resourcing it's a realistic goal at present.*
>
> *I would like something in our brochure for men so they feel they can contact us for more information. There needs to be something there that causes them to think this isn't just for the woman.*
>
> *My hope is that the brochure will generate a demand for services for men. I think it will increase the awareness of PND in Nelson. Sometimes it is the partner that recognises it first. I hope it will [also] provide better access for help as they'll know where to go. Quite a lot of our work is connecting clients with other organisations so I would see us as a point of referral.*

To supplement the connections with men that the brochure will hopefully facilitate it is planned to firstly trial the brochure with current clients for feedback and critique. Secondly, it is recognised that working with men poses new challenges as well as opportunities. To manage these issues policies will need to be visited and staff training will need to take place.

4.5.3 Summary

The Post Natal Depression Support Network's movement away from an almost total focus on women to one that regards PND as affecting other family members as well is not merely a shift in focus. It also requires a shift in policy and proceedures as well as the development of an extended skill mix and knowledge base in the staff. The network is committed to following this through.

> *As a [primarily] woman's organisation we have to be actively thinking about men. We recognise that there is a need for men affected directly or indirectly by PND. We are working towards reaching out to more men by supplying more information and connecting them to the right support.*

4.6 The Prostate Cancer Support Group (affiliated with the Cancer Society Nelson)

While the Cancer Society Nelson was part of the initial meeting of all the agencies participating in the project, for a variety of reasons outside of their control, the Society as a

whole were not able to continue their overall involvement with the project. This role was delegated to the facilitator of the Prostate Cancer Support group. Here there was a distinct point of difference to the experience of the other participating agencies as this was a service that specifically targeted men and had proved successful.

> *Generally we do well [in engaging with men]. We do have females initially greeting males. Overall, we're getting the information out there and doing pretty well.*

Of particular note was that the support group had proven successful over a sustained period of time.

> *I've got a stable support group with a core of members that have been together for 7 years. Some have still got cancer. Others are clear.*
>
> *The support group for prostate has worked because we've the numbers and a core of key people. Plus I get on the phone and talk to them. It does need perseverance.*

The facilitator saw the success of this targeted initiative provided a strong foundation that could be built upon to eventually engage with men and cancer more generally.

> *As far as the support for men is concerned, we're doing very well. My thinking is that once we've got the awareness out there about prostate, then lets diversify [to other areas].*

While this was but one small support group it is of interest that an initiative specifically targeting men has endured overall and has promoted sustained engagement from the group members, we suspect the success of this group can be attributed to having a passionate champion for the cause.

5. Discussion and conclusions

There are a number of limitations to this project that should be detailed here. Firstly, this is a project focussed in a small city. There are likely to be issues and findings that would differ elsewhere, for example in larger cities and/or more ethnically diverse communities. Secondly, this was a relatively short term project. Whether or not the gains made would be sustained is questionable, especially considering the financial support given to the agencies in order to implement their plan.

There is no doubt that the health status of men, on many measures, is compromised. There is also no doubt that many health-related services have difficulty in both attracting and engaging with males. This situation is commonly ascribed to men themselves insisting on engaging in activities that place their health at risk and taking little/no responsibility for their health.

This situation has been summarised as:

> *The focus in men's health literature has more been on the 'problem of men and their health' with the tone of the discussion being somewhat ambivalent. There is an attitude of both blaming, yet accepting of men's behavior as a cause for the current status of men's health.*
>
> McKinley, 2005.

Additionally, men are generally viewed as being reluctant to approach health services and when they do so, they present later than women. This project set out from the perspective that many agencies have a limited understanding of the needs of men and have difficulty providing a service that both attracts and effectively engages this group.

The selection of the agencies for the project was based on a comprehensive definition of health. The five agencies that were recruited worked in areas of sexual health, family health, mental health, and physical health. The agencies themselves were very diverse in their size, staffing mix, position nationally, and whether their structure was public, private or trust.

While this was a project of limited scope, certain common themes were observed both during and following the action phase of the project.

- All agencies supported the assumptions underpinning the project; that health should be considered comprehensively and not merely as the absence of disease. Also, agencies that attempt to support men and their health have a responsibility to build their capacity to the highest level that is sustainable.
- All agencies recognised they were not providing as effective a service for men and were keen to do something about this situation. Most saw this as a priority.
- While the staff believed the needs of men differed from those of women, they were unclear about the nature of these differences. The fact that most agencies were generally staffed by women compounded this point.
- All agencies developed, implemented and reviewed a plan that was appropriate to the resourcing and consistent with the vision of their organisation.
- All but one agency found the self assessment tool useful in raising awareness and beginning a conversation about how best to meet the needs of male clients. The one

agency who found otherwise had no male clients (the self-assessment tool assumed some contact with male clients).

- All agencies initially looked to the project facilitators (C & M Associates) to assist in developing and implementing their plans. This misunderstanding required the project design to be revisited with each agency on at least one occasion. What was clear however was that each agency initially looked for external support.
- While there was variation in the rate of progress throughout the project all agencies were able to affect a process in keeping with their culture and resourcing.
- All agencies reported the process to be positive and worthwhile. They also believed they would be able to sustain the progress they made.
- All agencies, when they met for a final (combined) meeting, agreed with the importance of further development in the area of supporting men and believed this needed coordination across services in order to succeed.

Overall, the agencies moved through the process of self-assessment, planning, implementation and evaluation smoothly and enthusiastically. The following quotations (previously reported) are typical of the responses overall.

> *The workers have identified the difficulties they've faced. They say males have different needs to their female clients and one of the things they wonder is if males are comfortable in working with the female worker.*
>
> *Of the staff surveys I collated about a third are saying they're not actively engaging with the men in the families they're working with.*
>
> *There's definitely room for improvement and it's quite exciting thinking about how we can develop our service in a way that is acceptable to all. I'm looking forward to a year's time when Men's Health is part of the culture, just part of what we do.*
>
> *Men's health has been lagging for a long time so it's good to have something like this to bring it to a point where everybody can see that's what's happening.*
>
> *We are concerned that young men are not getting their sexual health care from anybody. Although we know that our service is primarily a women's service we take the view that women are not the only species on the planet. We want to live in a world where men and women have access to the same kinds of services."*
>
> *I knew there were gaps there but it wasn't until we entered into this process that we had a wakeup call to get out there [and do something].*

These agencies demonstrated recognition for the need to build their capacity in the area of supporting men in their service. They also demonstrated a preparedness to critically reflect on and develop their current practice. The degree of professionalism and commitment to the principles of equitable access to services for all was commendable.

What is interesting was the ease with which the agencies entered into what was essentially a process that challenged current and traditional practice. This ease suggests these agencies were ready and perhaps searching for answers to questions they had about supporting the men their service had contact with. They had no difficulty in acknowledging gaps in their

capacity to support men. Given this recognition of need at the 'coal face' of service provision it is odd that little is being done in coordinating men's health at a national level.

It is of interest that the one agency that did enjoy success in supporting men was one that targeted men specifically (the Prostate Cancer Support Group). However, exploring this point of difference was beyond the scope of this report.

6. Implications

Mortality and morbidity data clearly indicate the health of men in New Zealand is at risk. Despite the efforts of pockets of people over the years there is currently no clearly coordinated national focus. Despite some excellent initiatives in the past, there is generally little collaboration between health professionals and the community regarding men's access to health care and gender inequalities in resourcing.

This project was innovative in that it explored a relatively uncommon perspective on men's health. Rather than exploring the reasons why men themselves access services less and later than women, this project explored the difficulties professionals themselves find in both attracting and engaging with male clients.

The project was successful in that it achieved its aim of sustained engagement from five agencies. This sustained engagement clearly resulted in a raised awareness of the agency staff in their ability to effectively attract and engage with the men they attempt to support, as well as the need for them to continue to develop their capacity in this area both individually and collectively.

The project design resulted in 'at the coal face' collaborative action drawing on the combined wisdom of those people involved and is arguably an effective way to facilitate sustained change that is in keeping with organisational cultures. The participants certainly believed this to be true. The ease with which the agency staff entered into the process of critical reflection and planning suggests a readiness for such initiatives.

While this project design and PAR methods are recommended as valuable tools to effect attitudinal/cultural change in organisations, it is also evident that the success of the project itself was a result of coordination at several levels, including governance, management, and operational levels. More importantly there were people who championed men's health in each of these areas. There was national coordination, resourcing and champions at government and Ministry levels. There were champions at Nelson Bays Primary Health (again at governance, management and operational levels). At the community level there were local champions in health services and men's support services.

Can the progress achieved in this project be replicated and sustained without each of these areas being present in support of the process? Without targeted resourcing and support, such as this project enjoyed, it is unlikely this will occur.

While various commentators have at times advocated for a men's health agency and/or a national policy on men's health, it seems unlikely these will eventuate in the near future. However this project has demonstrated that NBPH has the ability to develop, coordinate and otherwise support a particular strategy in this area. Using a process similar to that used in this project other PHOs, not currently active in the area of men's health and with the assistance of men's health champions, should support similar initiatives. It also seems reasonable to assume that, given the results of this project, PHOs could provide a base for a national network. Johnson, Field, & Stephenson, following a review of the benefits of men's health awareness activities aimed at developing a programme to improve men's health in New Zealand, support this point stating,

> *[This] review also notes that the New Zealand primary healthcare sector, with its enrolled populations, PHO structures with their 'blanket' of primary*

care management, high levels of computerisation, and sophisticated decision support tools, is well placed to provide systematic support for national programmes that target particular populations

Johnson, Field & Stephenson, 2006.

Johnson, in a later article, elaborates on this point. He suggests that for improvements in men’s health to be achieved a wider context needs to be appreciated.

PHOs definitely have a role in addressing these difficulties [in men’s health], but a national policy on men’s health could set the pace. Without political leadership from the Ministry of Health and possibly the financial sector, progress will be slow. Improving men’s health is critical to improving productivity and thus economic recovery.

Johnston, 2009, p260.

It is essential a broad approach is taken to improving men’s health in New Zealand. While recent literature points to initiatives in the health sector, particularly at the level of general practices, there is also a need to extend these initiatives to the wider health and social service environment. Similarly, while there are a range of initiatives being undertaken that appear to prove attractive to men, these are generally focussed on addressing what is seen as men’s poor understanding of health and their reluctance to engage with health professionals (eg. ‘Warrant of Fitness’ Health Checks). This project has demonstrated that initiatives need to be taken in another area, that of assisting service providers to critically reflect on their own practices and move to build their capacity to best support men.

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The NBPH project team

Jane Kinsey supports the development and implementation of programmes within NBPH. Jane is a physiotherapist with a Post Graduate Diploma in Community and International Development Studies in 1999 and has worked within a Health Promotion framework since employment within the PHO in 2004. She brings a strong emphasis to reducing health inequalities to any programme planning and emphasizes community partnership and ownership opportunities in programme and contract design.

Nelson Bays Primary Health is the local structure for leading and coordinating primary health care across Nelson Tasman. NBPH has made a strategic decision in acknowledging men's' health as an area of particular health inequality within our region and is committed to working across all areas of activity to improve health outcomes for men. In particular we are currently planning the following work areas;

- Vascular Risk Assessment with particular performance indicators for males and the development of a mobile clinic to enable more effective outreach services and extension of clinic hours to focus on reducing inequalities.
- Workplace Wellness Programme in collaboration with ACC, DOL, local industry leaders, and private occupational companies and practitioners. This will bring a greater breadth of health services into work sites of varying sizes and capacity particularly within rural areas.
- Tane health programme with local Maori Health Providers building robust programmes for physically inactive tane within community development models combining peer support, application of tikanga and physical activity.

C & M Associates (2006) Ltd. is a research, education and advocacy services company with a special interest in men's health and well being. David Mitchell & Philip Chapman are Partners in C & M Associates (2006) Ltd.

- David is also a senior academic staff member at the School of Health and Social Sciences, Nelson Marlborough Institute of Technology. He is active in applying critical research methods to provide an environment and process where participants can 'find their voice'.
- Philip is also a health promoter with the Public Health Unit, Nelson Marlborough District Health Board (NMDHB), as well as president of the New Zealand Fathering Foundation and Manager of The Male Room in Nelson.

C & M Associates have carried out a range of work within the field of men's health. In addition to providing education and seminars within health and social services agencies they have completed the following pieces of research in this area;

Mitchell, D., & Chapman, P. (2009). *Pathways Through Parental Separation: the experiences of a group of non-resident fathers.* Wellington: The Families Commission.

Mitchell, D. (2008). *'Supporting Men as Fathers' – A Workbook'* (Externally funded by the Nelson Marlborough District Health Board).

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Appendix #1: The Information Sheet.

C & M Associates (2006) Ltd.
Research, educational and
advocacy services

A Men's Health Innovation Fund Project

Information Sheet

Nelson Bays Primary Health, in partnership with C&M Associates, has been awarded funding from the Ministry of Health to undertake this Men's Health Innovation Fund project.
C & M Associates (2006) Ltd. Is a Nelson based company involved in research, educational and advocacy services. The Directors, Philip Chapman and David Mitchell, specialise in issues affecting men. They have been involved in a range of projects sponsored by organizations such as the Families Commission, Nelson Bays District Health Board, the Royal New Zealand Plunket Society and Otago University.
This current project aims to work with up to 6 existing health and social services agencies to enable them to build their capacity in meeting the needs of their male clients. The participating agencies in this project and the populations for which they cater will benefit directly and in turn these agencies will become champions for better meeting men's needs into the future.

Health and social services organisations that are willing to enter into this project need to commit to 3 key phases of the project.

1. An initial self-audit – agencies will be assisted to assess their overall effectiveness at engaging with men.

2. A plan of action – agencies will be assisted to develop and implement specific action plans that they believe are achievable and relevant for their needs and the needs of their clients.

3. A further plan of action - building on the previous plan, implemented and with a final evaluation of impacts and effectiveness.

The time commitment will vary however there will be at least four scheduled meetings as well as associated project work within each organization. The project work will be at the discretion of the participating agencies. Philip and David will be working with each organization to assist in constructing action plans that fit with their individual culture, resources and capacity. In acknowledgement that there will be additional work required by you in participating in this project, costs incurred in undertaking elements of this project will be reimbursed to a fair and reasonable extent.

The timeline has key phases including:

- an initial meeting of all agencies (during April 2009)
- the development of individual agency plans (during May 2009)
- The development of individual agency plans – phase 2 (during July 2009)
- A review of the process and closure (during October/November 2009)

(NB This schedule may vary depending on individual and collective agency progress)

We believe this project has the potential to provide guidance to a wide variety of health related agencies who wish to build their capacity in engaging with their male clients.
We look forward to working with you.

Philip Chapman & David Mitchell
C & M Associates (2006) Ltd.

Appendix #2: The Memorandum of Understanding

Memorandum of Understanding
between Nelson Bays Primary Health (NBPH) and [insert org]
for The Men's Health Innovation Fund Project

OUTLINE
This Agreement outlines the terms by which NBPH ("us", "we" or "our") and [insert org] ("you" or "your") will work together in the undertaking of this project as outlined in the Information Sheet appended with this Agreement.

OBLIGATIONS
Upon signing this Agreement you agree to actively participate in this project as outlined within the attached Information Sheet. Signing this Agreement does not constitute an absolute commitment to completing the project however we ask that you commit to participating to a fair and reasonable extent and in the case of withdrawal will undertake a follow up meeting with us to understand circumstances.

TERM
The term of this Agreement is the period from the date signed by both parties to expiry on 31st January 2010. The term may be extended by agreement between the parties on terms and conditions agreed by the parties.

TERMINATION
This Agreement may be terminated by either party without incurring any liability for costs or damages by giving not less than two week's written notice to the other party.

COSTS AND EXPENSES
It is acknowledged that there will be additional work required by you in participating in this project. Costs incurred by you in undertaking elements of this project will be reimbursed to an extent fair and reasonable up to a maximum of $2,000.

INTELLECTUAL PROPERTY
Intellectual property rights in the project results and any existing material will be the property of the NBPH and C&M Associates as such rights arise. We will however grant you full and free access to any such rights and results that may arise.

CONFIDENTIALITY
In the interests of transparency and public accountability all project results and outcomes will be public information. It is acknowledged that organisational information that is sensitive or confidential may at times be discussed in which case all parties shall respect the privacy of others as and where necessary.

DISPUTES AND RESOLUTION PROCESS
Any matter of disagreement, concern or dispute between the parties shall be resolved wherever possible through discussion at any appropriate level. In the event that matter remains unresolved it shall be referred to the Chief Executive or manager of parties concerned within two weeks of the need being raised.

INDEMNITY

You indemnify NBPH and C&M Associates (2006) Ltd. from and against all expenses and legal liabilities that may result from this Agreement above and beyond those made explicit and agreed in writing by us.

DESIGNATED CONTACTS FOR THIS AGREEMENT

Glenn Thomas, Health Promotion Adviser		name
Nelson Bays Primary Health Trust	&	insert
P.O Box 1776, Nelson 7040		address
Phone: 03 539 1170		Phone:

EXECUTION OF THIS AGREEMENT

Signed for and On behalf of	Nelson Bays Primary Health Trust	[insert]
Authorised Signatory:	………………….	………………….
Name:	………………….	………………….
Position:	………………….	………………….
Date:	………………….	………………….
Witness Signatory:	………………….	………………….
Name:	………………….	………………….
Position:	………………….	………………….
Date:	………………….	………………….

Appendix #3: The Assessment Tool

An assessment of male involvement in your service.

Rating guide:	Never 1 Occasionally 2 As much as possible 3 Always 4

Communication			
How active is your organisation in reaching out to males?	Rating	Does your organisation acknowledge differences in the needs of male clients?	Rating
Does your organisation acknowledge differences in the communication style of male clients?	Rating	Does your organisation encourage interaction between male clients?	Rating
Do staff speak directly to male clients or communicate to them through others?	Rating	Do staff relate differently to men and women in their professional role?	Rating
Do some staff feel more comfortable than others in working with male clients?	Rating	Do male clients feel more comfortable working with particular staff?	Rating
Do staff use appropriate techniques to reduce the caution that males often experience when approaching social services?	Rating	Are staff aware and respectful of gender differences in communication?	Rating

Notes

Participation			
Do staff encourage males to be involved in your services?	Rating	Do you expect males to be involved in your services?	Rating
Do you have any programs specific to males?	Rating	Do you seek the support of male advocates or resource people?	Rating
Do you have sessions specific to the needs of males?	Rating	Does your organisation recognise that males have something positive to contribute?	Rating

Does your organisation provide services outside normal working hours?	Rating	Do staff avoid stereotypes and generalisations such as all males are violent or perpetrators of abuse?	Rating
Does your organisation insist on the use of positive language in relation to males in fliers and other promotional material?	Rating	Does your organisation offer male clients choices about services that are available`?	Rating
Does your organisation encourage male clients to influence programme development?	Rating	Does your organisation provide a variety of options for males?	Rating
Are male friendly resources available for male clients?	Rating	Do staff feel safe in working 1:1 with male clients?	Rating

Organisational activities			
Does your organisation have male representatives on your governing body?	Rating	Does your organisation encourage males to be on your governing body?	Rating
Is there a good mix of genders on your staff?	Rating	Does your organisation seek male representatives on working parties?	Rating
Does your organisation employ male staff to work directly with male clients?	Rating	Does your organisation assess barriers to male involvement?	Rating
Does your organisation encourage gender appropriate delegation of staff to clients?	Rating	Does your organisation have policies that identify ways of targeting male clients?	Rating
Does your organisation seek feedback from male clients about the approachability of your service?	Rating	Are images displayed in your premises that depict positive male images?	Rating

Your rating overall :