

## **Men's Health in Bradford – Developing the Evidence Base for Practice**

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The health of men is increasingly seen as problematic but it is recognised as an under-researched area resulting in a weak evidence base for practice. The number of new projects and initiatives that are being set up is increasing rapidly as a response by practitioners to the relatively poor health of men. Bradford, which is recognised as an area of high inequalities in health, has recently been funded for work on Men's Health through the New Opportunities Fund. Within Bradford, the Health of Men group, comprising 12 of the most experienced practitioners and workers in this area have many projects set up and running. This group, with the support of the funding, provide one of the most fertile areas for practice development around this field, but there has been very little funding made available for the evaluation of this important work (£6,000 p.a. for 5 years).

This paper outlines the need for greater funding for this research to enable lessons to be learned about what works and what does not work when setting up projects with men.

### **Background**

A recent study on the state of men's health across Europe (White & Cash 2003a) explored a wide range of disease conditions (cardiovascular disease, lung, prostate, stomach, bowel and testicular cancers, accidents – including transport, work related accidents and violence, liver disease, diabetes, HIV/AIDS, sexually transmitted infection's, mental health and suicide) as well as the lifestyle issues of smoking, alcohol use, diet and weight. The study showed that men's health varies considerably between countries and between different ages. When the mortality statistics for men in comparison to women were considered it was seen that men are at a universal disadvantage compared to woman across all the major disease states.

There would appear to be three main possibilities as to why men should be as so much greater risk of premature death (White & Cash 2003b):

- Men are biologically more vulnerable than women
- Men's lifestyles (such as increased smoking, alcohol intake) create more life-limiting disease
- Men are more reluctant or unable to seek early medical attention.

It is to the last two areas that the majority of current activity aimed at improving men's health and well-being is occurring. In fact there has been an increasing amount of health professionals' time and effort being spent in this area.

For example, The Men's Health Forum Database of Projects and Initiatives on men's health across England and Wales in 2000 (White 2000) initially identified 80 projects that were specifically aimed at men and their health- there are now there are now over 200 projects on the database (see also Deville-Almond 2003). In 2002 the Men's Health Forum ran the first Men's Health Week with 300 events staged across England and Wales-- in 2003 over 1000 events were registered. Scotland has initiated a large-scale development and piloting of well man clinics, targeted health checks towards men and the establishment of a national advisory framework for employers to offer health screening and other services for men.

All of this work is predicated on the assumption that men under utilise the conventional health services and that by devising alternative approaches then the health of men will be improved. This hypothesis is in need of greater investigation such that the impact of these new initiatives can be determined. There is also a need to be able to differentiate between the different types of initiative and different population groups - such as those from different socio-economic or ethnic background.

### **Men's usage of health services**

The common impression is that men under-utilise the health service both in terms of access and the way in which the services that are accessed are being used. This was borne out during the Scoping Study on Men's Health commissioned by the Department of Health (White 2001). The key findings of the study suggested that the four main concerns over men's health were:

- Men's access to the health services
- Men's seeming lack of awareness of their health needs
- Men's lack of social networks
- Men's seeming inability to express emotions

Of these, the principal problem identified by the majority of the respondents was the seeming reluctance of men to access health care.

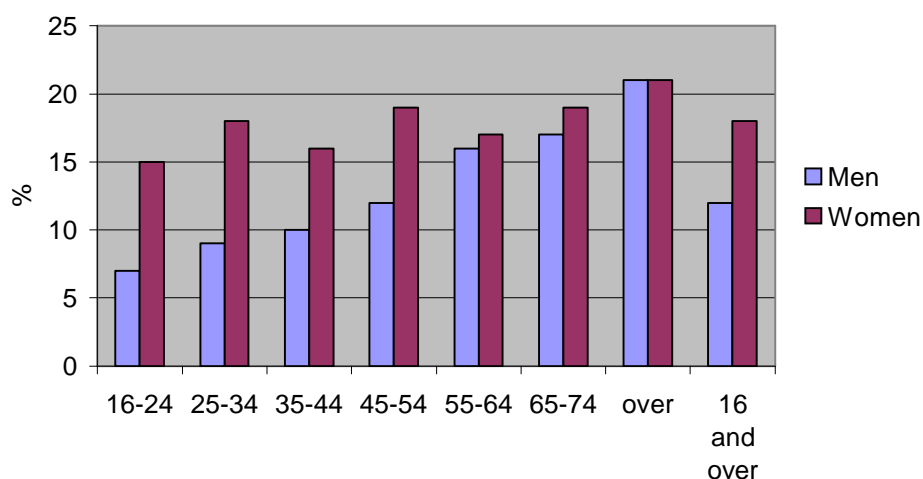
The main reasons cited for the delay in seeking help included:

- A lack of understanding of the processes of making appointments and negotiating with female receptionists
- Inappropriate opening times, which tend to coincide with work commitments.
- An unwillingness to wait for appointments
- A feeling that the service is primarily for women and children and sitting in the waiting room is uncomfortable for them.
- Even the name 'health centre' has been identified as problematic
- The negative response many men feel they get when presenting with difficulties that are not quickly dealt with.

- A lack of trust in the system, mainly around the issue of confidentiality, especially within the gay community and disclosure of HIV status.
- Great fears relating to shame if their concerns are judged to be of little consequence, or having to admit to another person that you may have a problem, and one that you can't solve.
- Lacking the vocabulary they feel they need to discuss issues of a sensitive nature, with the result that it is easier to go to the doctor with a non-embarrassing physical illness than when depressed or faced with the symptoms of, say, colo-rectal cancer or erectile dysfunction.

The 1992 Chief Medical Officer's Annual Report highlighted that men did not access health services in the same numbers as women, and this is borne out with data from the General Household Survey and GP returns (ONS 2003). The data demonstrates that boys and girls are present in approximately equal numbers until the teenage years when the attendance of women increases and the attendance of young men decreases. In part this may be due to women's need to access health services for contraception, issues relating to reproductive health, and pregnancy. But this cannot explain all the differences as women go the GP's more often than men up to the age of 54. Over the age of 55 men attendances at the GP increases until they mirror the number of visits made by women (see figure 1).

Figure 1 Consultations with an NHS GP in the two weeks before interview: by gender and age, 1998-99



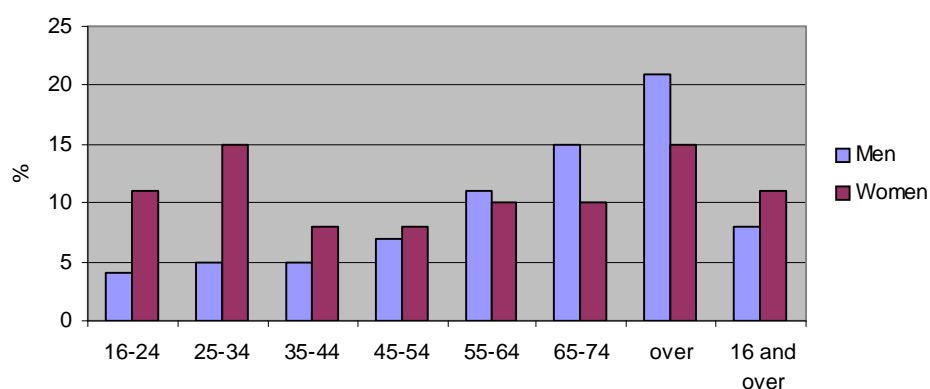
Source: General Household Survey, Office for National Statistics

There are socio-economic variations in the access to health services (ONS 2003), with a higher proportion of men from social class IV and V attending the GP than men social class I & II. If men are economically inactive they are also twice as likely to access the GP than men who are working.

Men from the lower social classes were also more likely to receive a prescription and less likely to receive health education and promotion than men from professional backgrounds, suggesting that though men from the lower economic groups were accessing the service more, men from the upper economic groups may have been gaining more from their visits.

Men's increasing use of GP services as they move beyond the age of 55 is mirrored by increasing in-patient stays suggesting that though men start to visit their GP they are presenting with illness that is more likely to warrant hospitalisation (see figure 2). The suggestion being that by delaying in presenting with a condition there are fewer treatment options open and a greater likelihood of a disease being further advanced (White & Banks forthcoming).

Figure 2 Inpatient use of the health service: by gender and age, 1998-99



Source: General Household Survey, Office for National Statistics

There are conflicting messages from the literature and research on men's help-seeking behaviour. Across a broad band of health issues men are reported to delay in seeking help from the conventional services for instance: men with HIV/AIDS (Randall & Barroso 2002, Petchley, Farnsworth & Williams 2000); men with emotional problems (Green & Pope 1999 Möller-Leimkühler 2002); men with chest pain (White 2002), as well as identifying specific groups of men who are reluctant users of the health services such as homeless men (Shiner 1995, Brush & Powers 2001); and young men (Davies et al 2000, Richardson & Rabiee 2001, Lloyd & Forrest 2002). (See also the comprehensive review of the literature by Addis & Mahalik 2003).

Whilst the majority of papers suggest that men do delay in seeking help from the health service there are some studies that seem to refute the idea that men and women are different in their access to health care. Macintyre et al (1999) in a review of the Scottish Twenty – 07 study found in relation to symptoms no evidence that men were less willing to report health related symptoms or to seek health care. They also found there was no difference in the degree of suffering experienced prior to seeking help. Wyke et al (1998) using the same data set found that though women reported more symptoms than men there was no difference in the likelihood of them reporting them. Similarly Adamson et al (2003) found no difference between men and women in the

Likelihood of them seeking health advice, the differences were based on socio-economic and ethnic background.

These studies however tended to depend on the analysis of questionnaire data rather than considering health behaviour and it is possible that what men report to be their intentions may not reflect actual actions.

Due to the strength of the received wisdom from the majority of practitioners in this area and the weight of articles stating the men do have difficulty with regards to their health behaviour this area warrants closer examination.

The problematics that seem to exist centre on the way men make decisions about their health and in part these can be elucidated from the literature on masculinity.

### Masculinity and men's health beliefs and behaviour

There is limited empirical research on men's health beliefs and health behaviour. However it is possible to gain an appreciation of the influences on men both through an analysis of the literature on masculinity and from the comparative studies that have been undertaken between men and women.

Newman (1997) suggests that male characteristics include: independence, pride, inner strength, competitiveness, achievement at work, success, self-control and physical strength, power and a feeling of invincibility. Characteristics when coupled with Saltonstall's (1993) findings that for men health related to being in control of your body, with action, function and capacity of the body of prime importance demonstrated that not only is health and help seeking is not only seen as a threat to the man's masculinity it may not even be a consideration. Connell (1995 p55) certainly argues this point when he notes that manual work calls for "strength, endurance, a degree of insensitivity and toughness, and group solidarity". The risks that men take with their bodies with regard to war, dangerous sports, not taking health precautions at work also suggest that the body is seen as invincible.

Help seeking would not seem to be helped by men's rationalistic – problem focused coping strategies (Stone & Neale 1984) and their tendency to rely on being self sufficient and private (Frydenberg & Lewis 1991).

The impact of the social expectations of men and socialisation are also powerful influences of men's health beliefs and behaviour. For instance male socialisation actively discourages men from expressing pain, whether physical or emotional (Bendelow 1993). Frosh et al's (2001) study on young masculinities highlights how adolescent boys are aware that they are not meant to display feelings, as this is the domain of girls and that any display of emotion can be seen as a sign of weakness or vulnerability. There is a recognition by men of the central importance of women with regard to their health. Umberson's now classic study (1992) showed how married men tend to have their health controlled by their spouse.

This notion of vulnerability and threat is important in understanding men's response to illness. Concern over what the consequences of the illness may have with regard to work and family security (Kristiansen 1989) may prevent men from accessing health services. For example studies that have been undertaken on men (White 2002, White, Owen & Kelsey 2002) have found that men engage in a complex process of negotiation prior to accessing health care.

The theory base of understanding men's health is not yet developed and we are certainly not at a position of predictability.

## **Bradford**

In order to map the patterns of negotiations and the strategies used to the actual behaviour of men the opportunity offered in Bradford is of prime importance. Bradford, with its broad socio-economic and ethnic demographic coupled with the extensive work of the Health of Men group provides an ideal location to undertake detailed analysis of men in relation to their health and usage of health services.

The Bradford Metropolitan District comprises 30 electoral wards and four Primary Care Teams: Airedale, Bradford City, North Bradford and South and West. Of the total population of 511,723, 255,686 are male and of these 60,277 (24%) are South Asian. Within the Bradford City PCT the proportion of south Asian to non-south Asian men increases to over 61%.

Many of the health concerns affecting men in Bradford are exacerbated by this high proportion of people from ethnic minority groups, which now includes a significant number of new immigrants and asylum seekers – often with language difficulties, a poor knowledge of the British health system, and the economic inequalities associated with their position

A recent analysis (using the Index of Multiple Deprivation and Townsend Score) confirms that Bradford has a higher than National average level of deprivation, but there is considerable variation between the four PCT's. The 9 of the wards occurring within the bottom 8% of deprived areas of England and of these 7 are in the Bradford City PCT. In contrast some wards within the Airedale PCT are within the top 10%. Suggesting that the broad remit of the Health of Men projects, which cover all four PCT's, will allow for comparison of different approaches within these very different areas of social need.

The international picture reported on earlier in this paper is reflected within the Bradford Metropolitan District, with differing health picture depending on the level of social deprivation, but across all the areas men's health has a poorer picture than that of women. Men's life expectancy in Bradford ranges from around 72 years for a man in Bradford PCT to around 76 in the Airedale PCT (national average 75.7 years). Bradford also has higher than national levels of coronary heart disease, cancers and deaths due to accidents. There are also higher levels of smoking and alcohol intake (Manson-Siddle 2001).

## Health of Men

The Health of Men (HoM) group was formed in 1997 by health professionals interested in how health care could be focused more effectively onto men's specific needs. The group has the general aims of:

- Raising the awareness of health issues in the male population by providing accessible services and information to the local population
- Delivering services and information through innovative practices to men away from traditional health settings
- The encouragement and facilitation of health enhancing activities and the improvement of health outcomes in the male population.

This year the HoM group received a Healthy Living Centre New Opportunities Fund grant (£950,000 over 5 years) for setting up a broad range of initiatives throughout the Bradford Metropolitan District. This grant will run for 5 years and when first commissioned comprised the largest funded project on men's usage of health care throughout Europe. However the evaluation budget for the five years is £30,000 (£6,000 p.a.).

### Services offered by the Health of Men Group

- Drop ins:
  - The Lad's Room
  - Bradford College
- Detached work
  - Pub quizzes and health checks within pubs
  - Health awareness days and events
  - The Barber shop initiative
  - Work with African Caribbean elderly men in working men's clubs
- Youth group work
- Work in schools
  - After school clubs
  - Anti bullying campaigns
  - Sexual health and relationship work
  - Boys health sessions
  - Work with teachers involved in teaching PSHE
- Employee health and well being initiative
- Housing project work
- Work with older men in nursing homes and rehabilitation sessions

- Setting up an allotment for young and older men to participate in its development
- Exercise groups
- Weight watchers groups
- Work with the alcohol services

All these projects are imaginative and developmental such as the 'The Lads Room', which is a drop in service for men aged between 12 and 25 run within a local information shop for young people in the city centre. It provides an opportunity for young men to gain help and information relating to their general health as well as matters pertaining to: sexual health; relationships; drug misuse; domestic violence / aggression; emotional health; sexuality; hepatitis C and diet and nutrition. The barber shop is another example of innovative practice. A South Asian health worker on the team has set up a health clinic in a barber's shop that is used as a meeting and social centre for ethnic minority men (including asylum seekers), He is seeing on average 10 men per session and it is usual to see up to a quarter of those being referred on due to previously un-diagnosed health conditions. The employee health and well being initiative in which the HoM group have set up health clinics in the council's Cleansing Department depots has seen a massive interest and usage by the men.

These projects, which are running across a wide geographical and socio-economic boundaries, offer a unique opportunity to explore and evaluate the effectiveness of the work being undertaken.

Traditionally projects are funded for a short period of time (1-3 years), with the expectation of quick results but studies, especially with projects involving young men suggest that it can take up to 3 years for a new service to become trusted. The longer term stable funding of this initiatives gives time to work with projects and chart the process involved in getting them established. It will also be an opportunity to discuss with users and potential users of services in different locations, different age groups and different ethnic origin what influenced their decision to either use or not use the new service.

## **Conclusion**

From our analysis of the literature we conclude that men are not good users of the health service. What is lacking is a detailed analysis of how men make decisions about their health and how those decisions link in with their health seeking behaviour.

There are 2 parts to this question – the first relates to an analysis of the decision making processes men employ when considering their health linked to an examination of the current services that are being offered by the HoM group and conventional services within Bradford.

We need to address the following key theoretical areas:

- The impact of masculinity on men's health beliefs and health behaviour
- Men's help seeking behaviour
- The intersection of age, social class, ethnicity and masculinity on men's health

Our aim is to create a model of decision making to help filter out the dynamics of successful access from the point of view of the users and the practitioners. The framework envisaged will be based on a model of negotiations that are influenced by masculinity and social and cultural pressures.

We wish to look at how the services that are being provided by the HoM group in Bradford mesh with this model.

- Do the men use the services differentially i.e. use the HoM for one health issue and conventional services for another?
- Do the men perceive the services as different, or the same but delivered in a different way?
- Is this a 'feel good' service or one that delivers a positive health advantage?
- Are the men who use the new services also using the conventional services?
- What are the barriers and facilitators to using either service?
- Are the new services used for non-normative health conditions?
- What are the characteristics of the men who use the new services?
- What are the benefits of the alternative services?
- Are they cost effective/efficient?
- What lessons can be learned for any potential modification of the conventional services?
- What are the longer term effects of using the new services?

We are not looking at 'is it working' due to the lack of controls; the large number of variables and the high degree of reflexivity that impact on the work that is being undertaken.

The study is intended to show 'work in progress' – highlighting what lessons can be learned, both positive and negative

The current evaluation is being designed under the philosophy of involving user groups and service users along with the HoM practitioners to develop an in-depth understanding of the processes that are at play within these new service initiatives and how they compare with conventional services.

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