

The Bradford & Airedale Health of Men Initiative: A study of its effectiveness in engaging with men



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Executive Summary

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Research Summary

The Health of Men (HoM) network received funding from the Big Lottery Fund in 2003 to establish a five year programme of dedicated work with men and boys. This enabled a team of practitioners to be creative and to build upon their existing skills to generate models of working with those men in the community that are usually seen as hard to reach.

The research which has accompanied of the work of team has explored why men use these new services and has demonstrated the following:

- Men do care about their health
- Men are willing and able to engage with their health when services are tailored to their needs
- Men from different culture groups and socio-economic backgrounds who are normally seen as hard to reach were accessed.
- A model encompassing a dedicated team working with men is worthy of further development

Much has been learnt from this project that has great relevance to the local Primary Care Trust (PCT), but has also proved a great source of information for the development of services to men on a Regional, National and International level.

The Research

The study was set up to run concurrently over the five years of the initiative, data collection commenced in 2003.

A qualitative methodology was adopted to gain an in-depth understanding of men's decision-making with regard to their health behaviour. Data collection included:

- Interviews with all the members of the HoM team
- One-to-one interviews and focus groups with the men and boys using the services
- Fieldwork during the delivery of services
- Case studies of seven of the services provided
- Interviews with key stakeholders

Findings

The research was focused onto trying to understand why men used these new health initiatives and to explore the work of the team.

The Men's Perspective

Talking to the men and watching them engage with the team brought home a series of key messages:

- All the men were aware that their health is important
- Getting to the Health Centre is a great difficulty due to work constraints
- The Doctor is a person you visit only when you are physically ill.
- Anonymity and confidentiality are very important, especially for the young
- When the team went out to the men it was appreciated and welcomed
- Once the men were with the Team they were very willing to talk about their physical and emotional health
- Men from different cultures and socio-economic groups were keen to engage with the team and their work.

The Team

Work with the team and through one-to-one interviews highlighted personal attributes that contributed to team member's ability to work with men in the community:

- Used a public health model
- Non-judgemental
- Able to see beyond the behaviour of the lads
- Non-threatening
- Creative
- Male focused
- Willing to wait for success
- Went to the men and the boys
- Able to use humour appropriately
- Realistic

The Team's Perspective

Interviews with the team members showed they had great empathy with the men they cared for and were able to identify key components of the men's relationships they have with their health and the health care service:

- Men do not develop the same relationship with their health or the health service as women
- Men are excluded from much of the current health promotion work
- Approaches need to be adapted for men of different socio-economic and ethnic backgrounds and for men of different ages
- Time is needed to develop services
- The service has to be marketed to ensure access is possible
- Incentives to get engagement are often needed

The Stakeholders perspective

A series of 15 interviews were undertaken with key stakeholders; the findings included:

- Men were seen to have specific health problems that were not being adequately tackled, which contributed to health inequalities
- All recognised the need for dedicated services for men
- Those working with the team appreciated their skills and did not know what they would do without them
- Managers could see the problems of integrating services into mainstream provision
- Being a service for men run by men was seen to be an advantage
- The team need to market their skills and their services more effectively to the wider audience
- Dissemination of what has been learnt is imperative

What has been learnt?

1. Men do care about their health
2. Tackling health inequalities in men from different socio-economic and cultural groups is possible as men will access health services for screening and preventative care if it is made available at a convenient time and place
3. Moving out from the Health Centre brings Primary Care to many more individuals, but men will attend clinics if given a medical reason or a specific appointment is made for them
4. Working with industry and community based services is effective at opening new avenues for the delivery of primary care
5. The time it takes to set up services is longer than for women due to the need for the credibility to be built up and 'word of mouth' support to grow. Incentives are often necessary to get the men engaged
6. Health screening alone is only part of the effectiveness of the service; by giving the men time to talk in confidence allows a much wider range of health issues to be identified
7. Anonymity is as important as confidentiality for young men
8. Practitioners engaging with men in their settings need specific skills
9. Male orientated resources need to be developed and tested
10. Having a team with a range of expertise enabled a broader range of activities to be supported

Further Information

For information on the evaluation and copies of the full report, please contact Professor Alan White, Centre for Men's Health, Leeds Metropolitan University, tel 0113 8124357; Email a.white@leedsmet.ac.uk

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1.0 Preamble

The health of men is increasingly seen as problematic and is recognised as an under-researched area resulting in a weak evidence base for practice (White 2006). The number of new projects and initiatives that are being set up around the country is increasing rapidly as a response by practitioners to the relatively poor health of men (Kierans, Robertson & Mair 2007). Within Bradford and Airedale, the Health of Men initiative provides a rich opportunity for research to enable lessons to be learned about what works and what does not work when setting up projects with men.

1.1 Context

In 1997 four health professionals started to collaborate on providing community based services for local men. This group expanded under the name 'Health of Men' (HoM) and in 2002 they submitted a successful £1 million grant from the New Opportunities Fund, which is now known as the Big Lottery Fund, to establish a Healthy Living Centre focused on their work. This grant, along with matched funding from the then four local Primary Care Trusts (PCTs), enabled each PCT to employ a full-time "key worker", a full-time 'half post' based in the Bradford District Public Health Partnership and 2 staff from 'Worksafe', a voluntary body which focuses on safety advice for young people. Each PCT also provided additional support to the project as their "in-kind" contribution. In one PCT this includes two additional dedicated "key workers". Though the team members were located within each of the four existing PCT's HoM runs as a cross city initiative.

This initiative comprised the largest single funded study on men's health in the UK and offered a unique opportunity to examine the gendered provision and use of health services to better understand how to provide for the health needs of different groups of men in the future, in Bradford, nationally and internationally. Since 2004, the Centre for Men's Health, at Leeds Metropolitan University has been conducting research on the HoM service. Researchers from the Centre for Men's Health have been following the initiative for the last three years to provide an insight into the views of the team, the men using the service and the stakeholders on the work undertaken and through field work and interviews provided an overview of seven 'cases' to represent the spectrum of provision provided.

1.1.1 Background

Two recent studies on the state of men's health (White & Cash 2003, White & Holmes 2006), which explored a wide range of disease conditions, have shown that when the mortality statistics for men in comparison to women are considered men are seen to

have a shorter life expectancy and that this was not just a result of the expected causes, such as accidents and coronary heart disease, but rather that men were dying sooner from the majority of conditions that should have affected men and women equally.

There would appear to be three main possibilities as to why men should be at so much greater risk of premature death (White & Cash 2004):

- 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 in 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. In 2002 the Men's Health Forum ran the first Men's Health Week with 300 events staged across England and Wales and in 2007 over 3500 events were registered. Scotland 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. Preston has run an extensive programme of work on men's health (Kierans, Robertson & Mair 2007),

Underlying this work is 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.

1.1.2 Men's usage of health services

The common impression is that men under-utilise health services 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). This study took the form of a wide-ranging survey of key individuals and organisations that have a role in the care of men. The key findings of the study suggested that their 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.

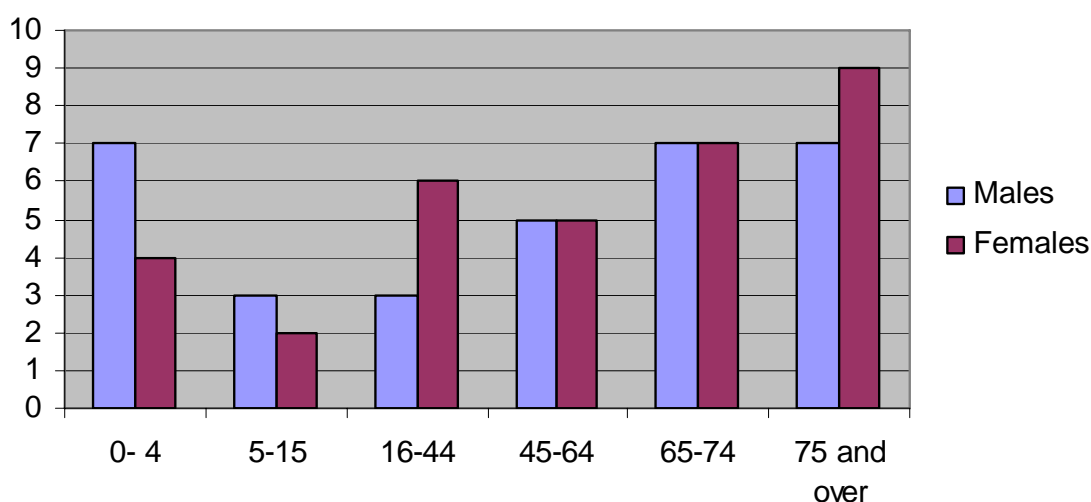
The main reasons cited for the delay in seeking help included:

- A lack of understanding of the processes of making appointments and negotiating with mainly female receptionists
- Opening times that 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, colorectal 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 attendances of men at the GP increases until they mirror the number of visits made by women (see figure 1).

Figure 1 Average number of NHS GP consultations per person per year by sex and age, 2002

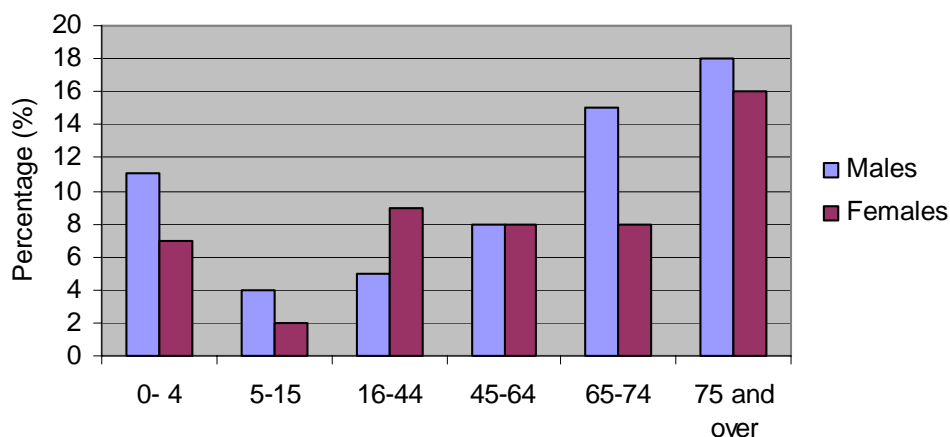


Living in Britain, 2002 National Statistics

There are socio-economic variations in the access to health services (ONS 2003), with a higher proportion of men from blue collar occupations attending the GP than men in professional roles. 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 2004, White 2007a,b).

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



Source: Living in Britain, 2002 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 2000), 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 2001). (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. However, these studies 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, the weight of articles stating the men do have difficulty with regards to their health behaviour this area warrants closer examination.

1.1.3 Masculinity and men's health belief's and behaviour

There is limited empirical research on men's health belief's 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.

Male characteristics related to health include: independence, pride, inner strength, competitiveness, achievement at work, success, self-control and physical strength, power and a feeling of invincibility (Newman (1997)). When these characteristics are coupled with Saltonstall's (1993) findings that for men health is related to being in control of your body, with action, function and capacity of the body of prime importance it can be seen that not only is health and help seeking seen as a threat to the man's masculinity but 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. Furthermore, 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 on 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 (2002) 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, a view supported by Umberson (1992) who found that 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. Kristiansen (1989) in a study exploring the meaning of illness found men had more concerns over what the consequences of the illness may have with regard to work and family security, an issue that may prevent men from accessing health services.

More recently there have been a number of key studies that have explored men's relationship with their health and with help seeking (White 1999, 2000, White & Johnson 2000, Robertson's 2003, 2007 Galdas et al 2005, Galdas 2006, O'Brien 2005, 2006, Richardson 2007) and what is emerging is a complex picture that recognises that men do have different ways of looking at their health to women, but that there are also issues in relation to how men differ between themselves as well.

1.1.4 Bradford and Airedale

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 and Airedale, 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).

1.1.5 Health of Men

Established in 1997, the initial network of four practitioners expanded following the successful grant application to a team of key workers from a variety of different backgrounds including nursing, health promotion and health care support workers; and the staff of 'Worksafe', a voluntary body which focuses on safety advice for young people. The team includes a business manager and administrator. The work of the team was supported by The Big Lottery Fund. Originally known as The New Opportunities Fund which was used to create Healthy Living Centres. The purpose was to target the most disadvantaged sections or groups of the population and address the

wider determinants of health and health inequalities, such as social exclusion, lack of access to services and socioeconomic deprivation.

The Overall aim of HoM is to:

“to encourage and facilitate the development of health promoting and illness prevention services, which are accessible and attractive to boys and men.”

The ethos of the team’s work was that it should be:

- Holistic in approach
- Preventative
- Inclusive
- Cross-boundary

1.1.5.1 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 an example being '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 for 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.

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 initiative 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.

1.1.6 Summary

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.

- 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?
- 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. But we are seeking to determine the underlying factors that impact on men's decision making when it comes to seeking health care and how this influences the development of services for men, both in conventional settings and through outreach.

2.0 The Study

2.1 *Methodology and research design*

A methodological challenge that was present within this study was trying to capture the impact of the relatively small scale but numerous focused initiatives within a broad range of population groups and locations. It was recognised that the commonality between the majority of the services offered was that the boys and men had to make a conscious effort to attend this new provision¹. There was a numerical analysis of usage being undertaken as part of the audit required by the New Opportunities Fund and then the Big Lottery Fund, this study was felt to be better placed in trying to understand from the perspective of the HoM team, the users of the service and the Stakeholders what it was that made the men use these services as opposed to conventional services.

To achieve this a qualitative approach was adopted utilising interviews and field notes based on field work within each of the sessions followed up. Each project was documented as a separate case, while conducting the research. The projects were tailored to the site, or sites, where they were delivered and, subsequently, the research conducted is outlined along with a description of the site where the project was run. While some of the stakeholders were involved with specific projects and/or sites, others were involved in different capacities so the stakeholders are also discussed as a single group.

2.2 *Data collection*

Two main methods of data collection were undertaken: observations based on fieldwork at the site of the projects and interviews, both formal and informal, with the men using the services and the HOM Key Worker's practitioners themselves and the stakeholders in the service`. The initial intention was that formal and informal interviews would be undertaken at each site with field notes also taken, however the reality of each setting was different such that it was not possible to undertake the same form of data collection. This has resulted in different forms of presentation of the seven cases.

¹ The exceptions, i.e. puberty and anti-bullying talks with boys, were provided within school time and have been omitted from this study as there was not a conscious decision on behalf of the boys to attend.

2.3 Observations

Where possible non-participant observation was used to collect data relating to the context within which the services were offered and to capture data relating to the interactions between the men using the service and the HOM staff. Informed consent was obtained from all who utilised the services, with anyone not wishing to participate in the study having no records kept of their involvement in the services provided.

2.4 Interviews

The interviews were intended to elicit an understanding of the reasons why the men chose to target this health opportunity therefore the questions were focused onto their decision making leading up to accessing the service.

Within each location it was hoped that approximately 12 interviews with participants would be undertaken, however as the study progressed it became apparent that in some settings, i.e. the barber shop and the youth centre, that individual interviews were not feasible due to the constraints of the environment, so the data from the field notes and informal conversations became the basis of the analysis.

Where it was possible to interview, the questions for the users of the service were based on three areas:

- Men's awareness of their health needs
- Men's access to health services
- Men's perceptions of the services under offer

The first two areas related to the context in which the men are making decisions around their health and the third area relates to their satisfaction with the new service under offer.

The HOM Key Worker's who are employed through the Big Lottery Fund or through Match funding were interviewed along with three other practitioners who have close links with the Health of Men team. All have a wealth of experience and knowledge relating to the provision of services targeted at men, in terms of these specific projects and in general. The intention of the interviews was to illicit this tacit knowledge.

Interviews were also undertaken with a range of stakeholders who were involved in the development and management of the project.

The interviews were taped, transcribed and then analysed following established social science procedure following the constant comparative method as outlined by Glaser & Strauss (1967). The data was managed using the QRS NVivo software programme.

2.5 Ethical & Research Governance issues

Ethical approval and R&D contracts were completed by May 2004. In line with the proposal submitted to both committees all those involved in the study, either directly via an interview or indirectly through the field work were informed of the study and their consent gained for inclusion. The information sheets relating to the study were given to all those who were interviewed and were freely available for the rest. Written consent was obtained where possible, but with the transient nature of much of the work verbal consent had to be accepted on many occasions.

2.6 Description of the sites

Seven sites were focused on during the study. They were chosen as they represented the breadth of the work undertaken by the Key Worker's: the Lad's Room; The Council Depot MOT drop-in; the Barber shop drop-in; the evening health classes run for the lads at the Youth Centre, a weight loss group in a Council Depot, health MOT's run within a Health Centre, and the work undertaken within the Teenage Information Centre Teenage Advice Centre (TICTAC), run within a school setting.

2.6.1 The Lad's Room

The Lad's Room is a facility set up by one of the Key Worker's of the HOM team in the 'Information Shop' located in the centre of Bradford. The Information Shop is a council run information centre for young men and women and provides help and support across a wide range of issues, such as job seeking, further education, CV development. The provision is mainly aimed at boys aged 15-25 years of age but boys as young as 11 are known to use the service and so do some older men. On a Tuesday and Thursday afternoon one room is made available for young men to use the facility as a 'drop-in' for health advice. This is a popular service having been established 4 years and in 2003 was used by 1,674 young people.

Eight sessions were attended with a total of 16 hours of field-work completed with 15 Interviews undertaken with 6 South Asian Males, 10 Caucasian Males, 2 Afro Caribbean Males, 2 Caucasian & 1 Afro Caribbean Girls. Ages ranging from 14 to 27 years. 2 group discussions were also held.

2.6.2 The Youth Club Initiative

As part of the work being undertaken with young disadvantaged men a series of evening sessions on health are undertaken by one of the Health of Men Key Worker's in partnership with the Youth Team with a group of lads at a Youth Centre on an inner city estate in Bradford. This youth centre is open each evening for boys and girls up to the age of 19 years.

There were six lads participating in the group and a total of five sessions were attended with field notes made of how the lads interacted with the sessions and one short group interview undertaken

2.6.3 Council Refuse Collection Depot

Organised with the Bradford Metropolitan Borough Council the HOM Key Worker's visit the depot of the Council Refuse department in order to carry out health checks [known as 'MOTs']. These are now run as a regular service offered at 6 month intervals.

One session was attended, with 12 semi-structured one-to-one interviews carried out with the men who attended for a consultation.

2.6.4 Barber Shop

The Barber Shop initiative runs weekly from a Barber shop in Bradford and comprises a bi-lingual Health Support Worker who is a member of the HOM team working alongside a qualified Key Worker offering health advice and screening to men. This Barber shop is situated in a predominantly South Asian part of the city and acts as a 'community centre' for many of the men, who meet there to chat and read the newspaper.

The Barber shop initiative has received a lot of publicity and is seen as an important opportunity to engage with the local male community and especially men from the ethnic minorities and asylum seekers.

Two field trips were made to the barber shop sessions, with informal interviews conducted with the men taking part in the sessions.

2.6.5 Parks & Landscapes Council Department Weight Management Programme

A development on from the MOT's held within the Parks and Landscapes Council Department was the running of a series of weight management programmes for the men.

Six sessions were attended with field notes made and semi structured one-to-one interviews with the men taking part.

2.6.6 Health MOT's within a Health Centre

The team have established Men's Health Checks within a Health Centre. These run as two sessions a week.

Three of these sessions were attended with semi structured one-to-one interviews undertaken with the men waiting for their appointment.

2.6.7 Teenage Information Centre Teenage Advice Centre (TICTAC)

TIC TAC is a National initiative aimed at bringing a 'teacher free' environment, staffed by health professionals to provide help and advice for secondary school pupils. This service, based within the school grounds, has been supported by members of the HOM team for a number of years, with one-to-one drop in sessions.

The aims of the project are to provide information and advice about personal, social and health issues to school age children. Young people have an opportunity to discuss issues which are important to them in a safe, confidential environment, either in groups or individually. Issues previously covered by users have included sexual health and contraception, drugs, alcohol, smoking, healthy eating and diet, and relationships. The group also provide health promotion literature.

The HoM team provide one worker for one session each week at lunchtimes in school term time.

A series of six focus groups were conducted, one each for years 5 to 11 and one with representatives from years 12 and 13. Each focus group had between 5 and 8 boys present. Interviews were also held with the TIC TAC coordinator and the HoM team members.

3.0 Findings

This section will present the main findings from the interviews with the Health of Men Key Workers, the seven sites and the interviews with the key stakeholders.

Each sub-section is organised in accordance with the key themes that emerged and includes the analysis of the interviews with the men, the field notes and any interviews or conversations held with the Key Worker running the events.

The findings are supported by quotes, which have been left anonymous and by Field Notes.

3.1 *The Interviews with the Health of Men Key Worker's*

The HoM team comprise key workers from a variety of different backgrounds: nursing, health promotion, and health care support workers. The team tend to have their own areas of expertise, but regularly join to support each other on activities that can be seen to be cross-cutting.

A series of ten semi-structured interviews were conducted with the team at their place of work and lasted between 45 and 65 minutes each. Findings from these have been combined with the extensive fieldwork undertaken whilst the men have been engaged in delivering services.

3.1.1 The attributes of the Key Worker's

During the analysis it became apparent that it was not just what the individual Key Worker's did that was important, it was how they did it. It was realised that the personal and professional attributes of the individuals needed to be integrated within the synthesis of all factors affecting the success of the operations.

3.1.2 Background of the HOM group

It is interesting to consider the professional background of the various Key Worker's as they are all pioneers of this work. What emerges is that they all have wide experience of working in settings that involve a high degree of autonomy suggesting that they prefer to practice in a non-routine independent way with a wish to work 'outside the box' – they did not seem tied to the medical model but had more of a public health perspective in their dealings with other health professionals and the men and boys they came in contact with. Many of the Key Worker's also recounted personal or professional experiences of where the health of men had been problematic and how this had had a big impact on their decision to start working with men.

3.1.3 Personal qualities

A strength of the Key Worker's was that they seemed to be able to gain the confidence of the men and to be accepted as individuals that could be trusted – this seemed to be based on their ability to make themselves non-threatening to the men and was summarised by one Key Worker as 'deference' - the use of smiling and the use of appropriate humour to break the ice, whilst maintaining a professional affect. This

adoption of a certain negotiation style enables them to enter environments that others using a more traditional approach would find difficult.

“This chap said to me, “I think if someone told me that if I don’t stop [smoking] I will die, then I would stop” so I said, “Okay, if you don’t stop you will die!”

The Key Worker’s see that it is important to be non-judgemental and able to see the man’s perspective. In part this is through being committed to the boys/men but also not being tied to a medical model of seeing the men as patients with problems and a willingness to ‘walk in the men’s shoes’.

“When I have done group work with men it comes across to me that we are ordinary blokes and ordinary blokes is what ordinary blokes relate to ...”

Their success was also influenced by the imaginative ways that they assessed the need and created the chances for health care to be taken to the individual.

There were, however, no illusions present and they realised that the work they were involved in was not easy and was not always welcomed by the men themselves or the organisations that needed to give permission for the Key Worker’s to gain access to the men. A further emerging characteristic therefore was persistence. The way the Key Worker’s talked about how they would have to sometimes wait long times for them to become either invited into a setting or to be accepted by the local boys or men displayed a great tenacity and an unwillingness to ‘give in’. This though was tempered by a realism that if they were not making progress then they would stop.

3.1.4 Men and their health

A variety of health issues were identified within the interviews as being particularly problematic for men, the issue of prostate and testicular cancer, hypertension, diabetes etc were noted, but mostly these were within an educational or screening context rather than from a treatment perspective. Indeed the Key Worker’s tended not to discuss men’s health in terms of disease processes or life expectancy, more in terms of lifestyle and public health issues in relation to smoking, alcohol and drugs, for instance.

The Key Worker's did recognise that there was a difference between how younger men and older men saw their health and that there is a tendency for men to take the body for granted until age became a factor.

The Key Worker's discussed the difficulty of men in sharing their health concerns with their friends.

... this guy came in, on a pre made appointment and his mate was outside taking the mickey out of coming in. And as soon as he'd gone, his mate popped in, "Can I just ask you about so-and-so?" ... so I think it's just typical bloke stuff; rip the mickey out of you then ask you what you're doing and then if it suits they'll ask you a question."

What emerged very strongly from the interviews was that men do care about their health, whether it be their physical health, sexual health, or emotional health. Men are also more than willing to discuss issues such as fatherhood, relationship problems and other broader issues as well as their physical health. The problem was that they saw the men lacking the opportunities to discuss these concerns with health professionals due to their perceptions of the health service as a place you went to when you were 'poorly' or due to the social constraints on them through being a man.

A further worrying feature was in relation to how limited they felt men's understanding of their health and health needs were and how many misconceptions surround the most common of conditions and that they have to educate men over issues such as in relation to personal hygiene or the male specific cancers. These were in part a consequence of number of factors ranging from lack of education on men's health at schools, failure of parents to cover basic health education with their children, men's unwillingness to discuss health or personal problems with friends or work colleagues for instance. There were also worrying concerns over the lack of appropriate role models for the young lads as in some areas it is the drug dealers who they look up to as they have the good cars, the available cash and the exciting life style.

3.1.5 Men and their emotions

In relation to the emotional health of the men and boys there were issues raised in relation to their feelings and how they manage difficulties in their lives ranging from stresses involved at work and through unemployment, to bullying at school, divorce, fatherhood, and mental health problems.

One of the Key Worker's talked a lot of the challenges in managing men with emotional problems. He recounted men who had difficulty in discussing how they felt, instead tending to talk about what they were thinking. He also noted that once men acknowledged there was a problem that they could talk about it, but it came at a cost with the recognition that by not talking they had been able to hide it away but with it being released then they had to face up to it as a reality.

3.1.6 Men's usage of the health service

When asked why they felt that men were using their services and not going directly to the Health Centres they reported that the majority of the men who used the services seemed to be directed to the benefit of easy access within their own environment – their 'comfort zone' [this is developed in Section 4]. The men did not see the GP as a place they felt comfortable taking the kinds of issues that they were seeing the HOM Key Worker's with. This lack of willingness to access conventional services they saw as being based on many issues, which included the perception that the G.P's were an 'illness service' where you went when 'poorly'. They also identified an anxiety in some of the men that the GP's were too close to their families, such that there was a strong possibility that parents or others may get to know you have been there.

The Key Worker's also picked up on the men's reluctance to 'bother the doctor' with what they perceived to be trivial or potentially embarrassing problems. However another aspect that they reported on was related to the men's lack of confidence in the doctor's ability, with a 'what do they know?' mentality being present.

What emerges is that men tend to have a pragmatic view of seeking health care. A common response was that they would 'go if it was needed' but the tendency was to 'see what it's like tomorrow'.

"... women get in the system much earlier, women use it when they are well, blokes go when something is wrong and as such they fail to see that you can access the service at other times, for health checks or health advice for instance".

The Key Worker's recognise that though the men are concerned about their health they lack the understanding of how the service works such that there is a fear that their condition may not be sufficiently bad enough that it warrants attention from the doctor. Many of the Key Worker's talked of how men would worry that they would be 'wasting

the doctors time', especially as they knew that the service was over stretched and their attendance may be taking the place of someone in greater need.

"...you know guys will come in to see you and the classic stuff. They don't want to waste the GPs' time, they feel as though they go and see the doctor when they're feeling well they'd be a complete fraud really. But once they've seen you, and whether their blood pressure's high, or whether they're obese or whether they putting weight on, whatever, they feel quite justified in going to see the doctor or the practice nurse or whoever. But you know, in either case people will pass the GP to come and see you at a drop-in somewhere, and then happily go and see the GP."

"They say that they don't want to waste the doctor's time, doctor being very busy, service is very stretched so if they go then someone might be not be able to. They feel they are a bit of a nuisance"

They also expressed the concern some men had in terms of the possible response they might receive if the problem was not deemed important. The ability of the service to make you feel guilty when trying to make an appointment and the ridicule some men report when they express a concern, for it to be treated as inconsequential by the member of the health care team makes some men reluctant to go through the process.

"... they find it hard to go to say "Well, I'm feeling fine but could you just check my blood pressure?" or "I'd like my cholesterol checking." And then sometimes maybe the response they've had in the past from, whether it be a nurse or a doctor, as in "Well, you're OK, you don't need it doing." Rather than going into the various risk factors with them, it might be "Well, you don't need it doing now." And they tell them not to worry. Do you know what I mean? They never seem to be encouraged to take a proactive stance in their health whether that's unintentional from the non-verbal signs they pick up from the nurse or the doctor that they go and see".

However the impression gained from the Key Worker's is that once a problem has been identified and they have been diagnosed with a problem then they seem willing to go to the doctors. However there was also the recognition that for some men the fear of what the doctor might find was also a serious impediment to going to the doctors, as was the realisation that they would lose control of their health 'once you are in the system you [the patient] are not in control' was how one member of the team expressed the anxiety in the men he had cared for.

There was another side to control, which related to how men behave in relation to managing the health consultation and how this was a feature of age.

“I think older men are more confident in their defences – they have worked for a long time – I’m thinking of this bloke who came to see me when I was doing the drop ins at [Chemist] in [local town] and he came in and controlled the whole thing, “ I want you to take my blood pressure I’ve had it taken a week ago I’m just checking I know all about it” and he told me all about his health and I said I was wondering why he was there and he was telling me what he wanted me to say to him

AW That’s the controlled bit isn’t it – that does not occur with youngsters?

“Well it does but they are not very good at it; they are learning how to do it but older blokes are better at it. Young lads they can sometimes do it and sometimes not – you poke them enough they get angry cos they have lost that control ... and they tend to do it as a pack as well; they share control between them, so they use the jokes and all these little catch phrases between them you know its like a ripple effect going from one to the next they are all getting strength from this – the joke or whatever it is going on and its like a defence whereas older men dig up ... or they internalise it. “

A feature that also emerged from the interviews was that doctors tend to deal with one problem that presents with the patient, but men usually have more than one and that it can take time for some of these to emerge. Such that when they are with the men in a longer consultation problems are revealed by the men that would probably not have been in a shorter doctor’s consultation. This is not helped by men’s tendency to somatise mental health problems (i.e. presenting with a physical problem (stomach complaint) when the cause may be emotional (divorce).

3.17 Gaining access

Once the men have made the decision to go to the doctor the next difficulty the Key Worker’s feel the men seem to have, is in gaining access to the doctor’s in the first instance.

“... the service makes you feel guilty if you try to get in to see someone”

With the Key Worker's recognising the problems some men had with Health Centre receptionists 'the lion on the desk' who are seen as difficult gate keeper's to get past to get to the doctor the HOM team are now working with receptionists to help them understand men's different way of using the health service.

"They [health centres] really don't fit in the way that men like to work, men make more snap decisions. They worry about this ache or pain and the time that they decide to do something about it they want to do it there and then, and they will never get that spontaneity in the health centre"

A recurring feature from the interviews was that to get to see the doctor at the health centre there was a need to make an appointment and that the service for many men was just not accessible, either the location or time of services. For the man at work it was felt very difficult to get the time off work to get to see the doctor.

"You say to your employer that you want some time off to go to the doctors, the first thing they will say is, 'why, what's up?' And often this is in an open area, not all bosses would take you into an office, shut the door and have a one-to-one chat, it depends on your relationship with your managers but for many men the boss is still the boss and he has a lot of control over what happens in your life. So any signs of weakness ... say there is redundancy and I have been to the doctor three times in the last couple of months, are they going to find a way of getting me out, am I at risk of getting sick. It reflects on men's ability and their vision of themselves".

With Health Centres closing early and not opening at the weekend there appears to be increasing barriers to the working man accessing clinics. This is a specific problem with men as they are more likely to be working full time, more likely to be working over 48 hours a week and are less likely to have a job that involves flexi time (DoH 2004).

This feeling of being unwelcome at the health centre seems to extend to other aspects of the service:

"If you run parent and toddler groups you're really running a mum and toddler group, men know that they are really not invited".

It was also seen in the lack of usage by men of the Family Planning services.

3.1.8 Men will go to health centres for health checks

However when a service is set up for men and men recognise it as a place for them then they will use the health centres for health checks. The Airedale and Keighley Key Worker's run a men's health clinic at the health centre every week, which is run on an appointment system. When it was first advertised only one man booked in. According to the Key Worker's there was mounting pressure for them to close the initiative down from the health professionals at the centre who saw it as a waste of resources, but the Key Worker's persevered due to the belief that they have got to be there in case someone turned up. They justified the time by taking other work that needed to be done to complete whilst they were waiting. Having re-thought their strategy they changed the posters, to display a large glass of beer, with 'Free' on the top and 'health checks for men' in smaller print underneath. The response to the service changed very quickly with now around 14 men being seen by 2 practitioners in the 2 ½ hour sessions and whereas the service was run fortnightly it is now run weekly with additional sessions being planned to cope with the demand.

"they came and they are still coming back, and we are having them coming back for yearly appointments and making appointments, whether they are doing it themselves or their partner makes them doesn't matter at least they are remembering that they were there a year ago and are making an appointment to see us. Also we are finding the men are taking away information for their son's."

3.1.9 Ethnicity

There are many groups experiencing problems with health inequalities and exclusion but the interviews highlighted specific issues in relation to those from different cultural backgrounds.

The Key Worker's have worked with the South Asian Community and African Caribbean older men and through the interviews carried out, issues as to how these groups can be targeted have emerged.

For the South Asian men it was found that by linking in with the Mosques and getting the agreement of the religious leaders was a good way of gaining access to the men. With this tacit approval the Key Worker's found that the men were more willing to listen to what they had to say. However there was a long process of reassurance needed by the Religious Leaders as there was concern that the material would not be suitable for such a setting, especially with regard to issues relating to prostate disease or testicular cancer with the 'sex' organs. By referring to 'men's specific problems' and also engaging with the leaders themselves with regards to problems they may be experiencing allowed them to appreciate what was being covered.

For the sessions run for younger men in the religious settings, discussions relating to sexual health messages were problematic and a successful approach has been to discuss the sexually transmitted infections and the consequences of unprotected sex rather than offering advice on contraception. For the younger men who are accessing the Lad's Room or in class room sessions there do not appear to be the same difficulties and they were willing to discuss sexual health issues.

Older men from the African Caribbean community were noted as being particularly reluctant to talk about issues that were related to the 'sexual organs', which made work around prostate cancer difficult. This was compounded as the age of the health care worker was also a problem for the men 'you're just a young man what do you know about older men's problems' being a common response to suggestions to talk about health.

The success the Key Worker's have had with this community is through persistence and also a willingness to get their respect and trust. In part this was achieved through joining in with common pastimes such as playing dominoes with them for a couple of weeks before suggesting that they have a chat about health before they play.

3.2 The Lads Room

This service has already been the subject of a formal evaluation, which took the form of interviews with men who were using the service. This evaluation concluded that there was a high level of satisfaction by the users of the service. This study adds to this evaluation through the use of Fieldwork to capture the lad's behaviour as well as perceptions with respect to using the services.

Eight sessions were attended with a total of 16 hours of field-work completed

15 Interviews undertaken with 6 South Asian Males, 10 Caucasian Males, 2 Afro Caribbean Males, 2 Caucasian & 1 Afro Caribbean Girls.

2 group discussions also held.

3.2.1 Getting to know about the service

When the lad's were asked how they became aware of the service most of the lads got to know about through word of mouth and knew of friends that had been before. The Lad's Room was also mentioned as part of the sex education lessons at school. There were some that had first realised the service was there when they visited the Information Shop, but no one mentioned any publicity material.

The majority knew the service as a place to get condoms and therefore it is not generally thought of as a place where you would take other health issues. This would seem to limit the potential of the service, or may need to be acknowledged and accepted as its principal purpose.

Many didn't know that the service was being delivered by a nurse, which again may limit the range of non sex related health queries.

3.2.2 Benefits of the service

Many benefits were identified by those interviewed and ranged from the location and freely accessible nature of the service to specific comments relating to the advice and guidance offered.

A key aspect that stood out in many conversations was the availability of free condoms and that no appointments were necessary. The service was seen as friendly and young person centred with the opportunity to choose the condoms that they wanted being seen as a major benefit.

The location was a major factor in its success. Being in the centre of the city many were able to access the service during breaks from work or as they were passing by. Not needing to make an appointment added to this sense of ease of access.

Some of the advantages are that the Information Shop is a service that is used to dealing with young people and therefore they feel welcome and there is a more relaxed atmosphere:

'everyone is very relaxed, they are all pretty cool about it" 20 year old Afro Caribbean Male

"Lot more convenient, lot of people use this of my age, don't have to worry about it being spread about - totally confidential, very good people, I would advise anybody I know to come here." 18 year old Caucasian Male.

Many of the positive comments related to the attributes of the Key Worker who runs the service:

"He makes you feel comfortable"

"It is the way he listens to you"

"You feel like you have got a friend"

"Sound guy, trust him," why? - "I've seen him before; he is the kind of guy you would get along with".

A down side to the service was that it was primarily seen as a sexual health service, with very few considering using the Lad's Room for other health issues.

3.2.3 Teaching about condom use

Discussions with the Key Worker reveal that a key aspect of his role is ensuring that the lads are aware of how to use the contraception correctly. He has a condom demonstrator that he uses to demonstrate how to put the condom on and is willing to give lads he knows are not in a partnership condoms so that they get use to opening the packets and developing the dexterity to put them on.

All the lads interviewed said that the Key Worker had taught them how to use the contraception correctly.

"How to put condoms on - useful - but I still get it wrong now, I am too randy me, and it either goes on or it doesn't. If it doesn't go on it doesn't go on. I know how to put it on, it's just I am in a rush to get it on when you're horny" 18 year old Caucasian Male

There is a need for a lot of tact in the teaching of the most appropriate contraceptive:

FN² "One pair of lads came in and I gave one lad the trim condoms and on the way out his mate said, 'he's given you the small ones, he must think you have a small willy'. The lad came back and threw them through the door and walked off. I called him back and said to him, 'is this too small for you (as he said this he had taken a condom out of a packet and he stretched the opening) or is it too short for you (and again demonstrated by stretching the condom how long it could be)? I told the lad it was for better sensitivity rather than being 'small'."

² FN – Field Note

3.2.4 Asking for condoms

When asked where they went for contraceptives if they did not get them from the Lad's Room there were a range of places suggested, from the pharmacist to pubs and supermarkets. It appears that some of the lads have no problems in asking for condoms, but others find it embarrassing:

"It is different [at the pharmacist], you have to pay, [and it is] not like in here, you get some and they are like, 'oh we know what you are going to get up to', you feel uncomfortable" 20 year old African Caribbean Male

"Going to Boots - you get embarrassed. People know what you are going to be doing, 'they might think you have got something as well'. Might think you have got a bird and you haven't got a bird" 18 year old Caucasian Male

I asked if they would consider going to the Family Planning Clinics and it was apparent that very few of the lads had considered this as an option, whereas the girls all knew about and used the service.

"Family planning clinics? - I would if I knew where they were - are they in chemist"? 18 year old Caucasian Male

"better come in here rather than family planning, it's all right, but there are too many people and you are waiting too long and you don't necessarily get what you want from them, they might offer an alternative, but they don't really have a lot there".

AW – [the Key Worker] has a better choice?

"Yes, but they just give you what they have; there is no choice, but [the Key Worker] offers what you need". 25 year old South Asian Male

This is a feature that distinguishes the service from the others on offer - the discretion the Key Worker seems to have to give out more than usual number of condoms depending on circumstances of the individual and of having a choice of different types.

3.2.5 Managing the lads

One aspect of the Fieldwork and from the conversations with the Key Worker was in respect of how the lads were managed. The majority of the lads who used the service come with their mates, either in two's or in larger groups. From the fieldwork observations it was apparent that there were different scenarios being played out by the lads as they came into the Information Shop to use the Lad's Room. Some were very confident and had a very 'matter of fact' approach to the service:

FN "Young lad, school uniform, went straight up to reception and said, "I want to see the man about the condoms'

Others were more hesitant, wandering around the information shop for a while before asking to see the Key Worker, or being asked by the Key Worker if they wanted to see him.

When the lad's came in in groups it was more challenging and the Key Worker rarely saw all the members of a group together as they would 'mess about' or would be reluctant to talk in front of their friends about issues they were uncertain about. However this was not always the case and one exception the Key Worker related was of one lad talking about his premature ejaculation in front of his friend.

This issue of dealing with boys in groups as opposed to individually was mentioned by another member of the team within the interviews reported on earlier. He was happy to see the boys in pairs but also noticed a mark difference in their behaviour:

"I do the 'TIC TAC' Services³, Keighley and quite often boys would come in pairs and they would just make jokes between them and ...

AW - Do you try and separate them?

No because that's not the point the point is that they come in and they come in how best they come in – some of them came in by themselves much quieter the

³ Teenage Information Centre, Teenage Advice Centre

ones who come in by themselves – much less willing to talk you had to drag things out of them like ‘what have you come for?’ – ‘I’ve come for condoms’ ‘do you know how to use them?’ ‘Yes’ ‘do you want me to show you?’ ‘Alright’; whereas the boys who come in pairs they have this banter going between them ‘oh he thinks I’m doing this’ ‘yeah but I am just shagging’ ‘yeah yeah’ “he has just shagged his mum him” “no he doesn’t shag” – yeah yeah – there is that kind of going on...

AW - It’s a bravado thing isn’t it – it’s a show – but the self confidence of the boy by himself, does he become less articulate?

...Dragging stuff out of him”

3.2.6 Aspirations of the Lads

The reasons why the lads were seeking the contraceptives were not included in the questions asked during the interviews, but what emerged from a discussion with a South Asian Sexual Outreach Worker, working specifically with Asian young men who was that many Asian men will use condoms not for protection but to avoid getting the girl pregnant, which will cause them a great deal of trouble with the father and brothers of the girl.

3.2.7 Other sexual health issues

Whilst the majority of those interviewed saw the service as being predominately about condoms there were some that said that they had talked to the Key Worker over their worries over HIV and AID’s. It also appeared that some used the Key Worker for advice on other issues relating to sexual health:

FN “[the Key Worker] reported on a lad who told him about one of his female relatives whose partner had gone off sex and she wanted to give him Viagra to see if that would help. [The Key Worker] said he pointed out the potential health risks of taking Viagra and the legal implications of giving someone a drug without them knowing”.

3.2.8 Non sexual health issues

When asked if they would use the Lad's Room for other health issues it was apparent that many of the lads had not considered this as an option, which may be an issue that needs to be addressed in terms of its publicity and how it is presented to the boys when they use the service. There were lads who did use the Key Worker for advice and to discuss other issues and for some he offers help that they do not think is available elsewhere.

"AW - would you talk to your mates about your problems?

'Naw' not what I talk to [the Key Worker] about'

AW - so where would you take them if [the Key Worker] wasn't here?

'I don't know, I would just leave them' 25 year old South Asian Male

"I ended up telling him about a past girlfriend and he actually listened, instead of being someone who kind of dozes off instead of listening to you, he asked me if I used contraception and I said I do apart from this one time and I got a girl pregnant and she's now got a kid, of mine, and has an injunction out on me as an unfit father. He asked if I was coping alright, and I said it's a case of having to...But if you can get classified as an unfit father by providing for the person you're caring for and your kid, all I can say is that rule is crap.

AW - Did you feel [the Key Worker] helped?

"Oh yes definitely. I will come and see him again; it is good to have someone else to talk to apart from my friends. I need to talk to some strangers, but I don't think I could go to a psychiatrist, I don't think I am that far gone yet."
[Laughing] 22year old Caucasian Male

However a further issue is in relation to the reluctance of some of the lads to accept that they would discuss any health issues anyway.

FN "I ask him if he would use the service for any other health issue

'I asked about pregnancy, but not any other problems, just about sex, I am not that open, I will talk to my friends if it is necessary... girls have the emotions' 17 year old Afro Caribbean Male

3.2.9 Using the doctors

All those interviewed were asked why they were using this service and had they considered going to the doctor instead. The responses suggest that the majority had not considered using the doctor for advice on sexual issues or for getting contraceptive advice or condoms. There was also an issue in relation to who the doctors were and the difference in the way they were accessed.

Who the doctors were was very important as it seemed that there was a fear that if they disclosed their sexual activities then their family would find out and this was especially the case for the South Asian lads (and girls).

'I couldn't tell my doctor about the things I tell [the Key Worker], of the other things I talk about in this building'. 25 year old South Asian Male

'you'd be embarrassed, they've got all your notes and he looks after your medical and then you go in and talk about stuff, and don't feel as comfy' 'so you want to keep this side of your life separate from that side?'. 17 year old Caucasian Male

Interestingly the girls interviewed had similar fears:

'Can't trust the doctors'. 18 year old Afro Caribbean Female

'You have a file at the doctors'. 14 year old Caucasian Female

'They will tell your mum'. 14 year old Caucasian Female

The fear appears to be that the doctors is where parents go and is almost seen as part of the family such that it is inevitable that if they go to the doctor with a problem then the family will find out.

'When I had my appendix out my grandmother went to see him (doctor) to get all the information' 18 year old South Asian Male

There was also a fear aspect evident in this same lad:

'Make the doctor upset and then worry about what will happen' 18 year old South Asian Male

The other aspects to the issue of using the doctors were in relation to the accessibility of the service and also the nature of the service offered by doctors. With respect to the accessibility the need to make an appointment and also the times of opening and the location of the health centre made it difficult to get to during the day. However a stronger theme that emerged from the interviews was that the doctors are seen as a place you go to when you were ill.

"I wouldn't talk to him [doctor] about sex" 17 year old Caucasian male

3.2.10 Girls using the service

What was interesting and increasingly noticeable as the fieldwork continued was the number of girls that were using the service. Usually they came in groups of other girls, but others came individually or with boys. Their ages ranged from 14 to 18 years and were Caucasian or Afro-Caribbean; no South Asian girls were seen using the service.

It was interesting to note how the girls entered the shop and accessed the Lad's Room. The girls usually made much more of an issue of getting into the shop and asking to see [the Key Worker], but then when they were in, they were much more sensible when they were actually in the consultation.

FN - I am sat chatting to [the Key Worker] by the leaflets by the front door 3 girls come into the shop giggling, 'can't do it' says one and they rushed out of the shop. They milled about outside for about 5 minutes then came back in much quieter. They walked in spoke to the receptionist who pointed out [the Key Worker].

When the girls were asked why they were using the Lad's Room two issues emerged, the first was in relation to the benefits of this service over the alternatives and the other was in relation to their awareness that this was a service primarily for boys. The advantages for using the Lads Room were in many ways similar to the boys, ease of access, no appointments, good range of condoms, the advice on offer, but there were other issues raised that were not mentioned by the boys with the majority focused onto the deficits of the family planning service⁴:

'They [the family planning service] will tell your mum'

'You hide your face when you go in so no one sees you'

'They preach at you'

No 'back biting' that goes on at Family Planning

The girls all relate the service to Family Planning, whereas the boys rarely do.

Most of the girls got to know about the service through their sex education classes at school, with the fact that it was a 'Lad's Room' and aimed at boys not appearing to be a barrier to them. The Key Worker commented that it would be unlikely that boys would willingly access a service that had been specifically set up for girls, and it could also be argued that they would most probably be stopped from doing so.

I asked one of the lads using the service who had expressed surprise when told that there were girls waiting to see the Key Worker:

"it is a bit surprising, cause I told my girl to come in and she said, "Naw it's a Lad's Room" but having seen that now I will tell her that you go and get them".
(Laugh). 20 year old African Caribbean Male

⁴ It is not possible from such a small sample of girls to take these comments as being representative of the family planning services in Bradford

3.2.11 Issues with the Lads Room

1. The majority of those using the service were using it for free condoms. After the first consultation where there is a talk and a demonstration on how to use the contraceptive effectively, the distribution of the condoms could be done by the information shop staff, except:
2. In those cases where discretion is being used i.e. a person at a higher than normal risk being offered more than the usual number.
3. The collection of the condoms leads into another issue that warrants a private consultation.
4. The service is only available for two afternoons a week; the majority of respondents felt that it should be open more days and for longer.
5. The consultation focused primarily on sexual health, with no mention made of other issues being broached i.e. testicular self examination, or other health areas. The majority of those interviewed did not feel that they would bring other health issues to this service. It would be worthwhile re-exploring the way the Lad's Room is advertised to ensure that the full potential of the service is realised.
6. The service has been set up by one member of the Health of Men team; it may be worthwhile considering alternating the member such that over dependence on one does not occur.

3.3 The Youth Club Initiative

The Youth Club, which is situated in the middle of an inner city estate, invited the HOM to work with them in developing a service for the lad's using the service. A member of the team has now been working with the lad's and the youth leaders for 2 years and has run 3 sets of health sessions prior to this current one.

Each set of sessions are usually followed by an event, of the boys choosing, as an incentive to get them to participate. This year the choice is a residential weekend. A previous session had Karting as their preferred option.

An anxiety of the HOM team was whether the actual health content of the sessions was useful or just a means for the lads to get onto a free outing. From this analysis it is not possible to show change in the lads actual health behaviour but it has become apparent that many positive health messages are being given to the boys, these include them working as a team towards a common goal, engaging with discussions around health issues, meeting and getting to know health professionals and becoming aware that they offer more than an service aimed at treating illness.

The topics for the sessions were decided by the lads in the first session, as experience from the initial work with the lads showed that unlikely to participate. The choice of sessions was therefore given over to the lads who were remarkably quick at identifying the topics that they wish to cover, however it was pointed out that some of the topics were ones that they had covered on the previous course that he had run.

Youth Club Health Sessions

- Testicular self examination
- Healthy Eating
- First Aid
- The bleep test and jogging
- Sponsored walk
- Fund raising
- Sexual health and STI's
- Hygiene
- Smoking
- Drugs.
- In addition there was lots of planning required for the residential weekend

During the sessions usually one of the members of the Youth Centre attended. It was a shame that the same member could not have been there for continuity. The first session

had a worker who stopped the boys from swearing and maintained an element of control, whereas in the other sessions the workers did not intervene. In the session on male hygiene a female worker came in to listen, which I felt was inappropriate, but the session went ahead and the boys engaged with the discussion, seemingly not minding her presence.

There were many interesting aspects of the sessions that need exploring. A key issue was how the groups and the lad's behaviour were managed. The sessions were held in a youth centre in the evenings, a location that the lads feel at ease, the sessions usually were very noisy with a lot of interruptions from the lads, with one lad being particularly rowdy.

The HOM team member had a very relaxed approach to the boys and seemed able to ignore the majority of the interruptions and continue to pass on information to the boys and to ask them questions about what was being said. Usually there were activities associated with the sessions, such as condoms and a prosthetic penis in the sexual health session; fruit was brought in for the session on healthy eating; in the session on drugs, glasses that altered visual acuity to simulate being drunk were popular. There were also quizzes and other activities such as jigsaws of sexually transmitted infections.

What was remarkable was the impact of these male focused activities. By creating the element of competition between the lads by splitting them into groups the boy's behaviour changed remarkably, settling quickly down to the task and engaging with the activity. Their attention span was not long, but within the time frame that was available there was a lot of good health messages given.

What was interesting was how the lads themselves dealt with the rowdiness. It appeared that the majority of the time it was treated as background noise and ignored, you could see them listening to the Key Worker and raising issues for him to address irrespective of the interruptions. However if a particular point was being made and the interruptions were getting in the way then they would tell whoever was involved to be quiet, thus exerting their own control on the proceedings.

Lloyd & Forrest⁵ talk of young lads 'physicality' and this was evident within the meetings, with few being able to sit still for the duration of the ½ hour session. Standing up and walking about was common, but more often it involved just general fidgeting.

During the session on healthy eating a large selection of fruits were brought in, which the lads ate during the session and the rest was taken out for the rest of the youth centre to finish off. This was followed by an evening where the entire centre had a talk on healthy eating and there only fresh fruit and healthy drinks on sale instead of the usual soft drinks and sweets. This proved more popular than had been anticipated with more money being taken on the evening than a usual evening where pop and sweets were sold.

A lot of time was spent on the planning for the weekend trip, whole evenings were devoted to the completion of the grant applications and this has extended the time for the sessions considerably. The first meeting with the lads to discuss the programme was in September and the 8 sessions were not completed until January.

A sponsored walk was organised to help raise money for the occasion, with 4 lads completing the 8 mile walk.

A brief recorded discussion with the lad's was held at the end of one of the sessions, without the presence of the Health of Men Key Worker or the members of the Youth Centre. What emerged from the conversation was that they felt that what they were getting from the sessions was different and more useful than what they got at school and that they learnt more about 'boy's issues' than they do elsewhere:

"Yeah, he's like laid back a lot more and he talks to you like a normal person"

"He doesn't talk to you like shit"

"He treats us with respect"

"He's different" [from teachers]

⁵ Lloyd, T. and S. Forrest (2001). Boy's and young men's health: literature and practice review. An Interim Report. London, Health Development Agency.

“He’s not a teacher, he’s sorted”

During this brief conversation I asked the lad’s if they would access the other services offered by this HOM team member and there was a mixed response. Some saying that they would and that they knew where he was based, others did not seem to know which health centre he worked from. There were two of the lads who also stated that they would not take other problems to him as they did not know him well enough. This was surprising considering the amount of time that he had been associated with the Youth Club, he had just run a series of sessions with them and had taken them on a sponsored walk.

3.3.1 Issues with the Youth Club Health Sessions

The key points that have emerged from this work are:

1. It is a long process of getting established in a setting such as this, the Key Worker had been involved with this one Youth Club for 2 years. There does now seem to be a model of engagement created by the Key Worker and this should be trailed in other Youth Club settings.
2. Incentives seem to help engage the lads on the task and it is difficult to determine how many of the lads would continue with the sessions if an incentive was not present. However, despite the use of incentives useful work can be achieved with young lads if they are engaged on their own terms.
3. More work would need to be done to ensure the lads see the HOM as a source of health care outside of this setting. Some of the lad’s seemed unaware of the Key Workers role outside of the sessions and how they could access him for other health matters.

3.4 The Council Refuse Collection Depot

The Bradford Metropolitan Council has been a key partner in the development of the HOM initiative with representation on the Partnership Board and at the regular team meetings. Their members have been very supportive in facilitating the HOM teams work and requested that they work with their own staff within the workplace as an addition to the Occupational Health Service that they offer.

The initial work with the council had been undertaken at another depot where the team used a bus as the basis for their consultations. When asked about this early work it appears that the men at the depot were initially quite sceptical, in part due to the team comprising male nurses and uncertainty over what they were offering, but once the team got established they seemed to be welcomed. The current depot had been visited 6 months before and so the men knew of the service and had met the team before. In this setting the team used offices within the main building for their consultations with two Key Workers of the HOM team holding sessions at the same time.

One of the managers at the depot had recently suffered from cancer and he was a main motivator for the men to go for a health check. The men had also been given the incentive of over-time pay to attend the session as it was occurring on what for many was their day off. As the HOM Key Workers have been to the depot before for some men it was their second check up.

One session of the MOT drop-in sessions at the council refuse depot was attended; however, at this session 12 men were interviewed following their consultation. The men were aged between 24 and 54 years and either had worked in a managerial capacity or as an operative. The interviews were conducted in a separate cabin across the yard from the offices where they had just had their consultation. The research interviews lasted between 5 minutes and 18 minutes as the men had to get back to their duty or were keen to go home. I was also conscious of not taking too much time with the interviews as I knew that other men were waiting to be seen.

3.4.1 Having a health check

The men were very impressed that the HOM Key Worker had come out to them and were generally happy with the service. There were generally very favourable comments about

the consultation, with a feeling that they were able to relax and speak freely of any concerns they may have and that generally they were pleased with the service.

“It’s like a medical and I know how much you pay for medicals. Where I have worked before they have not had this, I think it is great.” 24 year old Male

Improvements would be to have the capacity to do blood glucose and cholesterol levels as well as weight and height. One man also wished that it could be away from the main building as he was concerned about how sound proof the rooms were.

The impression gained from the men was that they would not have gone for a health check if this service had not been brought to them, and they did not see themselves as being particularly at risk of any health problem, but that as the service was there they would have it done ‘just in case’. Some of the men felt that as they were getting older they should start taking more attention to their health and having more health checks.

What made this service welcome was that it was free and easily accessible on site, which was referred to as their ‘comfort zone’:

“First time I came I was a bit worried, but here I was in my own area, I was in my comfort zone”. 37 year old Male.

“It was here, I am in the yard. It is not because I’m not feeling good it’s just get a check to see if I am all right.” 41 year old Male

3.4.2 General Practitioners and health checks

I asked if they would have gone to the doctors for a health check and the majority said that they would not, except for those who needed one completing for their HGV driving licence. Some had accessed the ‘stop smoking’ services offered by the health centres. Partially this reluctance was because of difficulty in getting to the doctors, but other features included their perceptions of what you went to the doctors for – with the predominate view being that you only went when you were poorly.

"... the thing is, I know it sounds daft, but it is nothing to do with being macho or stubborn, you go to the doctor if you are poorly. If you cut your hand or twist your leg to go to the hospital, if you have got a cold and it severe, or something on your chest you go to the doctors, but if it is something you can't physically feel or see you don't go. You have got no reason to go... and its like she said to me, cause it's a new doctor I have got now, ...I went when I was 41 because me boys wittered and pestered, so I went just to pacify them". 52 year old Male

But this in itself is problematic as the same man then had to decide how poorly he should be before he accessed the service.

"I think there are people out there that are more poorly than I am, and I could be taking one of their places." 52 year old Male

This reluctance to see the doctor was seen in the majority of the men interviewed:

"... well I am the sort who doesn't want to worry anybody, I tend to keep stuff like that to myself, which a lot of men do. It got to the stage where she [his wife] said, 'you had better get to the doctor' and I was saying, 'No, I will be alright', but eventually I did as it was just getting worse and worse and worse. ... My perception of doctors over the years is that you tend to go in and feel embarrassed when you say you have got this problem and that problem. And some doctors, they are probably not you feel they are saying 'Oh God, we have got another one here, get him out as quick as possible' and that was my perception." 42 year old Male

For one man his reluctance to go was due to their perceived limitations in the service on offer:

"Doctors? - useless, if I had to go there for this [health check] I'd say, 'I can't be bothered', but coming down here is easy. They make too many appointments; you can be sat for an hour... It winds me up that I have got to wait so long. What would happen here if I left people hanging on they would be hammering on the door wanting to know why? People just sit there, then they go in and come out and moan." 39 year old Male

But the same man acknowledged that when he got in to see his doctor he was very happy with the consultation

"He's [his doctor] great, you can say what you want to him, which is as it should be really" 39 year old Male

3.4.3 Family & the influence of the female partner

When considering how men use health services the role of the partner has been seen to be important (Umberson 1992⁶) and therefore the men were questioned as to how their partners influenced their health seeking behaviour. In line with previous studies it became apparent that the family and especially female partners had a major influence on the men's health.

"The GP asked if I have any worries - I have no worries - I let the wife do all that... If she thinks there is owt wrong she books me into the doctors, "I've booked you into the doctors" "why?" "Well you were complaining about your back yesterday or rubbing your knee", so she does all that". 54 year old male

Another man talked of his son's insistence that he cut down on his smoking and to reduce the amount of butter he ate.

A further influence on the men's health is the men's worries over their ability to support their family,

"The biggest thing now is my family; I want to be there as long as possible" 42 year old male

"Who's going to pay the bills if I am off sick"? 43 year old Male

⁶ Umberson, D. (1992). "Gender, Marital Status and the Social Control of Health Behavior." Social Science & Medicine **34**(8): 907-917.

3.4.4 Health problems

Some of the men had health problems and others had either had health scares in the past or were concerned about their increasing age and the impact that was having on their bodies.

The picture that emerged from talking to the men is of fit young men, who did not consider their health as they worked manually and played a lot of sport,

“You take health for granted when you are young, but I always kept myself fit” 42 year old Male

“When you are running behind a van all day you were very fit” 41 year old male

But as they have got older and moved to more sedentary jobs they have realised that they are not as fit, are putting on weight and are starting to develop problems such as hypertension, diabetes and chest problems.

“It’s important to keep on top of your health ... time to take stock, smoking 40 a day and sat on your arse ...” 39 year old Male

Many of the men have changed their drinking habits and stopped, or tried to stop smoking.

“I’ve done my drinking, 23 pints a night, but it got to the stage where my wife said it was either me or the beers, you can take your pick, well I don’t need the beer, same as with the cigs, so I just stopped”. 54 year old Male

3.4.5 Issues with the MOT’s

1. The MOT’s seem to be well received by the men and the interviews suggest that they would not have accessed the conventional services for the health checks given by the HOM team. Effort must be made to ensure that men are aware that they can obtain health checks at health centres – it is not just an ‘ill health’ service.
2. Some of the men interviewed wished that they could have had cholesterol check done. These are part of MOT’s undertaken elsewhere in the city, as are blood glucose levels. It would be useful to consider parity across the city.

3. There was an issue for one man about how sound-proof the rooms were that were being used with a wish that the MOT's were done off premises. This would have resource implications and may limit the number of Key Workers able to function at any one time – however a mobile clinic that can work across city may be a way forward.
4. There were incentives for the men to access this session, both monetary and through the involvement of the manager; it would be useful to compare this event with one in a different setting where no incentive had been offered.

3.5 The Barber's Shop

A barber's shop is in an area that has a substantial number of residents of South Asian origin especially from Pakistan. The owner has worked in the area for at least 15 years. The shop is strictly men only and no women were observed in the shop. Men came into the shop for a haircut, to meet other men, just to talk to the owner or to see the HOM workers.

The HOM worker had been using the shop for his own haircut and got talking to the owner. There was a mixture of serendipity about the choice: the awareness of possibility and the ability to negotiate access. The owner accepted because it would give him a business advantage. There would be an extra service delivered at his business.

The HOM worker would go to the shop at times described on a poster prominently placed in the shop. The poster also gave a description of the services available which included:

- Blood pressure monitoring
- A weight and body mass index (BMI) measurement
- Cholesterol and blood sugar measurement
- Advice on stopping smoking

The clientele were traditional, mixed, from elderly to children. There were a noticeable number of people who came in for a talk with the barber and then left, or who saw a friend in the shop through the window and came in for chat.

3.5.1 The approach

A man comes in for a haircut or just for a social meeting. The HOM worker was either seeing another person or sat on a seat in the shop. He asks who these people are. The barber tells him and the man sits down.

There were four sorts of response to the man:

- either the barber would ask if the man wanted to see the HOM man or
- the man would ask what was going on and then ask if he could have something done or
- the HOM worker would gently ask him if he wanted to, say, have his BP taken or
- the man was on a repeat visit to, for example, to have his blood sugars checked.

In the first three cases the approach was either in Urdu so the man could decline without the HOM workers being directly involved, or the approach was such that the man could decline without embarrassment. Refusals were observed.

3.5.2 The clinical interview

The interviews were in the body of the shop as there was no spare room available. If there was a sensitive issue then the man was interviewed outside, on the street. The shop is small and became crowded with 2 HOM workers, a barber and several customers. There was a divan against one wall with a table in front and some individual chairs against the other wall. The shop windows were clear and any customers could be seen from the street.

There was very little opportunity for a confidential conversation. The interviews were conducted sotto voce but could still be heard by an attentive listener elsewhere in the shop. There were no visible signs of embarrassment at discussing health issues in a public setting.

At the end of the examination and if there were any problems such as a raised blood pressure or blood sugar level, the man was given a referral note for his GP. The note asked the GP to give feedback to the HOM project on the subsequent clinical history of the man.

3.5.3 Two case studies

4.5.3.1 The man from abroad

One man came each week, but he didn't come for a haircut. He was from Islamabad and was visiting his family in England; he spoke little English and was a type II diabetic who was controlled by tablets. In England he couldn't afford the tablets and felt unable to register with a GP to get a prescription. He came into contact with the HOM Key Worker's when he came in for a haircut and had the routine check that they gave. He had a high blood sugar and came in routinely afterwards to have it monitored. He was returning to Pakistan after a few weeks. The situation of this man raises several questions.

1. His blood sugar was high enough to cause acute problems (it was in the high

twenties) when the first measurement was taken.

2. It was difficult to interview him in depth because there was a (natural) suspicion that because he was a visitor, there might be certain repercussions if he went to more orthodox health facilities.
3. The need for monitoring was the result of his being unable to afford the medication that he needed and to access orthodox health services.
4. There is a political and moral dimension to this case. The man was accessing health services in a situation where it would have been difficult to refuse health care (ignoring for the moment a possible moral imperative to deliver that care no matter what the status of the man) because to do so would have compromised the work in the barbers shop. If questions were asked about the legal status of a man then the Key Worker's could reasonably expect that the uptake of the service would be seriously jeopardised.

3.4.3.1 "My GP is not interested"

A local shopkeeper, with young children, who was worried about his weight and the impact that might have developing heart problems in the future. He was aware of the risks after having his BMI and blood pressure checked by the HOM Key Worker's. He had been referred through to his GP but had come back to the barber shop for regular monitoring. He felt that the GP did not consider his case as important, that "he didn't think that he was interested", that he was too busy to worry about such cases and would consider them as trivial. He came for regular weight and blood pressure checks and advice on his diet.

The man was clearly concerned about his weight and attended the barber shop without fail. He was steadily losing weight although he was still overweight.

Some Issues

- The man felt that reducing weight was not seen as important by the GP (no matter whether the GP thought this or not).
- He made use of a local and convenient service. The barber shop was within walking distance of his shop.
- The men only nature of the barber shop meant that he was relatively comfortable having his weight and blood pressure checked in the shop and discussing issues such as diet in public. The issue who is watching is important, and in this sense the

barber shop is self-selecting, if someone is uncomfortable with the public arena then they can refuse or even go to another shop.

3.5.4 Issues relating to the Barber Shop.

An important issue is whether this model can be replicated elsewhere. Two factors are important here:

1. The barber was a part of the community in a way that many barbers are no longer. It is a traditional barber's shop that is now probably specific to certain communities. It implies stability a regular clientele and little influence of fashion. There was a noticeable lack of fashion conscious young in the shop. The arrangement to use the BS was the result of a personal relationship and initiative of the HOM worker who made it.
2. It was a place to meet sociably, not just for an instrumental purpose of having a haircut. This was a result of both cultural factors and the personality of the barber.
3. Without a comparative study it is difficult to judge how specific to this shop was the freedom to have a conversation about health without apparent embarrassment.
4. The effectiveness of the project in getting men engaged with orthodox health services is difficult to estimate because there had been very little feedback from local GPs about the referrals to them. The HOM had structured the referral form to encourage feedback but less than 5 GPs had responded.

3.6 Parks & Landscapes Weight Management Programme

A six week work-based weight management programme was run by two members of the HoM team were conducted within a District Council Parks and Landscapes depot. The location of the depot adjoining a large park meant that a weekly 20-30 minute walk could be incorporated into the programme and sessions were extended to 90 minutes to allow for this.

3.6.1 Data collected

All six sessions were attended by a researcher. Field notes were taken during the sessions and four 10-15 minute recorded semi-structured interviews were conducted with service users with an extended interview conducted with Andrew Harrison, the HoM worker, in the final week. After being informed about the research in the first week, a different service user volunteered to be interviewed each week and interviews took place immediately after each session to discuss the men's usage of the service, reasons for attending and perceptions of the service. An information sheet was given out and written consent taken at the beginning of each interview.

3.6.2 Reasons for attending

Two of the men wanted to gain rather than lose weight, so it was agreed that pounds changed rather than lost should be the measure of achievement (although their BMI showed their weight in the ideal range, i.e. they didn't need to gain weight for their health). This raises the question of how men define or perceive a healthy weight and where men who perceive that their body weight needs increasing rather than decreasing can go to seek help or advice. The men both gained weight over the course of the programme but remained within the healthy range.

In the exercise on motivation in Week 5 all of the men gave positive reasons for attending the sessions and wanting to manage their weight, e.g. '4 myself', 'quality of life', 'mobility', 'more chance of living longer', 'feel better in yourself'. One of the HoM workers pointed out that when women did the same exercise they would typically give negative reasons, e.g. "I don't like the way I look." Among those who were interviewed, low self-esteem was not an obvious factor in the men's decision to attend, however neither of the men who had attended seeking to gain weight were interviewed. There

was little emphasis on self-esteem in the programme itself; however poor self esteem has been linked to poor outcome and dropout from weight loss interventions.

From the interviews it appeared that the men had each made firm personal decisions to address their weight or lifestyle for health reasons.

"I knew I was overweight, I was feeling unhealthy. That's the main reasons."

Service user - 54 yrs

"I decided to come to these weight management sessions because I know I need to lose weight. I'm very unhealthy at the moment – very unhealthy. I'm overweight, which I know. That's basically why." Service user - 57 yrs

Fear was commonly raised by the men as an issue regarding the decision of whether or not to attend: fear of being an embarrassment to one's children, fear of not living long enough to see one's grandchildren grow up, fear of embarrassment in attending the weight management programme.

A common theme was that the men had seen the programme as not simply for those wishing to lose weight but for those wishing to make general improvements in health lifestyles. There was a suggestion from some of the men in the first session that the programme had been 'sold' to them on this basis and that this was the reason why they had chosen to come along, perhaps suggesting a desire to appear not to be concerned with their weight in particular:

"Healthier eating really. I'm not too bothered about my weight although I've nearly lost half a stone." Service user - 49 yrs

One of the HoM workers suggested that this may have explained why the group had been less competitive with each other in their weight loss than other groups had been:

"It was sold to them more as a healthy lifestyle course. In other places it's been sold more as a weight watchers, slimming world type of thing so you get people coming who are already pretty motivated and know what it's going to be about..."

Other groups have been ultra competitive and they've sort of pulled each other along." HoM worker

Whether the men were genuinely primarily motivated by a desire to live a healthier lifestyle rather to change their weight or simply wanted to avoid having to effectively label themselves as 'fat' in front of other people was unclear.

3.6.3 Having the sessions in the workplace

All of the interviewees felt that having the sessions in the workplace, in work time, was a crucial factor in their decision to attend and was seen as very positive. There was a sense that even though quite strong decisions had been made to address their weight and/or lifestyle, had the programme not been available at their workplace they would have been unlikely to have actively sought help elsewhere:

"I might have done or I might have struggled. I think it's nice that it's come along now when it has done." Service user - 57 yrs

The convenience of having the programme in the workplace was seen as the key issue, rather than the fact that the men would be familiar with the other service users, which was largely seen as irrelevant.

"I think it was something I was looking to do whilst at work. I probably wouldn't do it out of work. Because it was inside work that was a factor for me... It's passed my mind quite a few times but I think because it's during work hours it's given me more motivation because I probably wouldn't do anything in the evenings myself. And that's helped a lot for me." Service user - 54 yrs

This suggests that the HoM service is not simply providing a more convenient way for men to access a service which they would have sought elsewhere but rather that without it some men with serious concerns about their health would have continued to go on without effective help. Workplace-based services like the HoM weight management programme are unusual and the question is therefore raised of how many men in similar situations could be reached with workplace based interventions were they to be used more widely.

3.6.4 The HoM Workers

All of the feedback regarding the HoM workers was positive:

"I think they're alright. I think they explain what they're doing and why they're doing it." Service user - 33 yrs

"Fine. Perfect. I couldn't fault them. I'm not just saying that. Nice personalities and I know what they're on about when they're talking. I can relate to what they're on about. No fault at all there. No problem." Service user - 57 yrs

Whether the sessions were run by men or women was largely seen as irrelevant:

"It wouldn't bother me at all, no. It could be a bloody alien for me. You know, I'm not bothered as long as it's going to help me. That's the main point isn't it?"
Service user - 33 yrs

Having become familiar with the HoM workers through the workplace-based MOTs (see Report on first phase of the study, 2005) which had been run earlier was seen as a key issue both in feeling comfortable with the workers and deciding to attend the programme:

"When they did the MOTs and stuff like that you get to know 'em anyway.... You feel comfortable don't you really?" Service user - 49 yrs

"There's that myth that blokes aren't interested in their health but they are. It's just providing a service where they feel comfortable really.... They will talk about what they eat and what their concerns are. They are interested. You don't have to pull stuff out of them; it's fairly free-flowing. The jokes might go off at a tangent but generally they stick to health." HoM worker

The 20-30 minute walk which was incorporated into the sessions proved to be particularly useful in providing a relaxed situation in which the men were able to talk to each other and to the HoM workers on a more individual basis:

“The guys talked a lot more when they were walking about quite personal stuff they wouldn’t have shared in the group. Because you’ve obviously got your strong characters [in a group] but when you’re out walking it’s more one to one it can be more personal.” HoM worker

The walks were an unusual feature of the sessions run at the Parks & Landscapes depot. It would therefore be interesting to investigate whether somehow providing a similar opportunity for service users to have informal individual discussions with the HoM workers would be valuable in groups run in other locations.

3.6.5 Raising Attendance

One man said that there were lots of overweight men who hadn’t come to the group and suggested that this was because they felt too embarrassed, although two new recruits were brought along by the men in Week 2:

“One of the guys said he works on a team of fourteen and a lot of them are big lads but they’re just embarrassed to come.” HoM worker

From the data collected it is not possible to say to what extent embarrassment was really a factor in keeping potential attendees away or whether changes to the programme or the way it was marketed may or may not have been effective in overcoming this issue. It did appear, however, that only limited consideration had been given to how the programme had been advertised to the men.

The men suggested that more informative and attractive advertising might have led to higher attendance:

“It was just a piece of paper that was handed out. You know, there was no pictures or anything. You know, it was just ‘Men’s Health’. It was an A4 piece of paper and that’s all... The words ‘men’s health’, that did it for me. You know, so it was that. But to encourage other people I would have thought posters or something like that.” Service user - 57 yrs

"Maybe like a booklet or a leaflet saying what the course is gonna consist of. Maybe a six page one because it's like a six week course. Just explaining what's gonna happen each week and just explaining similar things to what the lads do in there. Just like a little booklet. They might read through and be like 'oh it might not be so bad'. You know, it's alright people saying it but if you're actually reading what it's gonna be you don't feel as threatened do you? Some people feel threatened by people just saying 'oh this could help you' but if you're actually reading it in black and white you think 'oh why not? Why not give it a go?'"

Service user - 33 yrs

The interviewees all appeared to have clear determined reasons for attending the sessions and therefore perhaps required little in the way of persuasive advertising to get them through the door. There is of course a possibility that there were some more uncertain potential attendees who could have been reached by more effective marketing.

The men also felt, however, that within the workforce there was a significant proportion of people who would never be open to attending such events, simply because of the nature of their personalities, and that no amount of advertising or persuasion would make a difference to them.

3.6.6 Changing Attitudes and Health Behaviours

The exercise in week 2 prompted a discussion among the men about motivation. The question of how easy it would be to maintain self-motivation to exercise appeared to be a significant issue for the men, e.g.

"I do 30 minutes exercise a day."

- "Yeah but it's different when you've got kids."

"There's still things you can do if you're motivated. Do things with the kids."

"It's hard getting out of a rut when you're in a rut."

- "I think if you went swimming twice a week that would give you confidence."

In the interviews there was a clear sense of determination to maintain efforts to improve diet and exercise, coupled with some concern about maintaining momentum if the programme came to an end without plans for follow-up sessions in the future:

“For me to carry it on on my own I think it will be fairly easy because my target is not a big target. All I intend doing is to eat more healthily and walk more during the day if I can. That’s my target and I’m hoping eventually, say in a year’s time, to have lost at least a stone or two stone. If I can do that, that’d be great...

... Whether people would still go out walking I don’t know. It’s getting everybody to come together at the same time, especially when they’ve got other work to do and all this. OK, we’ve got these sessions planned but it might not happen in the future. But I think people would pop in and get weighed or get their blood pressure taken... You could say like every three months all get back together and just have a review of what’s happened and how we’ve gone so far or has everybody given up. Whatever, every six months, it could be a good idea to have a review.” Service user - 54 yrs

This raises a question of whether health professionals running services such as this have an ethical responsibility to put mechanisms in place to ensure that men can continue to access support and information once the intervention is at an end. Weight management groups are encouraged to continue meeting on their own if they wish, with money available to purchase equipment, such as weighing scales:

“The thing that always surprises me is the guys always want to continue it you know “where can we get the equipment?”. They adopt their own ways of recording it – a poster on the board where you can put your weight on if you want to or some keep books. We’ve set up six groups and they’ve all wanted to keep it going. And at the end of the day that’s what it’s about because you haven’t got the capacity to do it weekly...

...Some of the groups we started in January are still meeting a year down the line. For a group of guys to meet to weigh themselves is great really... A lot of it’s basic stuff. Some of the guys don’t even have scales at home. If the group fail to meet the equipment just comes back into the project and it’s used for other groups... When they meet up now weekly it’s only five or ten minutes. Jump on

the scales and write it down and they might think 'well, next month we'd like a dietician to come back in'." HoM worker

3.6.7 Structure of the Programme

Although the interviews suggested that a clearer sense of what the programme would include each week would have been beneficial in encouraging attendance, it was clearly felt by the HoM workers that flexibility in the structure of the programme and individual sessions was key to maintaining the men's interest and suiting their requirements:

"Ultimately, we want to know what they want to do it so we can plan it around that...You've got to be flexible. I think if you're too prescriptive it can scare people off." HoM worker

The location of the depot, for example, allowed a walk around the park to be incorporated into the sessions each week, which was received very positively by the men:

"I mean, the walking I think is a good thing, going out for a walk, because that puts you in the mood, in the frame of mind for it sort of thing. It keeps you motivated. Just doing a little bit helps with your motivation.... Yeah something real, something positive. You're actually doing something." Service user - 54 yrs

In the final week one of the men who had earlier been extolling the virtues of homemade smoothies brought in his blender and gave a smoothie making demonstration and tasting session for the men with fruit provided by the HoM workers. Despite initial scepticism from the rest of the men, this went down very well and received a lot of interest. One man said he would definitely buy a blender and start doing it himself.

The main recommendation from the men for improving the programme was to provide more information that could be taken away in the form of leaflets and more definite instruction about how they should be improving their individual lifestyles. Whilst men might typically be seen as reluctant to be preached at, once they had made that definite personal decision to address their health they wanted to be told what to do in quite straightforward terms:

"I think I'd have got the dietician in a lot quicker. Maybe on the actual first meeting that we had because I'd like somebody to do me a plan of sort of like 'try this for a week'. You know, write you a weekly plan out of what to eat in the morning, dinnertime, teatime and if you can stick to it, you know, see if you do lose weight. I think that's what I really need – somebody to push me in that sort of direction to do it." Service user - 33 yrs

"Yeah maybe a bit more practical. I mean we've had a bit of - I was surprised that there was no literature on it this morning [SESSION WITH DIETICIAN]. I thought it were important. It's alright but we've just taken it in haven't we? I was actually expecting some leaflets on it or something like that but there were none of that was there? But I don't know, is it me? I think it would be an idea to have a little booklet or something because you can't remember everything can you? I'm just surprised that she didn't turn up with a little booklet for everybody because the other week we got a load of information [SESSION WITH WALKING FOR HEALTH COORDINATOR] which is what I've still got in my office." Service user - 49 yrs

3.6.8 Issues with the Weight Loss group

1. The service was advertised as a group for men, but there were still a number of women interested in joining.
2. The MOT was the main way of recruiting the men to the service.
3. There were men who knew that they needed to lose weight but would not have accessed such a group if it was not provided at work.
4. Embarrassment remained a barrier for some wanting to attend the sessions.
5. Motivation was high in those men who attended.
6. Information on their weight and on healthy lifestyles was more welcome than advice.

4.7 Health MOT's within a Health Centre

3.7.1 Data collection

Data collection took place over three sessions of health checks – two were run by a nurse member of the HoM team and one run by one of the Health Care Support Workers. The researcher observed the health checks, with the consent of the patient, and then asked if they wished to be interviewed after the check. All patients consented to be interviewed and 5-10 minute recorded semi-structured interviews were conducted in a quiet part of the waiting area immediately after the patient had received their health check. An information sheet was given out and written consent taken at the start of each interview. 14 interviews were carried out in total with men aged over 50.

3.7.2 Reasons for attending

Having been invited personally by letter to attend a health check appeared to be a key issue in the men's decision to make an appointment, rather than, for example, if they had simply seen the service advertised on a poster. It could be that receiving an invitation helped to counter the feeling of concern about 'wasting the doctor's time:

"Getting a letter is a more personal thing – 'they've asked for me to come along, I'd better go sometime'. If I'd have seen it on a poster would I have come? If I'd seen it and taken it in I probably would have done, but is the emphasis on they want you to come for your own well-being or if you'd seen it on a poster would the emphasis be 'look, here it is if you really want it' and if it had been the latter I might have been touch and go."

"If you've got a letter I'd come straight away, whereas if you see a poster you'll go sometime, won't you? If I got a letter saying 'you've got to come next week' you'd do it then, there and then. If you see a poster you might never get round to it."

Although none of the men claimed to be attending simply because their wife had forced them into it, persuasion from their wives had in many cases been a significant factor in determining how quickly they had made an appointment.

Most of the men had attended simply for a general check up with no specific issues or problems in mind. Getting older and a sense that the prospect of ill health was now a greater concern for them than when they were younger was a common theme:

"I suppose as you get older you get a bit more worried about your health, don't you? And I do worry more about it now than I ever have done before. In the past you wait to get over things and your mind runs away with you more when you get older."

"I came for my own peace of mind to see what they've got to tell me about myself that I might not know... somebody's saying 'we'll give you summat for nowt' so you say 'yeah, I'll take it'."

In several cases, the recent ill health or deaths of family members or men of a similar age had been a key influence in the man's decision to attend:

"I'm over 50 so I thought 'it's a free do, I might as well have a check'. It's a wise move at my age... when you're over 50 you never know. You read in the papers week after week somebody's dropped dead."

"I decided to come along because my wife's brother just died early. He was 51 and he had a heart attack and my sisters and my wife said 'why don't you go get checked?'. I've not been to the Dr's for quite some time and as a coincidence... I got a leaflet from the surgery saying there was a men's health clinic running."

This raises the issue that whilst many men may live in a state of denial regarding the mortality of their own bodies, we cannot simply assume that they will remain in that state forever. There is a need not only to provide services which will meet men's health needs at whatever point in their lives they choose, or are forced, to address them, but to ensure that men are effectively informed about the existence of those services and how to use them, and will feel comfortable in doing so.

3.7.3 Meeting expectations

Almost all of the men said that the health check had broadly met their expectations and were happy to have had the check done:

“Sometimes when people explain about your diet and stuff like that you change your way of thinking. Like now, I’ll try to lose a few pounds and not drink so much and take it from there. Then I’ll look forward to when I come back again to see how well I’ve done. It’s not ‘I’ve come, I’ve had it done, forget it’ sort of thing. You’ve got to carry it on... it’s enlightened me a bit.”

Several men commented that they would have liked more tests to have been carried out:

“I probably expected a bit more than what there was. I don’t know what but I expected a little bit more... tests being done.”

Two men suggested that they could only see a point in the checks if there were physical tests being done:

“Don’t think I’ll come again... I see it as a bit of a waste of time... He’s only asked me what he’s done in the past... I don’t see why they can’t do a full blood test... I know nothing that I didn’t know before.”

3.7.4 Going to the GP

All of the men said that they were happy, or at least prepared, to visit their GP whenever they had a health concern which they felt warranted investigation, i.e. these were not men who were opposed to visiting the Dr, even if they didn’t feel especially comfortable in doing so:

“Once I’ve made that decision to come it’s no problem. It’s that initial decision to come to the Dr’s if there’s a problem... basically I’m sure in my own mind what’s the problem. It’s confirmation more than anything.”

"I'm alright till I get here and then I get myself in a bit of a panic. It's just the type of person I am.... But I wouldn't not come"

"If there's owt wrong I'll come. You've got to haven't you?"

In the same way that being invited by a letter may have had an effect in countering fears of 'wasting the GPs time, the fact that the MOTs were delivered by a HoM worker rather than a doctor or other regular member of the surgery staff appeared to help create a sense for the men that they could access the service without feeling that the person they were seeing would have something better to do. There was a sense that the HoM health checks relieved the GPs of a task and that this was a positive thing:

"I've always been one of these... if I've got aches and pains I don't bother. If I fell down in the street and I got worried about it then I'd go and see the Dr but otherwise I don't like to trouble them unless there's something wrong with me."

"It's when I get frightened about something... if I'm worried about something then I'll go see the Dr."

"I probably don't come as often as I should just to get a check up but it's not through any desire not to come, any fear or anything. I don't know, I just don't come. It's a place to come when you're poorly I think, you know, but this has sorted of prompted me to come and have a check up... it's like an invite isn't it? So whereas I probably wouldn't have thought 'oh yeah I haven't had a check up for a number of years I'd better go', when I received that in conjunction with what had happened [WIFE'S BROTHER DYING AT 51] I thought 'yeah I'll go and get a check up, why not?'"

3.7.5 Location

The location of the health checks was not felt by the men to be a significant factor in their decision to attend. Some of the men did not consider themselves familiar with the surgery anyway, although all were quite comfortable with having the checks there:

"It's comfortable, it's convenient really... but I would do it anywhere."

"I'd have gone anywhere."

There was no evidence from the interviews that the health checks had brought any men into the surgery that were otherwise particularly reluctant to visit it.

3.7.6 Views of the HoM health check service

All of the men stated that the gender of the worker would not be a decisive factor in their decision to attend.

"I'll probably feel more comfortable seeing a man than a woman but it makes no real odds."

"It's quite good, although it wouldn't bother me if I went to a lady."

There were mixed views regarding the provision of a service which was for men – many said that the fact that the health checks were a service specifically for men was not at all relevant to their decision to attend. Some thought that the idea of having a service for men was beneficial, whereas others seemed indifferent to the concept:

"I like the idea. Well why not? You get things set up for ladies don't you?.. Why shouldn't we have summut?"

"A lot of men don't talk about it as much as they should do. They tend to sweep it under the carpet."

"I think it's a good idea personally. Men seem to shrug stuff off and carry on... a lot of men feel more comfortable going to see male Drs and male people than going to see women... so I think it's a good idea."

"It's free advice and if there's people frightened of seeing women...it doesn't bother me but if you are that way inclined that's your chance to go and get it done."

For those for whom the male specific nature of the service was irrelevant, it would appear that simply having been invited for a health check was the key trigger to them attending. We must consider just how many men who would never request a health check from their GP would willingly turn up for one if only they were invited.

One man suggested that having a male specific service was actually unhelpful as it constituted positive discrimination. Another said that, whilst he believed men to be very well catered for by existing health services and would feel quite happy asking his GP to do a check up, he saw the HoM service as "the icing on the cake".

It is notable that in referring to issues around male reluctance to acknowledge and address health problems they tended to refer to 'men' as a group, rather than themselves as individuals. This may have been because the men who attended the health checks were more ready to engage with their own health or it could have reflected a desire not to be seen as 'afraid of the doctor' or unwilling to face up to health problems. It seems possible that just as in some contexts acknowledging illness might be perceived as a sign weakness, in a health setting acknowledging a fear of acknowledging illness may also seem like a sign of weakness (particularly when being interviewed on the subject of men's reluctance to access health services).

3.7.7 Re-attending and recommending the service

Nearly all of the men said that they would come again if they received another letter in a year's time and would recommend attending to others.

"I think it's a good thing... especially as you're getting older."

"You don't want it to stop happening, do you? If people don't come they won't do it... I think it's a good idea and I hope they do keep it going."

"I'll come back next year and the year after... you find out things before it gets bad, don't you?... I think if this hadn't come along I would have gone to the Dr and asked for one."

“I came last time and I think it’s a good idea to have a health check every year... it’s always worthwhile.”

One man said he had already recommended the service to others who had received letters and explained to them what would happen if they attended.

Two of the men who were disappointed by the lack of additional tests were doubtful about recommending the service or re-attending themselves:

“Not just as a routine visit, no. If I knew somebody who had a lump somewhere then fair enough, I’d recommend them if they don’t want to see a – but if you’ve got a lump somewhere I wouldn’t come and see these chaps as I see a male Dr. I can wait a day or two and I think if it were really serious I think I’d be prepared to see a female Dr.”

“If all he’s done is my weight and my height, what’s to pick up on that?... I suppose there’s only a point if there’s something wrong... might be a bit quick to do it every year.”

One man said that he would recommend the service but felt that it would be a lot better if there were some form of follow-up to the check, saying that it felt “a bit final” and was a case of “OK, now off you go”.

3.7.8 Issues with the MOT’s within the Health Centre

1. The men who attended the clinic were mainly influenced by the letter inviting them.
2. There were men interviewed that had health concerns that they would not have brought to their GP.
3. There seemed a reluctance to make an appointment to see their GP for a health screening.
4. There was an expectation that they would have a series of blood tests undertaken
5. HoM arose from a recognition that there is lack of general health services specifically catering to the needs of men and clearly the services which

the HoM team provide are not yet sufficient to completely fill the gap. When a man who would otherwise have felt unwilling to access his GP for a health check begins to engage with his health through receiving a HoM MOT where does he go for continuing support or information? Where there is a clear health issue which requires further attention the man will be referred to see his GP or another health professional and some men may feel more comfortable accessing mainstream services having received the MOT; for the man who still feels alienated from them, however, there may be a remaining sense of being unsupported.

3.8 Teenage Information Centre Teenage Advice Centre (TICTAC)

The TICTAC project has been running in this Secondary School since 2004 in association with the Community Health Development Team and the Health of Men team. A member of the HoM attends for one session a week and has their own room where they can hold private consultations with the boys at the school.

The centre was originally in a portable building in the school grounds and thus physically separate from the school. In 2006, however, shortly before the research was carried out, the TICTAC centre was relocated within the school building.

4.8.1 Data collected

Data collection was carried out in the form of focus groups to gain a sense of the boys' perceptions of TICTAC as a whole, the HoM aspect of the service and the way that service was used. Whilst the boys may have felt more willing and able to freely discuss usage of the service in individual interviews, the limited time and resources available meant that this was not a practical option to gather sufficient data. Prior to the focus groups being held, all those who had expressed an interest in taking part were sent an information leaflet. Written consent was taken at the start of each session. It was stressed throughout the focus group sessions that the theme was perceptions of the service and usage of the service across each year group, rather than the participants' individual usage of the service.

A series of six focus groups were conducted, one each for years 5 to 11 and one with representatives from years 12 and 13. Each focus group had between 5 and 8 boys present. Interviews were also held with the TIC TAC coordinator and the HoM team members.

3.8.2 Awareness of the service

Students were all aware of the TICTAC service and there was a reasonably good overall awareness of what the service offered, however there was a very poor level of awareness of the HoM aspect to the TICTAC service – only two boys out of all the focus groups could name a member of the HoM team. Whilst it was generally known that there were sometimes male staff there that students could choose to see, there was no awareness that this was provided by HoM rather than simply being a normal part of the TICTAC service. There is an issue here of whether achieving awareness of the HoM brand is seen as an important element in encouraging boys and men to access HoM services or whether the aim is simply to provide the services, i.e. does it matter that the students are unaware that HoM provide a dedicated male worker for TICTAC as long as the boys are aware that male workers are available for them to see? Having a male worker was generally valued, although there was a sense that a male worker only being present one day a week limited the impact of the HoM contribution to the service:

“They tell you stuff you don’t know. If you’ve got questions about yourself they’ll answer them in as much detail as they can.” Year 9

“The woman, right, we don’t feel comfortable going to talk to her because she’s like a woman” Year 7

“It would be better if there were a man right because the man knows what problems you get” Year 7

“He’s never in hardly. He’s only in like once a week” Year 7

The poor awareness of the HoM aspect of TICTAC severely limited the capacity for discussing the students’ usage of the HoM service specifically. To all of the students all aspects of TICTAC were simply ‘TICTAC’ and the provision of male workers was not seen as a special feature. The discussions were therefore largely limited to boys’ perceptions of the TICTAC service as a whole.

All year groups stated that the service was associated primarily with the provision of free condoms, although there was a broad sense that TICTAC was a place to go for advice

'about anything', including sexual health issues, healthy eating, problems at home or school and quitting smoking.

Many saw themselves as having a superior awareness of what was available at TICTAC in comparison with other (usually younger) pupils, i.e. that others thought the service was simply a source of free condoms but they knew that it offered more than that. This suggests that having an awareness of this kind of health service was seen by the boys as a sign of maturity rather than something to be embarrassed about.

3.8.3 Advertising

It was considered that the service needed better advertising to raise awareness of how to use it and what was available. There was a strong sense that many pupils felt ill-informed about the service and that this had an impact on how well the service was used and perceived. Some suggested that each new intake of pupils into the school should be given a formal introductory lesson about what the service was for and how to use it.

"I don't even know where it is. I never know what TICTAC is." Year 7

"They've got an orange sign and they're asking for advice on how to make it more attractive. It needs more colours." Year 9

3.8.4 What does it mean to be a TICTAC service user?

As it would have been inappropriate to ask students about their own individual usage of the service, the question remains as to whether this attitude that superior understanding of the service reflects greater maturity also applies to using the service, e.g. it could be that knowing what the service is for is regarded as something to be proud of, but actually using it is a cause of embarrassment or even to be avoided.

As a main feature of the service is its emphasis on confidentiality, clearly in a group discussion with their peers there is a limit to how much students will give away regarding their attitudes to using the service themselves. There was therefore a strong

underlying sense throughout the focus groups that students saw the service as being for other people. This could have reflected a genuine attitude that the service was something which they largely wouldn't need or choose to use themselves or it could simply have reflected their desire not to reveal personal usage of a confidential service in front of their friends. Indeed, the relationships between the participants was a further complicating factor as it was apparent that whilst some appeared to know and get along with each other well, others were less well acquainted and some were openly hostile to other individuals in the group.

All year groups acknowledged that many went to TICTAC simply for a laugh because they were bored or to get out of the rain at lunchtimes, yet even those who proudly admitted to doing this themselves expressed the view that this behaviour presented a problem which should be addressed, suggesting that the service was valued. Whilst acknowledging that TICTAC provided an irresistible opportunity to entertain themselves by messing about, students appeared concerned that the service should not be affected by such behaviour when they wished to use it themselves.

Sixth formers suggested that the popularity of the service with those who wished to use it as an opportunity to mess about meant that it had become seen as a place that was frequented by troublemakers. Concern over being labelled as a troublemaker by going to a place where they were seen to hangout was a seen as a strong issue for some people in deciding whether to use the service.

One year 7 pupil expressed concern that if a girl you fancied saw you in TICTAC she wouldn't want anything to do with you because she would then assume that you were sexually active.

3.8.5 Trust and confidentiality

The principle factor which distinguished TICTAC from the school in the minds of the students was that it was universally seen as a confidential service which could be

trusted. This was regarded as very important and seemed to be the critical factor which gave the service its value. Teachers were universally regarded as untrustworthy and were not considered an option when needing help or advice about any health or personal issues. The general view was that teachers would treat any personal issues which students discussed with them simply as gossip to be swapped amongst themselves in the staff room.

“I wouldn’t trust a teacher” Year 8

“Teachers’ll talk to other teachers and it’ll spread... there’s a lot of rumours... it can be round the school in ten minutes.” Year 9

“Teachers are the hardest people to trust and talk to.” Year 10

“If it wasn’t separate from the school I wouldn’t go... the teacher’s would tell your mum” Year 8

The concept of ‘vulnerability’ appeared to play a major part in the students’ thinking about who was or was not an appropriate person to go to with a particular issue. There was a sense that in taking a personal issue to a teacher one was making oneself vulnerable. In going to TICTAC the vulnerability came from the potential of being seen going in or out by other students or teachers, a concern which seemed to have been heightened by the relocation of the service:

“Now it’s upstairs people can see you going up there so like taking the mick out of you ‘oh you’re going to tic tac’ but when it was outside you could just be like ‘oh I’m off up the drive to meet a mate and then just come in’.” Year 7

“It were sorted when it were outside.” Year 7

“It were best keeping it outside in that cabin coz it were best place for it really.”
Year 7

Although there may still have been concerns for some over whether they felt comfortable with the person they were talking to, seeing someone at TICTAC appeared

not to involve concerns over vulnerability to judgement or gossip from others, as long as one could get in and out without being spotted.

"They don't tell you off if you're dressed scruffy or anything so you can chill a bit." Year 10

"If you're having problems at home... you can't always talk to teachers so you can go there." Year 10

3.8.6 Lack of other options

The school nurse was seen as someone you would go to if you scraped your knee but not to discuss personal issues or to seek advice.

"I know the school nurse and all she does is come and check up on us and see what us health's like and that and then just ask us about behaviour."

Year 7

The GP was frequently mentioned as someone who one could go to for sexual health advice but students acknowledged that they would be very unlikely to take this avenue themselves.

"It's confidential but doctors – you can't just tell 'em anything." Year 9

This highlights the need to provide services which not only meet the needs of the boys but are also perceived by the boys as appropriate and convenient places to go to have those needs met. TICTAC was seen as the appropriate place to go for advice on health or personal issues.

"We'd go to our friends [without TICTAC] but they wouldn't know the difference, they'd just come out with shit." Year 11

"It's a lot harder to buy them [condoms] in shops in public." Year 12

"I'd talk to a teacher about bullying or something but I wouldn't talk to a teacher about sexual problems or smoking... it's that teacher/student barrier really." Year 12

3.8.7 Convenience

The convenience of the service was an important issue both in decisions to use the service and not to use it.

"You want the service there and then – you can't be bothered waiting."

Year 11

"I wouldn't go out of my way to go and get a condom or anything but with it being here it's within the school premises and we also know the people really well." Year 9

Whilst having a trusted service within the school grounds certainly appeared to make pupils more likely to seek advice regarding a health or personal issue, for many the popularity of the service meant that the potential waiting times, and the prospect of giving up the better part of lunch break, were too high a price to pay.

"Most people don't go – they don't wanna waste their dinner time... It gets well busy sometimes... people take ages in there." Year 8

The convenience of the location was therefore something of a double-edged sword – whilst it made the decision to go a relatively easy one for the individual, the fact that it was just as easy for everyone else meant that getting seen by one of the workers may not happen instantly.

"When there's too many people in there they lock the door" Year 11

The convenience of having the service in the school also meant that there was a high chance of being spotted using the service. Concerns over being seen to be going to TICTAC by teachers and other pupils were regarded as a major issue by all year groups in any decision to use the service. One could speculate that some of the concern about the numbers of pupils attending the service may have been due to the desire to avoid being seen going by other pupils – even by others who were there (and who may have avoided fear of embarrassment themselves by being there for the primary purpose of messing about).

There was broad disagreement over what should or should not be done to make the service more convenient for pupils. Some suggested that an appointment system allowing pupils to go to TICTAC in lesson time would tackle the problem of waiting times and the dilemma over to whether to give up lunch time; others, however, argued that this would encourage non-genuine attenders simply looking to get out of lessons and would draw attention to who was using the service as well as losing the benefits of a drop-in system.

3.8.8 Valuing the service

Despite a consensus that TICTAC was largely used by people who were simply messing about, the service did appear to be widely valued across all year groups:

“Anything you could possibly need to know they’ve got answers for” Year 9

“It’s worth having it in school because they do tell you a lot of information which you don’t know” Year 9

The fact that the service offered a place to go and talk about problems, even if you didn’t actually use was seen as valuable:

“You might realise that you’re gay when you get into another year” Year 8

3.8.9 Deciding to use the service

The key issues involved in the decision making process about whether or not to attend TICTAC appear to be:

- Confidentiality
- Availability of alternative services or sources of advice which are *perceived* by the boys as appropriate places to go
- Convenience of the service
- Risk of being seen using the service and others’ perceptions of those using the service
- Being informed – how well informed the boys are about what the service should be used for and how to use it

Each of these factors will of course have a different level of importance in each boy’s decision about whether or not to use the service, but the decision making process is clearly not a straightforward one, with the convenience of the location, for example, being both a positive and negative influence.

3.8.10 Improving boys’ usage of the service

Awareness of the service appears to be the biggest issue affecting boys’ usage of TICTAC. Improving awareness of what the service is for, where it is, how to use it could have a significant impact on usage of the service. There is also a clear need to improve awareness of the HoM aspect of TICTAC as this was something which the boys’ appeared to be largely oblivious to.

“I don’t even know where it is. I never know what TICTAC is” Year 7

The issues of the location of the service and whether it would be better to have an appointment-based system or drop-in are less clear cut and refer to fundamental aspects of the nature of the service which are not easily changed.

"If you really need it then you really need it and you've got to go out of your lunch." Year 8

"If you had appointments after school you wouldn't have idiots coming round and people messing about." Year 7

"If you had an appointment you'd have to have something to talk about."
Year 7

The focus groups raised another important issue of what constitutes good or appropriate usage of a service such as TICTAC!

"They should put a plasma TV in there." Year 11

3.8.11 Issues with TICTAC

1. The lads were not aware that the service was being provided by a team member of HoM, they were more concerned with having a male practitioner they could speak to in confidence.
2. There were issues in relation to the pupils confidence in teachers keeping information confidential.
3. The School Nurse was seen as a person who you took physical problems to, with a reluctance in the boys to discuss with her the issues they discussed with the HoM team.
4. Being both a part of school and yet at the same time separate was seen as a great benefit.
5. The TICTAC rooms provided an alternative space for the young boys where they felt comfortable.
6. There are issues relating to how the boys perception of the service changes over their years at the school, with a need to market what is on offer more effectively to these different age groups.

3.9 Stakeholder interviews

The work of the HoM team has been supporting and being supported by a number of key stakeholders and their views needed to be considered within the study. These ranged from the members of the partnership board, managers of the team members and from services that were working collaboratively with the team.

15 semi structured one-to-one interviews were undertaken.

3.9.1 Recognition of need

The stakeholders recognised that men seemed to have specific problems with their health and that they seemed to have particular issues that were experienced differently to women and that dedicated work in this area was necessary. They saw that the work of the HoM team was a good way of targeting inequalities and to meet the new challenges for men that are emerging as a result of changes in society and a population increasing in age.

There was broad agreement from the majority of those interviewed that men delay going to services generally and that specifically there is an issue of men using specialist services such as

- Family planning
- GUM services
- Specific problems of those who are drug users (including steroid users) or gay

There was also agreement that the cost of treatment is greater than prevention and that the work being undertaken to get more men engaged with their health and with services is essential. There appeared to be a consensus that to achieve this there was a need to find new ways to engage with men:

‘its about delivering different things, in a different way, at different times, at different settings’

There was also a feeling present that this was not all the fault of men with much of what was currently provided as not being male focused and that it was not meeting men's needs. Specific mention was made of the lack of adequate provision for young boys at school where teachers and female school nurses are not felt to be as effective at doing

sexual health work with boys and that if the curriculum is examined boys needs have been missed out. Mention was also made of the worries some men felt over issues of confidentiality of current services, especially Occupation Health and GP.

The work being undertaken in Bradford was generally seen as extremely positive and mention was made frequently to the growing awareness of men's health nationally and that there was a sense of parity emerging with women's services and the rise in interest in women's health issues since the 1970's onwards.

3.9.2 Partnership board

The Partnership board came in for a degree of criticism, with a sense that the way the board had been set up did not lend to the creation of an over-arching strategy and was felt to be more of an advisory board. There were concerns that it had not met for a while and this had left a feeling of the project drifting.

Associated with this point was a comment made by some of the stakeholders that the project would have benefited from having a clinical manager alongside the business manager

3.9.3 The Key workers

The stakeholders views on the key workers were very revealing and demonstrated that it was not just the provision of new services that were important, but that who the key workers were as practitioners and their gender also had an important part to play in the work they were undertaking.

3.9.3.1 Attributes of the workers

The analysis of the interviews with the HoM team in the first phase of the study highlighted that they appeared to have certain attributes that made it possible to undertake the kind of work they do (see the first interim report and also Conrad 2007). The stakeholders also raised the issue of these skills as being an important part of the success the team have enjoyed.

There was a feeling that the team were motivated and held interesting ideas about how services should be developed. They were also praised as being able to work with boys,

specifically they were able to talk to them without getting embarrassed and could manage the boy's behaviour. They saw that this was because they seemed able to gain their respect, being able to talk to them on their level and could relax and have a laugh with them.

3.9.3.2 Gender of the workers

A central feature of many of the stakeholders comments on the HoM team was that was a service for men run by men and that being male is an advantage in many areas where the stakeholders were working. This was especially the case for those working in the fields of sexual health and in working with young men and boys:

"I: Do you think there's any kind of issue were lads would rather see a bloke?

R: Definitely with one or two specific males with sexual health problems who wanted to see **** rather than a female nurse. Having a male nurse has been really good."

"I think that we really do need somebody that can talk to the lads on their level and not be embarrassed. ... I could go in and talk to the lads about wet dreams, masturbation and all the rest of it and I wouldn't be embarrassed but they would. So they're not going to listen and it gets a bit silly and giddy because they're embarrassed. So I think it is important that they're there."

3.9.4 What the stakeholders like

The stakeholders were particularly impressed by the fact that the team were willing to go out to the men and into organisations where men were. They like the fact that they were male health care workers with a broad range of expertise such that they work across the field and that they were generally available and reliable.

Those working with boys and young men felt that they also provided a positive role model for boys.

A side benefit to the work of HoM is that it was seen to provide impetus to recruit more male health workers and that they created good collaborations with partner organisations

3.9.5 What caused / is causing problems

The stakeholder's views were not all complimentary and they raised a number of issues with the work being undertaken.

For those who were involved in the project from its inception there was a feeling that there would have been benefit if greater explanation from the start of what was being attempted as for some there was an expressed uncertainty of what it was about and perhaps a misunderstanding of the purpose of HoM.

There was regret that it was effectively too small in scale for any meaningful lessons to be learnt from it and this was coupled with recognition that there is difficulty in measuring success both in terms of long term impact and cost effectiveness.

There was also uncertainty over how it will develop and a feeling of lack of direction (which links to the earlier comments on the lack of input from the Partnership Board and a lack of a clinical manager to direct operations).

There were also concerns that there were problems of marketing and branding the work undertaken, with note made of some members of team unwilling to go beyond their own clinical work. One respondent noted that the majority of the work of HoM would normally fall within the remit of Community Development but this was not part of the majority of the team's background and a lack of understanding of the appropriate methodology held them back.

3.9.6 Lessons learnt

From the stakeholders interviews it was apparent that there were certain key lessons learnt over the last five years of the project.

They recognised the importance of getting out to where men are: into schools, into the community through the use of the Lad's room and the Barber shop work, into industry through the work of the MOT's, Sexual health outreach work through the targeting of massage parlours etc.

It was interesting to note that the Stakeholders felt that many users were not affected by the name (HoM), it was the fact that a male orientated service that is run by men (but there were differing views as to whether it always needs to be a man running the sessions) was the key issue.

To reinforce a point made earlier there was strong support for the recognition of men's specific needs and services that are male focused. The stakeholders noted that men like the face-to-face nature of the provision, that the team provided male focused information (leaflets, internet), that most of the services were easily accessible i.e. within work time or in the youth club. An important point that was raised was that they were seen as independent of teachers in the schools and management in the workplace and that it was a confidential service. A further key factor was that the felt the users recognised that it was for their benefit.

There was a warning that this service needs to be sold to business / industry as another commodity, but that it appeared that once it had been accepted businesses see great worth in the service, with managers and workforce getting involved. Nevertheless there were different challenges between large and small employers. A concern for some was that there would be a conflict over the seeming inequity of offering special services for men and not for women employees.

The stakeholders reinforced a finding from the analysis of the HoM team in that the recognised that it takes time to get established and that for men word of mouth very important. But that once the men had engaged with the HoM team they were also seeing increases in the use of other services as well i.e. increased usage of family planning

With young men there was a special note made by some that though sexual health issues may be a starting point of access for many lads this seemed to open up the possibility of discussing other problems and now a broad range of health matters are now being tackled including anger management.

One factor that emerged from all the interviews was that the work of the teams has become so central to their own work that demand outstrips the current capacity and that their need is for more not for less such that most stakeholders would not know what

they would do to replace the current provision. The central message is that they would be very hard to replace.

"I: That's the end of my questions unless you have anything more to say?

R: No, just more of him please! "

3.9.7 The future

Different views were given as to whether the team should become part of mainstream services or remain a discreet service, and this was linked into discussion over whether they should be self-sustaining, with the idea of becoming a charity mentioned or in terms of being a commissioned service.

There was a plea from some of the stakeholders that the team should engage in more dissemination of their work and skills, through training of other professionals, conferences and through improved marketing / branding. The question as to whether the work should remain local to Bradford was also raised with a feeling in some that it should become a resource open to the wider region.

The new NHS re-organisation was recognised as being a problem for the team as many of the new managers lacked the history behind the work and this could result in the team being subsumed back into general services, and going back to being target driven. It was felt by some that more use could be made of newly emerging ideas such as Health Trainers and the Self Care initiative.

The issue of the new Gender Equality Duty was not covered in all the interviews, but those who did raise it did note that the work of the HoM team was very important in meeting the requirements of this new legislation.

4.0 Conclusion

This broad ranging study into the services offered by the Health of Men team has created a greater understanding of what is involved in setting up activities that men consider useful. Through field work observations and interviews with men who are using the HoM services, through interviewing the team members and by interviews with the key stakeholders involved in the study a detailed picture has emerged of why men and boys would choose to use this alternative provision.

Taking the man's and boy's perspective has allowed their view-point to be the central determinant of whether male focused services delivered in the community has a part in the overall health service.

The key findings are that the men greatly appreciate the efforts of the team in going out to where they live and work to provide a service that they can see has a male focus and is delivered in a way that they find non-threatening but at the same time authoritative and professionally delivered.

There were no examples found of men who do not care about their health, quite the contrary all the men have expressed concerns, but they have also discussed difficulties over how to use the current health centre approach to services. In part this is due to difficulty of access, with the restricted opening time prohibitive for most men working full time, but it was also influenced by the men's perceptions of doctors, the appointment system and for some fears over a presumed lack of confidentiality and anonymity within the system.

What was evident however was that when a problem was identified by the team the men expressed a willingness to follow this up with an appointment to see a doctor for further diagnosis and treatment.

From the interviews with the team what also emerged was that more than clinical skills were needed to be effective in delivering services to men in these novel settings. As they were the ones pioneering much of the work in this area they had little in the way of guidance into what might work and what would not. There was a high degree of initiative shown in both developing these new services, both from initial conception

through to implementation. With the time frame needed to see some of these services accepted by local communities there was also a requirement to be very patient and to have the confidence to both wait for success when it was felt to be a good idea and to close services that were obviously not going to bring in sufficient men to make them viable.

Though these attributes can be seen to be those needed to initiate new ideas there were others that were evident to be able to work successfully with men and boys. Having the confidence to work with teenage boys or to engage a group of men in their workplace about their health requires many skills beyond basic competency in any one aspect of care. The total package appears to have to be right for successful running of these services (see Conrad 2007).

The stakeholder interviews however displayed a further aspect to the teams work. From their perspective the success of the team in targeting men was accepted, but there were concerns over how the service would be sustained once the Big Lottery Funding had ceased.

There is a paradox associated with this service that seems linked to stereotyped notions of what it is to be a man. This study demonstrates that HoM challenges understandings of men as a) unconcerned with their health, b) unwilling to talk about their health, and c) unwilling to use primary health care services. In contrast to this, HoM also appeals to, and therefore reinforces, these stereotypical notions of what it is to be man by, for example, taking services outside of their traditional primary care setting. The point would seem to be that if HoM can successfully challenge these stereotypical notions then traditional primary care services do not seem to need to change and there is no need for HoM. Alternatively, should HoM fail to challenge such stereotypes then it will become a service no different from the traditional primary care settings that are want to shun concern with preventative health and the needs of specific groups of men. Resolving this paradox was beyond the scope of our research but it may not be necessary to explore this further as this paradox may be what allows HoM to receive the support from traditional health governing bodies (such as the PCTs where they were located) to go beyond the boundaries of traditional primary health care.

4.1 Lessons learnt

From the study it is possible to identify key lessons:

1. Men do care about their health
2. Tackling health inequalities in men from different socio-economic and cultural groups is possible as men will access health services for screening and preventative care if it is made available at a convenient time and place
3. Moving out from the Health Centre brings Primary Care to many more individuals, but men will attend clinics if given a medical reason or a specific appointment is made for them
4. Working with industry and community based services is effective at opening new avenues for the delivery of primary care
5. The time it takes to set up services is longer than for women due to the need for the credibility to be built up and 'word of mouth' support to grow. Incentives are often necessary to get the men engaged
6. Health screening alone is only part of the effectiveness of the service; by giving the men time to talk in confidence allows a much wider range of health issues to be identified
7. Anonymity is as important as confidentiality for young men
8. Practitioners engaging with men in their settings need specific skills
9. Male orientated resources need to be developed and tested
10. Having a team with a range of expertise enabled a broader range of activities to be supported

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