Men's Perceptions of Health: Implications for the delivery of health education programs in Victoria

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Abstract

This dissertation has synthesised the arguments and conclusions of the four research projects and the advanced study units of this doctoral study with published work relevant to the body of knowledge within the framework of men's health. The key issue of concern behind this study was that there have been recent concerns about the gender-based discrepancies in morbidity and mortality rates amongst men and the scant attention generally held by Australian men towards their own health and well-being.

In this document, the arguments have brought together key elements from the author's empirical research which was based upon comments from selected participants in, and coordinators of men's health workshops, and general practitioners. Using concepts inherent in the health belief model (Janz & Becker 1984), several important themes have emerged from this research, including (i) the reticence of men in seeking access to health services in a preventative manner, (ii) the importance of targeting the females who are in relationships with the male as vectors for increased health awareness, and (iii) an increased focus on health services presence in the environments where men congregate, including men's workplaces and certain recreational venues.

In addition, the models of education that have emerged from this research as being appropriate for health delivery advice to urban, rural and disenfranchised men, suggest effective ways to reach out to Australian males. It is therefore anticipated that the knowledge generated within this dissertation will contribute to the enhancement of existing structures inherent within current health education approaches for Australian men.

Statement of Authorship

Except where explicit reference is made in the text of the thesis/portfolio, this thesis/portfolio contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgment in the main text and bibliography.

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Preamble

A personal perspective

The researcher has chosen this topic because of the experiences gained during his working life as a registered nurse and nursing lecturer. He has seen the disproportionate number of men occupying hospital beds as a result of unwise lifestyle choices, personal decisions and recklessness. Often, only when signs and symptoms are too painful, obvious and mostly irreversible, do men present to health services. Men are consistently reluctant to pay due attention to their own bodies and the servicing required. They may not slacken in the area of physical fitness, but often err in terms of denial and their unwillingness to seek out a male health practitioner. Even if two males do get together, the effectiveness of the communication between them when discussing any health issues is, at the very least, problematic. The author is equally culpable in this attitude of deliberate oversight. Statistics on mortality, the incidences of preventative life-threatening conditions and on suicide are testimony to this fact and are covered in the literature review chapter.

As a lecturer in nursing and having a background in clinical expertise, the researcher grew to realise that many male patients admitted to hospital did not understand their bodies and had a complete disregard for inappropriate lifestyle choices and preventative action. This was evident in his professional role, especially when it came to discharge planning and future health education of the male patient. This was underlined by the suicide of the researcher's rural cousin at the beginning of this study and the research into mortality and morbidity statistics published in Australian Bureau of Statistics yearly reports. These have highlighted the discrepancy between male and female deaths in the preventative category.

As a consequence, the intent of this study is to draw conclusions from the researcher’s experience of being involved as a participant observer in men’s health groups. What are the key ingredients in attracting men to participate in a health awareness program and what are the most effective methods for passing this information on to participants in such a way that might prompt a change in attitude and health behaviour? Unless men are shown the effects of their reticence regarding health care in a

supportive and helpful environment, the seeds of health apathy and ignorance are sown from an early age.

This study has been based on four projects that looked at different perspectives related to men's health education. These projects have contributed to an overview for the researcher, of approaches that are currently being carried out, and give indications to future planning, for men in rural and urban setting, and in a men's shelter in a provincial city. To give coherence to the investigation, a theoretical perspective provided by the health belief model (Janz & Becker, 1984; Nutbeam & Harris, 1999) has been used.

Chapter 1

Introduction

The context of this study

The current urgency for issues concerned with men's health in Australia is underscored by the release (25 November 2008) of the details for the development of a 'National Men's Health Policy for Australia' by the Hon Nicola Roxon, Minister for Health and Ageing [1]. It is explicitly stated in this report that the need for such a policy has been driven by a belief that men experience substantial cultural and psychological barriers in accessing health services and consequently there is widespread reticence amongst men to seek medical advice and treatment. In addition, it is stated that the policy will specifically address the needs of groups of men who experience poor health outcomes, in particular Aboriginal and Torres Strait Islander men, and men living in rural and remote areas.

This development of a National Men's Health Policy by the Australian Federal Government emphasises both the context and the continuing need for this current investigation titled *Men's Perceptions of Health: implications for the delivery of health education programs in Victoria*. It has long been apparent that, generally, Australian men do not proactively seek medical support (Laws, 2006; Davidson & Lloyd, 2001). Whether this is because of ingrained gendered cultural influences (Harrison & Dignan, 1999) or the deliberate decision to do nothing until life-threatening illnesses or risk-taking behaviour arise (Laws, 2006), it appears that preventative and community health initiatives have tended to be the province of women and children (Galgut, 2007). Indeed, it has only been in the past five to 10 years that there has been a growing realisation of the needless reduced quality of life and degree of health problems suffered by men which, it is thought, are caused largely by their own bravado and ignorance. The pervasive nature of this phenomenon has been commented on by Shilton (in Harrison & Dignan, 1999) who stated, 'the social body constrains how the physical body is perceived and experienced. Therefore combative, competitive and risk taking behaviour as perceived, experienced and exhibited in the male physical body is socioculturally constructed' (p.53).

The aims of the study

The general area of men's health is very broad, and to ensure depth and integrity to this study, the aims and key research questions of this study have been focussed on one of the major area of Australian men's health that has, until now, been relatively neglected. This investigation has been designed to identify strategies which can be introduced to attract men to health workshops, to identify issues which create an impact on their health awareness, and to delineate the key factors inherent in a successful workshop or health practice. The approach will cover such areas as teaching methods, the role of informal adult learning, the choice of subject matter and the effectiveness of follow-up procedures for participants. As will be indicated in more detail below, a further innovation introduced into the study relates to the sample selection for the study, a refinement which has been necessary because different cultural groups in Australian society have very different pressures acting upon them.

Some important definitions

When engaged with the topic of men's health, there are several concepts which require clarification and further examination to allow precision of meaning because of their contested nature. The two words "men's" and "health", each contain a myriad of implicit meanings and intricate relationships, which need to be defined more closely in the context of a scholarly investigation. The main themes which emerge in this respect are, first, those of masculinity and gender, and second, the definition of health appropriate for the cohort being studied. In addition, attention must be given to the way that the current literature related to men's health and health education interprets these concepts, and cognisance of the various theoretical models which have been used by investigators must also inform the study.

The social meaning of 'male'

This investigation is concerned specifically with Australian men living in the state of Victoria, the relevant cultural issues and support structures for this population must be carefully identified. For the purposes of this study, the term "man" is defined in terms of males over the age of 18 years living in either rural Victoria or the capital city, Melbourne. Being male within such a society brings with it particular cultural

expectations and norms related to role taking, physical appearance and expectations of masculinity.

Using a biological approach, Harris, Nagy and Vardaxis (2006), define being male as ‘pertaining to the sex that produces sperm cells and fertilises the female egg to beget offspring; masculine, a man’ (p.1055). However, for the issues with which this thesis is concerned, definitions need to be directed at constructed understandings that emerge from a specific societal group. With the groups chosen to be at the focus of this study, gender occupies a central role in their culture, and these understandings of gender dictate how males behave and conform to society’s expectations. Whilst males can be defined as being of a particular genetic gender which Shilton (in Harrison & Dignan, 1999), refers to as ‘the genetic composition or genotype of an individual and is represented by X and Y chromosomal presentation, XY being male, XX being female’ (p.52), he goes on to expand on the notion of social gender which is socioculturally determined and influences how an individual will behave and feel according to gender. He refers to the notion that, within social gender, the individual consists of two bodies; the social body and the physical body. This notion of social body constrains and dictates how the physical body is perceived and experienced.

Further, apart from obvious physical differences that exist between males and females, Gray (2005) alludes to the way that these differences are interpreted as being pivotal to how men see their bodies. Gray (2005), comments that ‘culturally, women’s bodies are seen as open, both in relation to sexual penetration and through giving birth or menstruating; men’s bodies are seen as closed, strong and invincible, as evidenced from the risk-taking men engage in’ (p.3). In a similar fashion, Gillon (2007) refers to investigations carried out on the question of male gender and the attributes associated with this term such as aggressiveness, strength, competitiveness, non-emotionality, separateness and problem-solving. Gillon (2007), says ‘these characteristics are often formulated in oppositional terms to attributes commonly defined as ‘feminine’ and indeed it is often argued that the distinction between the two is pivotal in the establishment and maintenance of male identity’ (p.10).

A definition of ‘health’

Health is described by Smeltzer-Bare (2000), as ‘a dynamic, ever-changing condition that enables a person to function at an optimal potential at any given time’ (p.46). A similar notion of health is presented by Ewles and Simnett (2003) who suggest ‘health is a dynamic state, that each person’s potential is different, and that each person’s health needs are different. Working for health is both an individual and a societal responsibility and involves empowering people to improve their quality of life’ (p.7). Because of the specific issues involved in the population at the centre of this study this investigation will follow an approach that mirrors Ewles and Simnett’s notion that health is a personal issue, and that health practices are impacted upon by external situations. Implicit in this choice is that, in Australian society, health is recognised as a very personal issue for males, and that there are significant cultural and societal expectations on a male regarding stoicism that powerfully impact upon health promotion decisions. Therefore it is recognised here that health is socially constructed and has an important influence on health-seeking behaviours.

A theoretical perspective consistent with these definitions

Because the area of health is so important at the personal and societal level and also because it is a universal and continual area of concern and development, there have been many health models advanced by various authors to deal with specific health issues. The potential of theory to drive the development of health promotion ideas and implementation can never be underestimated (Nutbeam & Harris, 1999). Some of the major models that have been used to underpin health investigations include the biomedical model, (traditional approach to medicine, treating individuals via surgery or drugs), the biopsychosocial model (extension of biomedical model, focuses on the individual taking in biological, psychological and social factors), the web of causation (used to identify risk factors between the agent, for example a virus, the host and the environment), the ecological model (addressing environmental impact between human interaction, social organisation and the natural environment) and the new public health model (focusing on social determinants of health with the prevention of illness through community participation) (Germov, 2005). However, to assist in the systematic formulation of this work, it was judged that the health belief model (Janz

& Becker, 1984) best informs the research question under investigation. This is a useful theoretical approach for studies into men's health since it involves reference to the perceived susceptibility, seriousness, benefits and barriers to personal health behaviour, which, as indicated above, are all significant issues for men. Nutbeam and Harris (1999) state 'the health belief model is one of the longest established theoretical models designed to explain health behaviour by better understanding beliefs about health' (p. 19) including the perceived threats and outcome expectations. This model will be more fully introduced and described in Chapter 4.

Background to the study

Behind this study are two particular concerns. First, there is the issue of what it is about men's health in Australia that sparks such a public need for attitudinal research into men's health behaviour, and second, what are the effects of existing men's health educational workshops? In essence, it might be asked, perhaps rhetorically, why worry about men's health and what can be done about it? The immediate response to this question will include the observation that health statistics published in the past five to ten years are cause for significant alarm and this fact alone provides the impetus for this research. Thus, to help set the background for this study, the following published information is provided, and it clearly implies that men's health is in need of significant attention.

The life expectancy of Australian men is 77.0 years and for women it is 82.4 years, indicating that, on average, men's lives are more than five years shorter. Closer examination of these figures indicate that the number of male deaths are greater at all ages beginning with infancy until age 65 (Laws, 2006**)**. However, men visit their doctors around 15% less often than is the case with women (Gillon, 2007; Pattison, 1998; Webb, in Harrison & Dignan, 1999). Up to the age of 14, boys are twice as likely as girls to die from accidental injury, in, for example, motor vehicle accidents and from drowning. In the 15-24 years age group, males are three times more likely to die from motor vehicle accidents and four times more likely to commit suicide (Australian Institute of Health and Welfare, 2006).The overall death rate for males in this age group is 2.65 times that of females (Pattison, 1998).

Men are four times more likely than women in the 25-64 age group to die from coronary artery heart disease and have significant higher death rates from conditions such as stroke and diabetes (Laws, 2006). Approximately 50% of men are overweight compared to one third of women, and around twice as many men die of skin cancer than women (Healey, 2008). Men are more likely to abuse alcohol and drugs and have a higher suicide rate than women, behaviours that are linked to depression (Barton, 2000). Men are more likely to use illicit drugs and are at least three times more likely to die from alcoholic liver disease (Daniels, 2001; Pattison, 1998). Such statistics suggest that there is a social construct at work which influences the health-related behaviour of men which is a key part of this study.

Importance of the study

This study will look at men's health from a social-cultural perspective rather than from an anatomical or physiological stance. Within the constraints of the particular population chosen for the study, the investigation attempts to seek out and define the most efficient ways to reach these men, to determine why they are so reticent about issues related to their health and to uncover the most effective methods of teaching men about health and lifestyle issues in terms of the lasting impact on their health belief attitudes. Whilst in recent times, there has been a significant increase in literature on related men's health topics (Gibson & Denner, 2000; Laws, 2006; Buckley & Lower, 2002; Noone & Stephens, 2008) little published work exists on the question of how to meaningfully engage men in health-centred discussion or on the different health needs of men obtained from their own perspective.

Boundaries to the study

This investigation has chosen not to include the contributions of various self-interest health groups, since it is predominantly concerned with those men who have, or seem to have, barriers to their self-health promotion. Further, it is recognised that there are a number of specific groups of males in Australian society that have significant health promotion issues, but for purposes of focus and depth of intent of the study, these groups have not been included [2]. From the theoretical point of view, the feminist perspective on health has not been selected for comment, although the work of women scholars in raising health awareness issues is recognised and acknowledged.

Overview

There is a well documented problem related to the reticence of men to access health facilities which consequently can exacerbate health related problems in their later life.

This has been the impetus behind the study leading to the research focus:

How do men perceive issues related to health maintenance and what implications does this have for the delivery of health education programs in Victoria?

This has been broken down into four related studies. They provide different perspectives on the research question from professionals, rural men, urban men and disenfranchised men:

- The first is a study of a men's health workshop in a small rural town
- The second is a study of men's health workshop conducted in Melbourne
- The third is a study of a men's shelter at a major Victorian town for disenfranchised men
- The fourth is a study of key personnel within the area of men's health

Each study consisted of the following data collection methods:

Participant-observation, in-depth interviews, questionnaires

These results allowed us to gain the following information:

- Identification of the successful marketing strategies adopted, the appropriate style of educational approaches undertaken, and the perceived effect of this interaction on rural men's approaches to health
- Identification of the differences in environment between rural and urban dwelling which may give rise to different stressors, circumstances and lifestyle
- Identification of the health needs and major effects on disenfranchised men within a men's shelter in a major Victorian town, including an overview of their educational needs
- An evaluation of the experiences and knowledge gained by men attending health education programs

This leads to the conclusions that:

- Men are appreciative of any effort to reach them
- The primary aim must be to reach men under 40 years old
- It is important to infuse into school programs the concept of men's health
- Men learn differently to women – different strategies are required to reach them
- Participating rural men concentrate on physical aspects such as poisons, injuries, blood pressure; urban men focus on emotions
- Men can be reached through mobile community health programs
- Women are important vectors in influencing men's health seeking behaviours

Figure 1. Overview of the dissertation *Men's perception of health: Implications for the delivery of health education programs in Victoria*

The research projects

This investigation was not designed to focus upon any particular illness or condition, but rather intended to provide a 'thick' (Geertz, 1975) overview of the context of men's relationships to health promotion behaviour in the chosen population. The researcher completed four projects, each yielding a different insight into men's health issues related to the chosen population, each playing a part in the aim to find the most successful ways of approaching men about their health. The research projects which form the basis of this program of study are: Project 1 (Appendix 1), a men's health workshop in rural Victoria held over a five-week period where the researcher was a participant-observer; Project 2 (Appendix 2), a comparative study of a continuing men's health gathering held in suburban Melbourne, which sought to provide an overview of dynamics, method of delivery and aspects of health relevant to these men from an urban perspective; Project 3 (Appendix 3), which included health education strategies at a men's shelter at a large regional Victorian town, looking at ways of engaging men and ensuring their health was assessed and maintained; and Project 4 (Appendix 4), which focused on the thoughts of the co-ordinators and their views on the most effective ways to engage men and the strategies needed in delivering health information to them. These four linked projects were carried out because multiple perspectives were required to contribute to and validate the research findings. In particular, the purpose of involving practitioners was to assess whether there were any links between the perspectives of health professionals and the views of the men from the different groups.

Table 1: Research project focus and methods

Projects	Focus	Methods
Project 1	Men's health workshop in a small rural town. Recruitment, content, teaching strategies and effect.	Participant-observer, questionnaire, interviews.
Project 2	Comparative study of men's health workshop conducted in Melbourne. Recruitment, content, teaching strategies and effect.	Participant-observer, questionnaire, interviews.
Project 3	Men's shelter in a major Victorian town. Health needs, education, major effects.	Participant-observer, questionnaire, interviews.
Project 4	Leaders in men's health – strategies to deliver health education to men.	Interviews.

Data from these projects will be analysed to highlight commonalities in the barriers to men's health, and to raise awareness about potential adult educational approaches that might be appropriate for these groups. In the literature review, this paper looks at men's health from an Australian perspective, although it is acknowledged that there are similarities in other western countries. It includes an examination of current tertiary courses on men's health studies which reveals a not-surprising dearth of options, the flavour of Australian masculinity, our cultural leaning towards condoning risk-taking behaviour and male expectations. Adult education strategies and their application to men in this context of preventative health, plus differences in learning patterns amongst different groups will be discussed, as will the general health status of Australian males.

The research question

The main question that has been developed to drive this research is:

> How will men in rural and urban Victoria perceive issues related to health and what implications does this have for the delivery of health education programs in Victoria?

The structure of the dissertation

The dissertation will synthesise the arguments and conclusions of the four research project units, and synthesise them with published works in order to contribute to the current body of knowledge in the area of men's health in rural and urban Victoria. The implications for men's health education that will evolve from this research will reflect current trends and the diversity of health education in an Australian cultural context, and it is anticipated that the knowledge generated in this dissertation will be able to inform and enhance the existing structures inherent in the health education platform for some Australian men.

The work comprises six chapters. The Introduction, Chapter 1, has indicated the current significance of the study, presented statistical data to emphasise the

importance and need for the investigation, and given an overview of the research design. The significance of the study will be presented in Chapter 2, and Chapter 3, the Literature Review, will examine the current situation in regard to health statistics for Australian men, adult learning models, educational studies in men's health, cultural implications related to masculinity issues and community health approaches. Chapter 4 will look in detail at the research methodology, outlining and describing the general research domain throughout the study, the data collection methods utilised in each project and their rationale. Reference will be made in this chapter to seminal studies that have been used for similar purposes. Chapter 5 will give the results of the analysis in summary form, and will discuss the findings in terms of the theoretical background of the health belief model. The final chapter, Chapter 6, will present the conclusions to the study and set out recommendations that have sprung from this research - what health promotion practices should be put in place in Victoria, what current practices should be maintained and enhanced, and what future options there might be for the health promotion of rural and urban males in Victoria. The four contributing research projects are reported separately in Appendices A – D.

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[1] (http://http://www.health.gov.au/).

[2] For example, there are more than 400 workplace deaths each year in Australia. Men account for more than 93% of these deaths, yet they constitute only about 56% of the workforce. Such an observation suggests that this population would be itself an important focus for investigation. Also, the average life expectancy of Aboriginal males is about 58 years, around 17 years less than non-Aboriginal males. In the 35-44 years age group, the death rate of Aboriginal males is 11 times that of non-indigenous males. Statistics such as these indicate that there are special groups in Australian society that deserve and warrant special study, and should not be subsumed in a larger work. Consequently, problems that beset specific groups of males were not followed up due to the complexity and specificity of the environments in each case.

Chapter 2

Significance of the study

The societal perspective

In setting the context for this study, it is apposite to reflect briefly on the reasons why the issue of men's health has been chosen as an appropriate research investigation at the doctoral level, and to indicate how this study will significantly contribute to the existing body of knowledge relating to men's health. In particular, it is appropriate to indicate why the particular focus of this study has been chosen, which has led to the formal research question:

> How do men in rural and urban Victoria perceive issues related to health and what implications does this have for the delivery of health education programs in Victoria?

First, as indicated in the previous chapter, there is, currently, a paucity of information regarding the topic of men's health in Australia. Indeed, it is only in the last decade that there has been evidence of a serious concern about the state of men's health across the nation (Smith, 2007). Whilst this lack of concern seems to have its genesis in a number of related areas, one of the main factors is the nature of the Australian male psyche and the nation's cultural views of masculinity (Laws, 2006). Other relevant factors, which are perhaps not as immediately obvious but nevertheless need to be recognised since they too have contributed to the lack of attention to this area, will be mentioned in the course of the dissertation. However, whatever the reason for this apparent oversight, examination of the literature on men's health reveals that the majority of scholarly contributions in this area deal with disease processes, focussing in particular on those conditions that affect males in particular, such as prostate cancer, cholesterol levels and testicular cancer (Laws, 2006; Robertson, 2007). There are some general works that deal with the notion of masculinity (Gillon, 2007; Renaurd, 1993), and comments on the rise of the feminist movement and the male response (Davidson & Lloyd, 2001; Germov, 2005), together with broad reports on men's health dealing with the demographics of workshops held for men (for example,

Gibson & Denner, 2000) that indicate numbers, location, age of participant and material covered. Consequently, it is anticipated that this investigation will present a serious attempt to provide a more detailed consideration of the factors that contribute to men's health: in particular to those issues which relate to knowledge of health maintenance issues.

Second, there is a particular issue of how the health profession can meaningfully connect with Australian males and, in the context of health workshops, how they can deliver an effective program that would impact on men's health choices. There are men's health magazines on newsagents' shelves which cover areas of health, but in general they are presented in a format in a similar style to popular women's magazines, dealing more with sexual prowess, muscle definition and money matters than with the more personal health awareness that also need attention, such as encouraging men to seek advice about their long-term health and the importance of regular medical checks. This investigation will build on the growing interest in men's health and in men's health workshops, and it is anticipated that this work will develop key ideas to assist relevant health services in presenting successful men's health workshops.

Finally, it appears that men's health has been, in general, considered to be a relatively unimportant issue in societal discourse until recent years. In the area of politics, for example, it seems a poor vote-catcher at either local or federal level and, in terms of budget allocation, is little valued as a community service (Luck, Bamford & Williamson, 2000). As a result, there has been a low level of interest toward the issue of why men are dying younger than women, why men generally appear to not be taking responsibility for their health and why young men in particular are staying away from men's health workshops and continue to exercise risk-taking behaviours (Verrinder & Denner, 2000). Over the past couple of years there has been a significant shift towards developing awareness of the state of men's health. This has come in the form of the introduction of men's health week (www.menshealthweek.com.au), also a web site dedicated to men's health and its components (www.menshealthaustralia) and a Federal Government men's health policy as mentioned earlier (www.health.gov.au/menshealthpolicy). It is anticipated that a significant outcome of

this study is that it will contribute to this growing movement to put men's health higher on the agenda in the mind of the Australian public.

The methodology

A significant contribution to the knowledge in this field which this study will make lies in the fact that all four components have been undertaken as a participant-observer in men's health education workshops, not from a detached outsider's view. This approach has allowed data to emerge from a qualitative viewpoint, capturing the intricacies and nuances of what issues make up a successful workshop and to more intimately gauge the reactions of the participating men. This has opened the way for a deeper analysis of how men learn more effectively about topics which are often regarded as taboo, and to be more open to their personal and private thoughts about the workshops.

In an attempt to provide a more general overview of this topic, the study is not limited to just one interest group, nor only one workshop. It has been designed to provide a more balanced view by breaking the research into smaller, manageable parts: one study looking at a country workshop, while another providing a comparative study of a men's health workshop in the city. A further dimension was added by investigating how informal health teaching can take place in a men's refuge centre for disenfranchised men at a large rural town. In each of these three projects, not only were the participants observed, interviewed and questionnaires completed, but the co-ordinators for the projects were also interviewed.

Finally, in order to gain a broader perspective, seven co-ordinators of programs in men's health were interviewed. Talking to these co-ordinators, who between them see many men and have conducted a great number of courses, complemented the data gained from the participants themselves. Each of these key informants has an extensive background in health and all had conducted sessions for men and counselled men individually. Collectively, they provided a good insight into the approaches needed for the advancement of men's health.

The challenge

Because of the general apathy of men towards their own health, the term ‘men’s health’ is seen to discourage many males, and further often fails to interest funding authorities who provide support for targeted health research projects. Both governments and the Australian public need to be more clearly and openly informed about current problems related to men’s health and their attitude to health-related issues. Another term used that will be discussed later is ‘workshop’ which can be a negative for many men when asked to attend outside their working hours. The challenge in Australia is to create a socio-cultural change in the approach to men’s health which requires energy, positivity, commitment and time.

In order to help focus and limit the remit of this study, the following definitions have been used to define and clarify the parameters of the investigation.

Urban: refers to the special characteristics that arise from living within a large city where there is a concentration of population.
Rural: refers to characteristics of living in a country area where a participant might be exposed to country life as distinct from living in a city area.
Disenfranchised men: refers to those men who, for a variety of reasons, are deprived of their normal social rights and privileges and are not afforded the respect of the community.

Chapter 3

Literature Review

Part one: the health-related terrain of the Australian male

This literature review examines reported discussions and studies related to the question of the need for specific educational approaches and a change in cultural expectations related to the state of men's health in Australia. In order to contextualise this need, issues related to the metaphorical terrain and environment of the Australian adult male, underscoring the part that pressures of culture, masculinity, peer pressure and societal expectations have played in determining issues related to health and longevity, will be explored.

In addition, as indicated in an earlier section, there is an imperative to clearly define how the term 'health promotion' is being used in this study, since this will determine the nature of the recommendations made as a result of these investigations. At one level, there are straightforward definitions that might be used such as that of Bunton and MacDonald (2002), for example, who suggest that:

> ...stated simply, health promotion is a strategy for promoting the health of whole populations…definitions of health promotion, like health itself, are subject to social and political influence and are, therefore, likely to vary across organizations and social contexts, making universal definition almost impossible (p.10).

According to this definition, health covers such a broad spectrum of concepts with many varying interpretations, that community health programs need to recognise this diversity. Adams, Amos and Munro (2002) refer to this by saying:

> … how health is defined remains central to the business of health promotion. This is also true for "community development", a dynamic concept meaning different things to different people, according to time, place, culture and purpose (p.84).

The most common definition of health comes from the World Health Organisation and is reported in Duckett (2004), as 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (p.13). This

wider definition, encompassing the mental and social aspects of a person's life, might provide a pointer to the reticence of men to seek help from others. Whilst sustaining physical damage to the body can confer some degree of respect from other males because of the inferred disregard for hurt, any suggestion of mental or social infirmity is more likely to attract approbation and scorn because it is commonly linked to inherent weakness or lack of personal strength.

The literature indicates issues that need to be scrutinised are embedded in our cultural and societal expectations, and are reflected in the lethargy that Australian males demonstrate when looking after their health (Noone & Stephens, 2008; Germov, 2005; Robertson, 2007). Australian men generally fail to seek professional advice on maintaining their health and, for various psychological and cultural reasons, commonly neglect all but the most rudimentary personal health practices. There have been numbers of public health programs available for some years (Verrinder & Denner, 2000; Laws, 2006), but many men, especially those under middle age, have not responded because they often regard them as irrelevant and appropriate only for women and children (Gray, 2005). Davidson and Lloyd (2001) state:

> ...primary healthcare services (PHC) have, on the whole, developed with the needs of women and children in mind. Opening hours are a good indicator of the priorities of many PHC services. Daytime surgeries are the norm and evening surgeries often operate without an appointment system, leading to longer waiting times (p.26).

Some authors contend that men's health usually has a very personal aspect, as men generally do not know how to express themselves (Gillon, 2007; Luck, Bamford & Williamson, 2000). For example, grief is not often shared and one question that needs to be asked is "what does emotional well-being mean for men?" In this respect, men find it hard to be emotionally intimate with other men because, in Australian culture, there is often a fear of misinterpreted sexuality involved. This attitude has led to the notion of "homophobia". Indeed, Hamilton-Smith (in Laws, 1998) states, 'despite some more enlightened attitudes, there is still widespread disapproval and marginalisation of male homosexuality' (p.92).

Furthermore, in Australia, there is a strong cultural notion of a "do it yourself " imperative, which is most likely a legacy of the experiences of the early settlers, who often had no neighbours and forged a nation from an isolated and often hostile

environment (Ward, 1966). One significant outcome of this somewhat introverted attitude is that women appear to have become the main instigators when it comes to prompting men to attend to their health. For example, at a recent men's health conference held in rural Victoria in September, 2006 where the author was present, approximately 50 per cent of the participants were women. The steering committee that organised the conference had seven members, of which five were women.

Presentation to health services

It has been observed that many of the health problems that men manifest are preventable (Smith, Braunack-Mayer & Wittert, 2006) which is, in one sense at least, an encouraging situation since there exists the possibility of public education programs having a part to play in men's health promotion. This is of central importance to this investigation because whilst it is centred upon the question of why men are currently avoiding health promotion programs, there must be achievable targets for the programs.

It appears that lifestyle and socialisation within the Australian identity are important factors when discussing the risk behaviour and poor health status of Australian males (Germov, 2005). Researchers in the field (for example, Noone & Stephens, 2008) believe that the reluctance of men to seek medical advice is deeply rooted in the psyche of the Australian male. In this respect, it has been noted by earlier authors on men's health such as Mathers (1995) that:

> Working age women report 40% more hospital episodes, 35% more doctor visits, 16% more outpatient visits, 24% more dental visits and 25% more other health professional visits than working age men (p.17).

Further, Napthine (1998) states:

> On the whole, men do behave badly…at a broader level, men do not look after themselves. They are less aware of how their body works: they have less insight into how "body maintenance" is repaid in long-term health benefits; they indulge in more risk-taking behaviours; they are less likely to seek health advice, whether from family, friends or health professionals (p.32).

More recently there has been a slight but significant trend towards 'an increase in the proportion of encounters that were with males, although females still

accounted for 56% of all G.P. encounters in 2006-2007' (Australian Institute of Health and Welfare, 2008, p.319).

Women tend to use health services more frequently than men for a wider range of conditions, especially for those of a non-life threatening, chronic nature. This is a significant observation, and as Huggins, Somerford and Rouse (1996) state:

> … socialised gender roles have a very real influence on health service utilisation. When morbidity is perceived as being mild, then men feel they should deny feelings and symptoms and not seek medical advice. However, once the morbidity is perceived to be serious, then it is okay for them to seek help. Men often present with life-threatening illness, the symptoms of which they have kept to themselves for a dangerous period of time (p.12).

In this regard, it is unclear whether this reticence is due simply to the powerful forces of socialisation, or whether there is a degree of uncertainty based in ignorance which is preventing a male seeking advice. A telling statistic here, (keeping in mind that males are the predominant gender working in dangerous industries) which indicates that this phenomenon is certainly gendered across the lifespan, is provided by The Australian Institute of Health and Welfare (2006), who state:

> ...death during working ages is more common among males than females. At age 25 years, male deaths are three times as common as female deaths, falling to 1.5 times as common at age 50 years, before beginning to rise again to age 64 to approach being twice as common (p.213).

Recent research in this area confirms the above observation. Grbich (2004) states:

> Australian men and women rate their own health status in very similar ways. In the 2001 National Health Survey just over 50% of men and 53% of women rated their health as excellent or very good. Then we have notable differences between men and women in their likelihood of consulting a doctor or other health professional. In the previous 2 week period 27% of women and 21% of men consulted a doctor. A similar differential exists for consultations with a variety of other health care providers including those providing complementary or alternative medicine (p.137).

There is little available data on the characteristics of general practitioners' patients, the problems or diagnoses managed, and nature of the management. There clearly is a need for primary health care data in this area, and to this end the Australian Institute of Health and Welfare and the University of Sydney are collaborating on a national continuous survey of general practitioners' activities. Data collection began in April,

1998, and each year the project sampled about 1000 general practitioners on a rolling basis. They are asked to supply information on themselves and on 100 consecutive patient encounters, including home visits and consultations in nursing homes and hospitals. This may be important in identifying why females go to doctors more often, as the frequency may be biologically determined, due to conditions such as menstruation or female contraception.

An important finding to date is given by the Australian Institute of Health and Welfare (1998), which claims:

> …this difference in GP consultation rates between the two sexes becomes progressively wider with rurality and remoteness. Males in "capital cities" visit the GP 24% less often than female counterparts, and males in "other remote areas" visit the GP 35% less often than females (p.43).

It is this relationship between the rural and regional nature of lack of health care awareness that is of particular concern and has led to some contributing projects of this study being focused in a rural area. Australian Institute of Health and Welfare (2008) states that:

> … compared with those in major cities, rates of death in regional areas were 1.1 times as high for all ages, and 1.2 times as high for people aged under 65 years. For very remote areas, death rates were 1.7 times as high for people across all ages and 2.7 times as high for people aged under 65 years (p.84).

Male consultations in general practice in Australia 1999-2000, recently released by the University of Sydney and the Australian Institute of Health and Welfare (2006), reveals that almost one in four males has not seen a doctor in 12 months compared with one in 10 females (Australian Institute of Health and Welfare, 2006). Bayram, Britt, Kelly and Valenti (cited in Monaem, MacDonald, Woods, Hughes, Orchard & Jasprizza (2008)), state:

> The Bettering the Evaluation and Care of Health (BEACH) project findings in Australia support the notion that men attend general practice less often than women (p.4).

One indication of the importance of adult male culture in this regard is given by the following observations. Table 2 illustrates that up to the age of 14, there are approximately equal numbers of males and females visiting health professionals. It is

after this age that a disparity emerges which continues throughout the whole life cycle, which suggests it is usually the mother who takes her children to the doctor on an equal basis, and after becoming independent, males prefer not to seek regular medical advice. This is supported by Verrinder and Denner (2000), who state:

> ...the rural and regional population of men at large also seem to be poor attenders at GP surgeries: in recent studies in Bendigo and the Mallee, only approximately 30% of the clientele of GPs were men (p.82).

This suggests that men traditionally go to their doctors only when they have symptoms or injury rather than including preventative health care in their regular health promotion habits. Indeed, over the past 10 years, there has been a measured difference between the genders of frequencies of visiting a health professional. The Australian Institute of Health and Welfare (2004), has reported that:

> On an age-standardised basis, in 1984-85 males consulted a GP or specialist on average 4.2 times per year and the female population averaged 6.0 times per year. The peak was in 1995-96 (5.7 and 7.7 respectively) and in 2002-03 these rates were 5.0 and 6.7 respectively (p.297).

Table 2. General practitioner consultations: age and sex of patient

Age	Male (%)	Female (%)	Persons
<1	1.0	1.0	2.0
1-4	3.0	2.8	5.8
5-14	4.0	3.9	7.9
15-24	4.4	7.7	2.1
25-44	10.6	16.8	27.4
45-64	9.8	12.9	22.7
65-74	5.4	6.6	12.0
75+	3.7	6.4	10.1

Source: Australian Institute of Health and Welfare (1998, p. 212)

This could, at face value, suggest that women are ‘overserviced’. That is, women utilise services more because of their biological differences as well as a greater acceptance of these services. Davidson and Lloyd (2001), recognise this possibility, stating that:

> … clearly the number of GP visits made by women will be inflated because of family planning, pregnancy, childbirth and children. Nevertheless, the gender differences apparent from these figures are thought to highlight the way women use GPs (i.e. as a point of referral) and that men go more hesitantly (p.24).

Further, Kirby, Carson, Kirby and Farah (2004) make similar comment, saying:

> ...men's bodies do not undergo the same physiological changes that women experience in the effect of their monthly hormonal cycles and pregnancy. The majority of illnesses are short-lived and usually have an external cause such as accidents and infections, such that when visits to the doctor are required they are practical events to receive treatment (p.4).

Referring to doctor visits and hospitalization, the Australian Institute of Health and Welfare (2006), has found that:

> ...males and females aged 25-34 years received 5.4 and 12.9 Medicare services respectively, rising to an average of 15.7 and 18.7 services among males and females aged 55-64 years (p.211).

This observation again emphasises this reduced frequency of visits to medical practitioners by males over their whole life-cycle.

Notwithstanding the arguments advanced above for the greater frequency of female use of medical services, there is a clear paradox emerging, which leads to the question of 'why do men have higher death rates from many preventable diseases, suicide and trauma compared to females?' Gibson and Denner (2000) referred to John Anderson, the then Federal Minister for Primary Industries and Energy, who was addressing the National Rural Public Health Forum in 1997 and suggested:

> … the exact answers to such questions, of course, are not known, but major contributing factors are the health awareness level of men in general, a higher level of risk-taking by men in many activities, males ignoring early warning signs or denying health problems and a reluctance in many cases to visit a doctor when they should. They often leave it too late (p.4).

It would seem from these comments that women are not 'overserviced' in the area of health, but for unknown reasons, men are underserviced, and it is this underservicing with which thesis investigation is concerned.

Health overview

A key issue in this investigation is that health is a broad concept and has to be looked at from a holistic perspective, rather than purely from the medical model, which is more concerned with the curative than the preventative approach. With regard to health education, a central concern of this investigation, it appears that community health centres became a focus of health promotion activities in the 1970s in Australia. Swerissen and Duckett (in Gardner & Barraclough, 2002) state:

> … during the period of the Whitlam Labor government (1972-1975), attempts were made to reform primary care through the introduction of a community health program, which sought to establish community controlled health services to provide integrated primary health care, including medical and nursing care, particularly in areas with poor access to these services (p.18).

It is suggested that primary health care service was seen as a balance between treatment and prevention, with the emphasis on prevention. However, funding for preventative health has subsequently been overshadowed by a somewhat reactionary approach within the health care system which is significantly guided by a treatment-oriented medical fraternity. In this regard, the current balance of medical funding for intervention programs is less than desirable. Indeed, Keleher and Murphy (2005) state:

> ...public health expenditure by governments, infrastructure within governments (rather than the private sector) and state funding for interventions are essential for good health. [However], in Australia, public health expenditure is only about 2 per cent of the total health budget (p.104).

This observation has important implications for health education programs with which this investigation is deeply concerned. Indeed, Laws (2006) has stated that:

> … the term ‘health promotion’ is now difficult to separate from terms such as ‘primary health care’, ‘public health’ … and ‘community health’, because the boundaries between them are not constant and there may be overlapping meanings to each (p. 37).

Perhaps as a consequence of this general paucity of public funding for health education programs, and particularly those aimed at males, there is still a marked

discrepancy between preventable deaths for men compared with women as is illustrated in Table 3. Preventable death not only refers to suicide or accidental deaths, but to chronic diseases which come as late presentation by men to health services, and in this context, the term 'preventable' means 'to hinder the occurrence of an illness or to decrease the incidence of a disease' (Harris, Nagy & Vardaxis, 2006).

Table 3. Leading causes of death – 1997

	Males	**Females**	**Persons**	**Proportion of total deaths (%)**
All causes	**67752**	**61598**	**129350**	**100**
Malignant neoplasms (cancer)	19279	15037	34316	26.5
Malignant neoplasms of trachea, bronchus and lung	4605	2058	6663	5.2
Ischaemic heart disease	15565	13486	29051	22.5
Cerebro vascular disease (stroke)	4879	7254	12133	9.4
Chronic obstructive pulmonary disease and allied conditions	3830	2627	6457	5.0
Pneumonia and influenza	2151	2866	5017	3.9
Accidents	2935	1617	4552	3.5
Motor vehicle traffic accidents	1240	561	1801	1.4
Diseases of arteries, arterioles and capillaries	1538	1395	2933	2.3
Diabetes mellitus	1425	1420	2845	2.2
Suicide	2146	577	2723	2.1
Hereditary and degenerative diseases of the central nervous system	896	1112	2008	1.6
All other causes	13018	14207	27315	21.1

Source: McLennan (2000, p. 217).

Apart from hereditary factors, all of the above are mostly preventable by appropriate lifestyle and health choices coupled with regular health checks. The overt preventable causes are work-related or home accidents, motor vehicle traffic accidents and suicide. This table is of historical interest in considering the relative mortality rates between males and females. In every category apart from suicide, there has been a gradual decline in numbers for both genders (Laws, 2006). This is so especially in the area of motor vehicle accidents, where there has been a concerted educational effort

directed towards consciousness-raising within the general population. Clearly, public education programs, in conjunction with policy changes and legal ramifications associated with drink-driving, the mandatory use of seatbelts and the introduction of bike helmets has dramatically reduced the statistics related to road trauma.

More recently, the Australian Bureau of Statistics (2009) presented the leading causes of death by gender for both males and females in 2007 with 12,119 and 10,610 deaths respectively. Those causes where there was a high proportion of males was trachea and lung cancer (62%), suicide (77%), blood and lymph cancer (including leukemia) (57%) and chronic lower respiratory diseases (55%).

A parallel is drawn here with avoidable mortality, and it is postulated as part of this thesis that this is an area where health education may have a key role in today's society, especially when directed at males. Although avoidable mortality through, for example traffic accidents, has generally declined in recent years, it still shows a disproportionate weighting towards males in Australia. Australian Institute of Health and Welfare (2008) state that 'as with overall mortality, the avoidable death rate among males was higher than among females; 232 per 100,000 for males compared with 121 per 100, 000 for females' (p. 51). Prior to this, the Australian Institute of Health and Welfare (2004) had stated that:

> ...suicide is a leading cause of injury death, comprising nearly 30% of all such deaths in 2002. As in previous years, the male suicide rate was considerably higher than that for females, across all age groups. Similarly, the male rate showed characteristic peaks in early adulthood (25-39 years) and old age (85 years and over), whereas the female rate remained relatively constant across all age ranges (p.37).

It is suggested here that this fact needs to be taken into consideration when planning educational programs for men, as this mortality rate from this avoidable cause is at an unacceptably high level and should not be condoned in a civilised society. Hence, counselling in areas of self-esteem and personal problems, together with recognition of early signs of depression in males, especially in the older age bracket, needs to be made a priority in the education process.

With the passage of time, suicide rates are not being reversed, but are increasing. Historically, higher mortality rates for males have been recorded, and the Australian Institute of Health and Welfare (2004) noted that:

> A total of 133,707 deaths were recorded in Australia in 2002, approximately 5200 more than in 2001. The median ages at death in 2002 were 76.2 years for males and 82.2 years for females, and the age-standardised rates were 821 deaths per 100,000 males and 543 deaths per 100,000 females (p.43).

Statistics gathered in Victoria indicate that males are more likely to succeed with suicide attempts, where 'the standardised total avoidable mortality rate was 75 to 100 per cent higher in males compared to females between 1997 and 2003, the difference being statistically significant in all seven years' (Department of Human Services, 2007, p.24), and 'for intentional self-inflicted injury deaths in 2005, 1609 males died compared to 420 females in the same year' (Australian Institute of Health and Welfare, 2008, p. 234.)

Another telling comparison presents standardised death rates which enable a comparison between populations with different age structures by relating them to a standard population. In Table 4, the standard population was taken to be all persons in the 1991 Australian population. Figures are expressed per 100,000 persons.

Table 4. Death by suicide in Australia: 1988-1997

Years	Males (Number)	Females (Number)	Totals (Number)	Males (Rate)	Females (Rate)	Persons (Rate)	Sex (Ratio)
1988	1730	467	2197	21.5	5.6	13.4	3.8:1
1989	1658	438	2096	20.1	5.2	12.5	3.6:1
1990	1735	426	2161	20.7	4.9	12.7	4.0:1
1991	1847	513	3360	21.7	5.9	13.7	4.4:1
1992	1820	474	2294	21.1	5.3	13.1	3.6:1
1993	1687	394	2081	19.3	4.3	11.7	3.6:1
1994	1830	428	2258	20.7	4.7	12.6	4.8:1
1995	1873	495	2368	20.9	5.4	13.0	4.4:1
1996	1931	462	2393	21.3	4.9	13.0	3.9:1
1997	2146	577	2723	23.4	6.1	14.6	3.8:1

Source: McLennan (2000, p.218)

Today, the trends with suicide are changing but there is still a disproportionate rate with male suicides. There were 1,881 deaths from suicide registered in 2007 nearly three quarters (71%) of suicides were males. In 2007, 21% of all male deaths under 35 years were due to suicide. Throughout the period 1998 – 2007 the male age-standardised suicide death rate was approximately four times higher than the corresponding female rate (Australian Bureau of Statistics, 2009).

It is also clear that the disparity between genders in regard to average life span is not decreasing. Data published by Australian Bureau of Statistics (ABS) (Table 5) reinforces the differences between males and females in Australia over the last 90 years. The question needs to be asked: what is it about being male and female at this time in history that results in such a wide disparity with respect to life expectancies?

Table 5. Average life expectancy at birth and at age 65, 1905 to 1993, Australia

At birth	1905	1921	1947	1966	1993
Males	55.2	59.2	66.1	67.6	75.0
Females	58.8	63.3	70.6	74.2	80.9

Source: Australian Bureau of Statistics (cited in Mathers, C. (1995) *Health differentials between Australian males and females: a statistical profile*. p.2.)

If these average life expectancies are brought forward, based on current mortality rates a boy born in 2005-2007 can expect to live 79.0 years while a girl can expect to live 83.7 years (Australian Bureau of Statistics, 2009), suggesting that there are still significant gender-based issues that need to be addressed in the health-related areas.

Health perceptions

One important perception of health (Miller-Keane, 1997) is that it is:

> ...a relative state in which one is able to function well physically, mentally, socially and spiritually in order to express the full range of one's unique potentialities within the environment in which one is living (p. 697).

According to this suggestion, it is not merely the absence of disease that indicates health, but a balance and optimal functioning of all areas of an individual's life. However, the perception of "health" may have different meanings to different individuals (Noone & Stephens, 2008). Napthine (1998) suggests that in many women's magazines, the term may relate more to personal appearance, sexual interest or a self-satisfying feeling of pleasing oneself rather than to health behaviour or healthy functioning. In recent editions of men's magazines, health matters are often displayed under the guise of improved sexual prowess, muscle development, managing alcohol intake and subjects that appeal to the male machismo rather than an holistic health focus as described above. This is demonstrated by the subject headings of a random issue of the *Australian Men's Health* magazine (February, 2003), which included: 'Get more sex! 30 signs she secretly wants you'; 'Hard muscles fast. Your complete one hour work-out'; 'A night to remember'; 'Work less, earn more'; 'Decked out. Hot fashion for the high seas'; 'Is that tasty?'

These headings, among others, overtly appeal to the masculine-conscious rather than the health-conscious male. It suggests that this approach is the only way to get men to read articles about health, garnishing the stories with promises of sex appeal, muscle definition or money management. The essential ingredients of women's magazines that appeal to female readers are duplicated for the male reader, with masculinity the key difference. Hoare (1993) suggests in this regard that:

> …men are difficult to access for health promotion, or even illness monitoring. "Male" magazines do not generally provide much space for health issues and do not have the mass circulation (or appeal) of "women's" magazines, which may be a better vehicle for male health issues…marketing of health promotion to men may therefore require a journey to where men are gathered, be it the workplace, the football, races or the pub, and to present information and services in a way which is attractive, relevant and accessible (p. 67).

Hoare's observation is interesting and is one which is being applied in many places around Australia. Numerous attempts have been made to conduct men's health workshops in health clinics and schools, with minimal effect. An example is a report from a small town in New South Wales, which was presented at the "Clinical skills in men's health – healing men in practice" conference held at the University of Newcastle in September, 1999. As a part of health improvement planning, monthly

meetings were held at the local health centre at night, yet it was mentioned at the conference that numbers of men attending were disappointing even after extensive advertising. By comparison, success stories have come from gatherings of men at hotels, sporting nights and sport venues, which are places where men feel comfortable and in their own environment (Gibson & Denner 2000).

Another disturbing trend with men's health, and one that will be of global significance, is the general drop in sperm counts. De Krester (1996), writing in the *British Medical Journal*, says:

> ...the controversy over sperm counts began with a meta-analysis.... which showed a decline in sperm concentrations from $113x10^6$/ml to $66x10^6$/ml between 1940 and 1990. These findings were supported by Auger et al. (1996) in a study of 1351 fertile men in Paris (p.457).

Johnson (1997) refers to these figures and says, 'between 1981 and 1991, men with no mature sperm cells rose from 8% to 20%. Men born in the 1970s produced an average 25% fewer sperm than those born in the 1950s' (p.37). This may be a symptom of reduced health and a changing environment facing men today, and if this trend is extrapolated, even with *in vitro* fertilization techniques, the future of the human race will be at risk within the next century. Surprisingly, even with research to confirm this trend, minimal action has been initiated to confront this problem or even to alert the community. De Krester (1996) reminds us that a significant impairment of fertility is often not detected until sperm concentration drops to below $5x10^6$/ ml. However it is important to appreciate the changing use of statistics when looking at this area, since the methods of clarifying this information now are much more sophisticated than in the 1950s, which may have to be considered when interpreting this data.

Male health funding

Although health services attempt to provide cover to most people within a community, as indicated earlier there is a disparity in the delivery of services and education between the sexes. Since the rise of feminist consciousness, women's health has been high on the political agenda and information on health issues is now freely available to many women.

Further, Smith (1994) states, 'what emerges is an unflattering portrait of a group that almost literally will not lift a finger to help itself' (p. 59). The lack of information regarding prostate cancer is severely deficient when compared to comparable women's health education. This is an exclusively male health problem, as testosterone is the hormone that affects the growth of the prostate.

The disparity continues today. 'Health system expenditure allocated by disease was 18% higher for females than for males – $28.5 billion compared to 24.1 billion. Expenditure per person was $2781 for females which was 17% higher than the $2377 for males. When maternal conditions are excluded, expenditure per person for females was 10 % higher than for males' (Australian Institute of Heath and Welfare, 2008, p. 412).

Clearly, there appears to be a lack of interest in researching men's health by men, as it is men who predominantly determine research funding and where it should be invested. When looking at this issue, Verrinder and Denner (2000) noted:

> Arguably, rural men's health is not receiving its share of research. A search of material published in the period 1993 to March 1998, using the Current Contents database with the search terms "men's health + rural", yielded one study, a sexual behaviour survey of males and females in rural Tanzania. The search term "women's health" yielded 842 studies, while "men's health" on its own yielded only 60 studies, the vast majority being on acquired immune deficiency syndrome (AIDS) (p.82).

It appears that while most men do not consider their health to be an issue of high importance, it is exacerbated by the findings of related research in Australia showing that it is the lower socio-economic groups that suffer higher mortality and sickness rates. For example, Germov (2005) says:

> ...if we look at almost every health indicator – such as the rates of accidents, death, mental illness and acute and chronic illness – we find that the poor die younger, have a shorter life expectancy and suffer higher rates of illness (p.26).

This underscores the importance of Project 3 of this investigation which explicitly examined the case of disenfranchised men from lower socio-economic circumstances.

In a similar vein, Ots (1996) believes the need for advocacy is evident when individuals or groups do not have the social, economic or political power to obtain resources and opportunities equally from the total resources funding within society. Therefore, in addition to the health status of men being an issue because of apparent inequalities of health outcomes as compared with women, there is now significant evidence that males from lower socio-economic groups are more at risk compared to females from their attitudes to self-health promotion. This is a key consideration for this investigation, and as a contribution to this topic, one of the contributing projects has been conducted in a disadvantaged men's shelter.

History has shown that women have been able to politically raise awareness of their health needs in Australia far more successfully than their male counterparts. In this respect, Laura (1998) writes:

> … drawing attention to these conspicuous discrepancies in the state of men's and women's health is not to suggest that men are in every case victims of disease, mental anguish and self-destruction…it is intended primarily to illustrate that men have a long way to go to catch up to the current state of female health awareness, coupled with preventive health behaviour (p.8).

Further to this comment, Healey (2008) makes the observation that:

> Figures compiled in 2001 by men's health advocate Michael Woods show that the amount of Federal Government funding for women-only health programs was more than 200 times greater than for men-only programs: $212 million versus just $1 million (p.3).

Such findings suggest that there is a political element at work here, and for reasons which are still unclear, men are not as well organised with respect to political issues when compared to the well-orchestrated and substantive efforts of women's groups over a considerable period of time.

Masculinity

It is often claimed that 'masculinity' is an important factor in the determination of attitudes towards men's health practices (Noone & Stephens, 2008; Laws, 2006), and that hegemonic masculinity puts the male at a significant disadvantage in the area of

health management. Lee and Owens (2002) define the notion of 'hegemonic masculinity' as:

> ...the traditional patriarchial view of men and men's behaviour … a man is characterised by toughness, unemotionality, physical competence, competitiveness and aggression. According to this model, men must compete to demonstrate their superiority to other men (p.3).

These authors argue that the effect of socio-cultural expectation must also be considered, suggesting:

> The causes of gender differences in health behaviour arise from men being socialised to disregard knowledge about healthy lifestyles and to choose harmful behaviours, as one way of acting out the male script, while women are socialised to be cautious with their own health and protection of the health of others' (p.13).

As implied earlier in this review, Australian males relate more to their own sex on a physical, rather than emotional, level. Stoicism to pain and injury and a refusal to admit weaknesses are required in our culture as overt displays of masculinity (Smith, Braunack-Mayer & Wittert, 2006). This failure to relate and share concerns is arguably a factor in Australian males' approach to their health needs, and showing emotion is often seen in Australian culture as an act of weakness. Recognised examples of this are the well-publicised tearful displays of Australian Prime Minister Bob Hawke when asked about his daughter and drugs, and Roger Federer after losing the 2009 Australian Tennis Final, which attracted much media commentary interest.

Further to this, Taylor, Stewart and Parker (in Laws, 1998) have observed that:

> In an analysis of 296 taped visits by patients with a serious illness to their doctors, male patients gave less information and asked fewer questions than female patients. However, men gave twice as much information to female doctors as they gave to male doctors. Men do not wish to appear "weak" in front of other men (p.20).

This apparently contradictory behaviour about revealing personal illnesses is another significant indicator that a strong masculine cultural element is at work. In a similar way, it appears that men present to health and medical clinics on a less frequent basis (Galgut, 2007), possibly because they find medical waiting rooms less male user-

friendly than women, as experienced by participants in this research study, given waiting room's greater emphasis on child and female well-being through displayed posters and pamphlets.

It appears from the above examples that one of the main issues in men's health is masculinity and its associated cultural and social expectations. Many of the problems preventing men nurturing their health arise from the pressures linked to the concept of masculinity. In this regard, Laws (2006) states that:

> ...there are social practices and behaviours linked to masculinity which predispose men to health problems/injury (eg the habitual use of alcohol, risk-taking and violence). Issues arise out of society's expectations of maleness (homophobia) (p.5).

In the last thirty years, with the rise of feminist consciousness, gay rights and changing work practices, men have undergone a massive change in self-concept and male role patterns. The significant change in social norms that these movements have catalysed, have resulted in a growing identity crisis amongst Australian males. Robertson (2007) believes that:

> ...peer pressure seemed important in encouraging health practices such as smoking and alcohol consumption and in dissuading men from making health dietary choices. Discussions about weight and fitness levels seemed acceptable, but talking directly about health or illness was seen as 'wussy' and was thought to indicate signs of weakness. Perhaps because of this, the research suggests that men distance themselves from health issues and their own health needs. Many of the men also felt overwhelmed by health information that often seemed contradictory, and they had concerns about how health information was transmitted (p.23).

It appears that male-centred culture dictates to a large degree how men see themselves and defines the boundaries that exist within. These changing societal views of masculinity have caused a male identity crisis, and appropriate courses of action are becoming blurred and confused for many Australian males. A major contributor to this conundrum is the media portrayal of the male species. The work of Macnamara (2004), himself a journalist, focused on the current media image of men. He states that:

> ...with the exception of a small minority of positive media portrayals of male heroes … the only males presented positively are men and boys who have been 'feminised' such as 'metrosexuals' and males who exhibit a feminine side. Maleness is widely represented as innately and culturally evil, and characteristics of masculinity are principally portrayed as undesirable and anachronistic (p.276).

This observation seems to suggest that there is not a consistent passing-down of male values, belief systems and stories to the next generation. Further, it may imply that there is a reactionary tendency amongst males as they distance themselves from the feminisation of maleness which could be manifested in increased self-destructive and risk-taking behaviour.

As a consequence of these media messages and societal changes, the notion of masculinity and traditional connection with 'maleness' is being challenged in the minds of many men. There is a resultant confusion of the male role, identity and place in society. The differences between masculinity and femininity are no longer seen as a natural pairing of genders which are required to strengthen and complement each other, but rather as a source of discomfort. Macnamara (2004) examines this situation, and observes that:

> ...given the celebratory tone of feminism toward being a woman and femininity, this suggests that being a woman is a laudible accomplishment, a source of pride. But the widespread criticism and at times vitriolic attacks on men and masculinity suggest that being a man/male is a failing and a cause for shame (pp.291-292).

Resonances of this position can be seen in community health advertising and statistical evidence where the male is seen as the role perpetrator for child abuse and domestic violence. Indeed, Macnamara (2004) states in the conclusion to his investigation that 'in turn, imbalanced discourse, policies and legislation is likely to trigger resentment, frustration and anger among men' (p.298). Although this has to be recognized as the opinion of a journalist rather than the output of academic research, the observations made appear to resonate with what is occurring in the current sociocultural context.

What the foregoing discussion highlights is that there is a male dilemma which is yet to strike a balance between being seen as tough, capable and resilient, but still willing

to show a sensitive side. While the gender issue, with its associated physical and psychological differences, is well documented, Sabo and Gordon (1995) state that:

> ...what has received less attention, however, are the negative impacts on men's health and longevity that flow from men's immersion in and pursuit of masculine identity and roles and their accompanying power and privileges (p.56).

This is a key platform in the recognition and advancement of men taking responsibility for their health, and forcefully underscores the central role of male culture in any initiatives in this area. Germov (2005) has specifically stated that:

> ...in parallel to women's health initiatives, men's health advocates have identified the importance of investigating the role of masculinity in men's health, recognising that certain elements of masculine identity and behaviour can be hazardous to health. These insights suggest that improving men's health will entail slow and careful shifts in understandings of what it means to be a man in contemporary society (p.107).

As indicated here, a misguided focus upon masculinity for its own sake appears to get in the way of health-seeking behaviours for men. This deliberate cast of mind has been identified and squarely presented by Gillon (2007), who notes:

> ...help seeking [amongst men] denotes vulnerability, failure and hence weakness; attributes that run contrary to the terms of hegemonic masculinity, and thus to be resisted wherever possible. Hence many men avoid contact with services offering help, preferring to ignore difficulties, work them out themselves or cope in other ways rather than succumb to the shame and distress of asking for assistance (p.2).

Male mentoring

It has been observed by a number of commentators **(**Gray, 2005; Gillon, 2007), that we are currently seeing the results of a lack of good role models for boys, and within this criticism has been a focus on poor fathering practices. For example, Biddulph (1995) writes that:

> …boys in our society are horrendously under-fathered and are not given the processes or the mentor figures to help their growth into mature men. With no deep training in masculinity, boys' bodies get bigger, but they don't have the inner changes to match (p.3).

This failure in fathering and role modelling may be partly manifested in boys as low self-esteem, lack of self-discipline and a poor appreciation of how to care for their bodies. Self-esteem can be a factor in the higher rates of male suicide mentioned earlier, and lack of self-discipline and inability to appropriately nurture their bodies is directly related to the neglectful health promotion behaviour that is central to this study.

Of relevance to male mentoring practices, is the realisation that masculinity is a term that is not as revered today as it once was, and is in danger of outliving its usefulness Renaurd (1993). Traditionally, it has been accepted as the role, or indeed the prerogative, for men to serve in community protection and hunting for survival. Further, Renaurd has looked at the question of whether these changing ideas of masculinity have affected the physical and mental health of the male species. As a result of his investigations, he has suggested that:

> … in less than two hundred years of technology and progress the unique physical advantages possessed by man have become superfluous to a large extent. He is no longer exclusively capable of fighting wild animals nor curbing the wilderness, conducting wars – nor is he necessary to propagating the race. Modern technology and test tube fertilization have taken over to perform the most basic of functions (p.1).

As a result of these emerging perspectives, it appears that it is not constructive to look at masculinity or femininity as separate entities but rather as a combination, each having positive and complementary functions. In an important way, masculinity has been lost in the 'battle of the sexes', and masculine traits have been targeted as being no longer appropriate nor relevant. Renaurd (1993) further alludes to this when he says:

> …anger was designed by nature to protect primitive man from predators who threatened his existence. Most of those threats no longer exist and so anger becomes a clogging agent in the male psyche. Men have learned not to express emotions or 'feelings' (p.2).

This may be a factor behind the current rise in street and domestic violence due to inappropriate release of pent-up frustrations. When considering the traditional role of man in society, the expectations and parameters that controlled behaviour have been

drastically altered in the past decades. In a study related to the effects of recent global conflicts which had such horrendous and unprecedented death tolls, Buchbinder (1994) states:

> ...in the 20th century, the fact of two world wars, Korea and Vietnam, had an important effect on traditional masculinity. The male population of western societies was significantly reduced, requiring women to take on roles and responsibilities that had previously been the province of men (p.8).

Notwithstanding these deep-seated changes to traditional roles, many men have retained older ways of being, and part of this vestigial cultural masculinity manifests in a reluctance to seek help or be seen to be overly concerned with one's health. But it is clear that the times are changing, and as Morton (1997) wryly observes:

> Men, however, have failed to grasp the implications of what is happening. Many men are still locked into patterns of behaviour that were appropriate in the 1950s, but are out of step with women's needs and aspirations in the 1990s (p.8).

When looking at the deeper genesis of these patterns, it is possible that some blame could be directed at understandings that have emerged from the work-related occupations of males in essentially male-dominated areas that carried with them continual elements of danger, not only in the short-term, but over longer periods. Weisner (1993) has noted that:

> ...more men than women are engaged in outdoor work – in open cut mining, as labourers, horticulturalists, gardeners and construction workers…it was male miners who worked with blue asbestos, male naval engineers and sailors who sweated in asbestos-ridden ships and it is males who are now being diagnosed with mesothelioma – an occupational cancer attributed to asbestos fibres (p.18).

This long term relationship between male workers and dangerous occupations is a factor in the development of cultural and societal expectations. This is also reflected in the sporting world, where traditionally men have engaged in contests based upon strength and male prowess, making them more prone to blatantly exhibit their masculinity through risk-taking and direct physical challenge, which inevitably leads to long-term injuries. Indeed**,** Sabo and Gordon (1995) refers to this when he observes that:

> Violence, pain and injury are frequently internalised and rationalised by players, coaches and spectators at both amateur and professional levels of competition. Tolerance of risk and injury is in fact, sometimes reframed and legitimated as a means of impressing coaches, or as a way of establishing kudos, prestige and identity within the team setting (p.159).

Embedded in this observation, are concepts such as kudos, prestige and identity, which are central to the development and maintenance of a culture and which are difficult to reverse or even modify. This may underlie the reason why there has been little attention devoted to the effects of masculinity and its related health outcomes. Germov (2005) has remarked on this issue, saying that it is:

> ...perhaps a surprising consequence of attempts to rethink health research is that it highlights the neglect of masculinity – as well as femininity – in health and health research … there has, until recently, been little detectable effort to consider how masculinity may figure in health and diseases (p.104).

Recently, however, at the highest level of sport, where significant amounts of money are involved, more care is taken to protect key players and there is an increasing awareness that risk-taking has to be controlled by rules, counselling and proper assessment of the environment and the athlete. Laura (1998) has seen that:

> A good coach knows when other health professionals should be called upon to provide invaluable pre-season assessments and will not hesitate in referring an athlete to the wide array of resource people now available in sport (p. 48).

This effect, although still mainly focused upon elite sportspeople, may be one of the ways into more widely spread interest in proactive health care if used in a role-modelling sense with emerging players.

In concluding this section, there is still the difficult question of why men die earlier than women. Surveys of those typically male behaviours, which it is suspected have a peer or role modeling aspect, indicate that many self-damaging practices are still common. Recent studies (Davidson & Lloyd, 2001; Harrison & Dignan, 1999; Gillon, 2007) indicate that males exhibit worrying health-related behaviours and symptoms which include not having regular medical checkups, smoking, excessive consumption of alcohol, high cholesterol levels, hypertension, inadequate diet, poor levels of exercise and over-exposure to the sun. As a possible consequence, many men die two

or three years after retirement, apparently unable to cope with the changed lifestyle and separation from the culture of their working life. By comparison, women manage home life and retirement more effectively than men and, with the availability of women's self-help programs, can get assistance through this period of their lives.

As indicated in an earlier section, a related issue here is the financial status of the individual. In this respect, Morton (1997) talks about the relationship between health and economics when he says:

> ...there is a great deal of sociological and statistical data to support the view, for example, that there is a close relationship between being poor and being in poor health. There is a link between economic and social inequality and the condition of our lives (p. 35).

Although this clearly impacts on both genders, it becomes somewhat exacerbated when a male leaves employment and is reliant upon a pension, since both a perceived reduced quality of life and lack of dignity present significant strains to the masculine image. Male mentoring may need to be more directed to men in financial difficulties as this has been clearly proven to be associated with their health status.

Mental health, including workplace issues and ethnic background

Importantly, there are societal factors that intimately affect male mental health, and, as indicated in the discussion of the definition of health, these factors play a key role in health-related behaviour. Paradoxically, although men are continually in jeopardy of mental ill-health, it is not permissible with a male culture to exhibit or admit such strains. Authors such as Grey (2005), Gillon (2007) and Noone and Stephens (2008) however, point out the magnitude of this problem, describing areas which directly affect the mental health of men. Many of these areas are, ironically perhaps, related to the way in which masculinity is manifested. For example, there is the effect of war and the results of combat on returning soldiers. Most of the armed forces sent to Vietnam, Korea and the world wars were men, whose experience often had a lasting legacy on their health and mental status after they returned. This can be seen with the Vietnam veterans and the ongoing adjustments they have had to deal with concerned with their health, both physically and psychologically.

Unemployment, especially if it is long-term, can lead to depression. The current downsizing of corporations and reduction in staffing on the factory floor coinciding with the rise in technology has had an effect on people's self-esteem and health. For those in the workplace, added stress and longer hours to keep their positions produce stress-related symptoms such as gastric ulcers, high blood pressure, inadequate diet and alcohol-related problems. The extent of this issue is reported by Abraham and Krowchuk (1996) who state:

> ...unemployment at the level of the individual and his family may be best understood as stress due to excessively demanding life events. Many of the health problems observed among the unemployed are similar to those noted among other people under psychological stress: hypertension, cardiovascular disease, myocardial infarction, stroke, depression, aggression, psychosis and child abuse (p.41).

Hazardous male-dominated professions such as police, fire officers and ambulance officers are high risk and stressful and place their members in a vulnerable situation in regard to their health. It has been noted (Australian Institute of Health and Welfare, 2006) that 'around 6% of all deaths registered in Australia in 2004 were considered to be due to injury, almost 22 per day. The overall injury death rate was more than twice as high for males as for females' (p.123). In addition, workplace related psychoses are an increasing feature of lost time as a result of the increase in stress caused by the complexities of the modern industrial and economic world (Germov, 2005).

In the current economic climate, homelessness is becoming an increasing problem that affects both genders. In particular, many young men are now experiencing tough home lives as teenagers and have no training in communication, relationships or how to run a family, and fathers are not coping well with children leaving home and are not maintaining contact with these children (Lee & Owens, 2002). A related issue is the increase in separation and divorce, and it appears that the majority of divorces are initiated by women. Because of a general trait amongst women to reveal and share intimate feelings, men often have a problem with communicating and expressing frustrations and difficulties until conditions have escalated to such an extent that the female is forced to take drastic measures such as a separation. Healey (2008) says that 'as in previous years, more females (40.0%) than males (29.5%) lodged applications for divorce in 2006' (p.4). This discrepancy again illustrates the possible lack of

insight that men have in an emotional relationship which can lead to unresolved frustration and related health issues.

Living with a female partner appears to improve a man's health. Laws (2006) mentions that men may have more extreme responses to separation and divorce, suffering health problems such as depression, headaches, emotional trauma, sleeplessness and a poor appetite. Baum (2003) argues that men may have a distinct way of mourning which starts later than women and expressed through action rather than in words or obvious manifestations of grief. Taber (2001) says men start to recover after six months to a year, after this they may require professional help. Divorced men are 2.5 times more likely to commit suicide than married men, and more than eight times as likely as divorced women.

An important strain that arises with pubescent children is that of uncertainty about sexuality and sexual behaviour, which can often lead to severe mental trauma (Davidson & Lloyd, 2001). This may be partly due to a lack of education regarding such issues, and it has been noted by McGrane and Patience (1993), that:

> In the Victorian education system, sexuality education is taught, if at all, within the Personal Development Framework. According to Ministry of Education guidelines in 1991, health education received 'between 6-10 per cent of personal development teaching time in years 7-10, [whilst] physical education received 50-60 per cent of personal development teaching time (p.43).

Although this reference is somewhat dated and it refers only to one facet of the formal learning opportunities that characterize our society, it nevertheless indicates a gap in the way accurate sexual knowledge is transmitted within contemporary society. Particularly for boys who went through this period of schooling, the intervening culture of male privacy regarding sexual matters may have resulted in a generation of young men who show evidence of a lack of knowledge regarding their own health and lifestyle decisions due to this lack of appropriate information.

In Australia, an added factor of importance in this study is the high percentage of residents from non-English speaking backgrounds. Apart from the ethnic cultural and religious aspects that attend personal development, lack of facility with English and possible alienation from the host community can result in barriers to a male seeking

health services or indeed being ignorant of what services are available. Fortunately, significant efforts have already been made to allow people from non-English speaking backgrounds the opportunity to be able to read in their own language important health care facts. For example, at the Royal Melbourne Hospital, there are over 100 different languages represented in their health fact sheets, which is recognition of the multi-cultural character of their clientele. Notwithstanding these efforts, it has been found that non-English speaking background males seek psychological counseling at a greater rate than their English speaking counterparts (Germov, 2005).

Another pressing Australian issue is that associated with Aboriginal communities. It is clear that substance abuse amongst men, in the form of alcohol abuse, petrol and glue sniffing, over-medication or drug addiction brought on by depression, boredom, biological intolerance or ignorance is common. Reid and Trompf (1994) refer specifically to the alcohol problem when they state:

> ...the available evidence confirms that the consumption of alcohol by many Aborigines is higher than that of Australians generally….while the factors underlying Aboriginal use of alcohol are undoubtedly complex, and multi-factorial, it is probable that, for many Aborigines, a sense of powerlessness, and an awareness of that powerlessness, are of key importance (p.69).

Although this is not only a male-related problem, the frequency and seriousness of substance abuse within the Aboriginal community warrants close attention at all levels of the community, and counselors need to be continually alert for signs of psychological stress. A historical perspective from the past twenty five years on the magnitude of this issue can be gained from the 1994 National Aboriginal and Torres Strait Islander Survey (NATSIS) which was conducted by the Australian Bureau of Statistics in 1994. Involving 15,700 participants, the relevant results regarding substance abuse are shown in Table 6.

Table 6. Perceived substance use problems among people aged 13 years and over, by place of residence, 1994 (per cent).

Cause	Capital city	Other urban	Rural
Alcohol	64	84	76
Marijuana	48	65	41

Petrol sniffing	12	65	41
Other drugs	29	26	11
Glue sniffing	15	14	6
Other dangerous substances	13	17	10

Source: Australian Institute of Health and Welfare (1996, p.28).

Fast forward to the present day and there is still a disturbing trend of poor health and substance abuse within the general Indigenous population. Of interest to this study is that in the 2004-5 National Health Survey, Indigenous males 18 years and over were twice as likely to be current smokers compared to non-indigenous males. For Indigenous males, hazardous alcohol intake peaked in the 35-44 years age group with 17% reporting high level risks of alcohol consumption. The median age at death ranged from 45 to 59 years for indigenous males and from 65 to 78 years for non-indigenous males (Healey, 2008).

As indicated in the discussions above, the role of the male in Australian society has become blurred in recent years. No longer is the male image one of primary earner, protector and decision-maker. With the rise in feminism, these standards have been tempered, and in some cases, even reversed. In an overview of this change, Pattison (1998) reflects that:

> ...in addition to all this, many men seem to be struggling with their role. Many are confused, stressed and not satisfied with their life. Many have difficulties with issues such as power and control. In this context, some men are prone to act violently, especially within the home (p.139).

These cases of violence unfortunately tend to become a label for all men and males could easily feel uncomfortable when confronted by warning posters in medical waiting rooms regarding male violence. Living in society today means being in a time of enormous upheaval and change, and labels become a way of giving sense to uncertainties and a way of giving some understanding to our lives. One such label is the mid-life crisis, usually attached to people in their 40s and 50s, but sometimes as early as those in their 30s. Relevant to this issue is a comment by Hamilton (1994), who says:

> ...men today feel under more pressure than at any other time in history. Their role as breadwinner has been replaced by the dual career couple and their status in the home has been eroded (p.59).

With the disturbing proliferation of guns in the community (even with the Howard Government buy-back scheme), as evidenced by crime reports and the recent motorcycle gang violence, the role of male protector of the family in the physical sense has been seriously undermined, thus taking away one of man's original roles in life. When added to the recent advances in sperm donors, *in vitro* fertilisation programs and genetic modification, it can be seen that, at the beginning of the 21st century, men are increasingly frustrated and confused about their societal roles. In considering this situation, Scanlan (2003) has encapsulated these observations by saying:

> ...the result of all these changes has left men feeling more stress than ever before. Going to war was once considered their most stressful challenge, but now it is everyday life. The male role is now unclear, his purpose has been downgraded and all too often is not even needed (p.18).

It is suggested that the future of men's health is dependent on men changing the way they approach their thinking about health and not becoming stereotyped into the masculinity role of societal expectations. This change needs to occur earlier in the life cycle so that it becomes a way of life, and not a drastic change of direction further down the line. Following this line, Harrison and Dignan (1999) assert that:

> …there needs to be a massive change in the way society sees men's health. This should begin at school where boys can learn not only about their bodies, but also about the social aspects of taking responsibility for their own care and demanding equal status with women's health (p.12).

To achieve this change, there has to be a co-ordinated effort aimed at the mindset of risk-taking, machismo and aversion to preventative health behaviour amongst Australian males. Gibson and Denner (2000) state categorically that:

> … at present, men's health is still at the stage of identifying how we best approach men, inspire their interest in preventative health care, attract their attention to public health programs and generally raise their awareness of the health services and health professionals available for their use (p.5).

The waiting room at the local health clinic is a prime example of a facility that urgently needs to change to meet the health needs of men. Issues such as general accessibility, a reduction in the amount of time spent waiting for appointments and spending more time with the individual are ways that doctors can work more effectively with men. In a recent study of health services, Buckley and Lower (2002) concluded that:

> ...men not unduly concerned by privacy were 2.57 times more likely to visit a health service than those who showed concern for privacy issues. As such, the adoption of measures to ensure privacy for rural men who use health services is required. This could include locating services for men in discreet areas that increase anonymity and adhering to appointment times, thereby minimising time spent in waiting rooms and the potential to be "seen" by other locals (p. 14).

Furthermore, health facilities, including community health centres and health professionals such as community health nurses, are often viewed by men as being focused primarily on the needs of women and children (Laws, 2006). Clearly, if this is a wide-spread perception amongst males, it may significantly influence the success of programs conducted for men from these venues, as men will not relate closely to community centres.

What has become obvious from searching the literature into men's health is the overall lack of dedicated books and specific support services compared to those available for women's health. The promising aspect is the recent increase in journal articles and conference proceedings committed to this topic over the past five years, which reflect a slowly changing trend of recognising the importance of this issue. In addition, the issues raised in men's health are becoming more inclusive, relating to both physical and mental health. However, it will only be with careful and progressive marketing of health education to men that these issues can be widely addressed and not just limited to philosophical jousting in conferences and workshops.

It seems from the preceding discussions that Australian male culture is partly a contributor to this problem of dissemination of information. Men's relationship to health and their behaviour patterns are culturally engraved and difficult to shift. As a consequence, it appears from the studies into men's health that many men in this country do not even recognise that they have a problem, but if they do, they are then

limited in their options by a lack of appropriate health seminars, by the literature and facilities that are available and the cultural expectations of how a man should behave. The enculturation of health behaviour and the delivery of health education programs needs to be targeted from an early age to achieve positive results in the area of men's health, and this observation is a key motivator behind this investigation.

Part two: Adult education and men's health

One of the first issues to be addressed when teasing out the educational needs of men is a consideration of the essential triggers that facilitate the passing on of knowledge to the adult male population. Hayes (2006) states that 'compared with children, adults have a vast wealth of knowledge, gained in formal and informal settings, which they bring to new learning situations' (p. 4). The implicit notion here is that adults have different learning strategies and behaviours to children, therefore a focus on the theory of adult education, called andragogy (Knowles, Holton & Swanson, 1998; Hayes, 2006; Burns, 2003), is appropriate in this investigation. In addition, the environment that has attempted to tackle the area of education for men's health comes under the area of community education and outreach programs, in-service programs in the workplace and, to a lesser extent, the tertiary education sector (Scanlan, 2003), which again emphasises the adult nature of the clientele. Consequently, this review will look closely at the andragogical model in an attempt to discern more clearly what constitutes the educational notion of an adult if we are talking about their education and targeting processes.

Definitions of adult education usually assume that because of the adult status of the students, that the education experience is intentional. Merriam and Brockett (1997) state that adult education refers to 'activities intentionally designed for the purpose of bringing about learning among those whose age, social roles or self-perception define them as adults'(p.8). This somewhat self-obvious definition does, however, highlight the importance of fixing the notion of 'adult' since adult status can be classified very differently according to cultural norms and can be more complex that simply reference to chronological age. Definitions of adulthood therefore do not always directly relate to maturity, which is dependent on age and experience and can occur at

different times in the life of an individual. In this regard, Tight (1996), says 'adulthood may thus be considered as a state of being which both accords status and rights to individuals and simultaneously confers duties or responsibilities upon them' (p.14).

Knowles et al. (1998), when dealing with andragogy suggest that there are four viable definitions for the term "adult". They note:

> First, the biological definition….when we reach the age at which we can reproduce…. Second, the legal definition….when we reach the age at which the law says we can vote, get a driver's licence, marry without consent and the like. Third, the social definition….when we start performing adult roles, such as the role of full-time worker, spouse, parent….finally, the psychological definition….when we arrive at a self-concept of being responsible for our own lives, of being self-directed (p.64).

Of these four perceptions, the last concept, where the key term 'self-conception' appears, is the one which seems most important for the learning behaviour of an individual, and is commonly regarded as the most important factor of interest to educational researchers. Galbraith (2004) recognises this and states:

> With all this emotional tension, it is not surprising that learner self-esteem (confidence and satisfaction in oneself) should also be an important component for teachers of adults to understand and deal with in the teaching and learning process (p.16).

According to Burns (2002), the term androgogy was first used by a German grammar school teacher, Alexander Kapp, in 1833 during his description of the educational theory of the Greek philosopher Plato. For some time after this, the term went out of favour but reappeared in 1921 through the work of the German social scientist Eugen Rosenstock. However, it was not until the mid 1950s that other Europeans started using this term, and consequently the term andragogy has been extended to not only encompass adult education, but also refer to social work and community involvement (Knowles et al., 1998).

The currently accepted andragogical model is the treatment constructed by Knowles et al. which is based upon the European model, and which contains a broad definition of andragogy as the art and science of helping adults learn. This perspective came

from the beginnings of adult learning in two streams of enquiry - the scientific stream and the artistic or intuitive/reflective stream. Knowles et al. (1998) credit the scientific stream to Edward Thorndike and the publication of his *Adult Learning* in 1928 which was not specifically related to the process of adult learning, but rather with learning ability of adults. The artistic stream was launched by Eduard Lindeman with his book, *The Meaning of Adult Education,* in 1926. In this book, Lindeman (cited in Knowles et al., 1998) states:

> … one of the chief distinctions between conventional and adult education is to be found in the learning process itself. None but the humble become good teachers of adults. In an adult class, the student's experience counts for as much as the teacher's knowledge….indeed, in some of the best adult classes, it is sometimes difficult to discover who is learning most, the teacher or the student (p.39).

Knowles et al. (1998) summarise Lindeman's key assumptions about adult learners as follows:

1. Adults are motivated to learn as they experience needs and interests that learning will satisfy.
2. Adults' orientation to learning is life-centred.
3. Experience is the richest source for adults' learning.
4. Adults have a deep need to be self-directing.
5. Individual differences among people increase with age.

The first presumption based on Knowles' model is that adults need to know why they need to learn something before undertaking it, and this is taken to be one of the major factors in motivating an adult to actively seek to be a successful learner. Consequently for meaningful adult learning to take place, it is imperative that the facilitator deals with issues related to 'need-to-know' when delivering an adult education program. The learner has to come to the point in his life of having a self-concept of being responsible for his decisions and seen by others that he can be self-directed in his learning. As a result, this androgogic model does not admit a didactic style of teaching, but emphasises freedom of expression and the opportunity for the adult student to explore a range of possibilities in their learning quest.

As indicated earlier, being an adult and having lived longer brings with it an accumulation of life experiences and a broad knowledge base. The importance of this situation to education is summarized by Knowles et al. (1998) who say:

> ...for many kinds of learning, the richest resources for learning reside in the adult learners themselves. Hence, the emphasis on adult education is on experiential techniques – techniques that tap into the experience of the learners, such as group discussions, simulation exercises, problem-solving activities, case method and laboratory methods instead of transmittal techniques (p.66).

However, it has also been argued (Hayes, 2006) that this exposure to life experience has another side, and the suggestion is that some adults become entrenched in their self-constructed views and are unwilling to embrace critical thinking. This resistance to alternative perspective can, in some cases, create a significant challenge for the teacher of adults.

As a consequence, the notion of 'readiness to learn' is another important assumption upon which the andragogical model is based. This issue became evident within this research, particularly in the light of the wide range of age of groups of men coming to the men's health workshops. It is critical for behaviour modification of this nature that the adult learner has to be at a stage in life where he can see the possibilities of education and the value of the course he intends to undertake.

Notwithstanding the influential contribution of Knowles et al., there are critics of the term "adult education" who associate it as "catching up" type of education which has connotations with deficit in earlier education. These critics prefer the term "continuing education", and as a result it takes the debate away from the centrality of the definition of 'adult' and leads to the preferred term that is now commonly used of "adult and continuing education".

Another important distinction is that between education and learning, which aligns itself primarily to the program or teacher and the learner. Knowles et al. (1998) state:

> … education is an activity undertaken or initiated by one or more agents that is designed to effect changes in the knowledge, skill, and attitudes of individuals, groups or communities. The term emphasises the [role of the] educator, the agent of change who presents stimuli and reinforcement for learning and designs activities to induce change (p.11).

Change in the individual's knowledge is a common theme when one looks at the term "education" and change is expected in the learning outcomes of education. In this respect, Jarvis (cited in Tight, 1996) defines education as, 'organised and sustained instruction designed to communicate a combination of knowledge, skills and understanding valuable for all the activities of life' (p.16).

Particularly for adults, learning takes place when the student realises their need to increase knowledge. This situation is encapsulated in a Chinese proverb that says 'the teacher arrives when the student is ready' and is most appropriate in this instance. Further, Boyd et al. (cited in Knowles et al., 1998) state:

> … the term learning, by contrast, emphasises the person in whom the change occurs or is expected to occur. Learning is the act or process by which behavioural change, knowledge, skills, and attitudes are acquired (p. 11).

The principal foundation of education is not only the attainment of knowledge, but of understanding and the ability to utilise knowledge. Such a situation can only come about when the individual accepts the need to accumulate knowledge and recognises the influence it can have on his life. Therefore, it is assumed in this investigation that in the area of men's health, the emphasis needs to be on constructing the content to what the men want and what they feel is important to them. Only when men agree that information is useful for them can these programs be successful and learning take place. The importance of this approach is underscored by the remark of Tight (1996), who, when referring to the more traditional views of learning suggests learning is seen in terms of its objectives or outcomes.

Another important realisation for the educator is that learning takes place both consciously and subconsciously in both formal and informal settings (Galbraith, 2004). As a result, a student may not realise that they are being involved in the learning process, since in many situations it is just as natural as the function of breathing. Again, it is this observation of the social element which accompanies adult learning that has informed the approach in this investigation.

An important practical issue that emerges from these considerations is that to cater for adults who want to attend classes, the educator has to know his/her subject and to

present it to the students in an interesting and entertaining style. Malouf (1994) offers his SAFE model based on the belief that education has to be:

> Social. Because we learn with and from other people; Activity based: Because we learn most of all by being involved; Fun: Because if we are having fun, we are alert and ready to learn; Environmentally secure: because people who are nervous or afraid can only think about their nerves or their fear (p.9).

Redman (2001) reinforces this view of adult learning (especially with reference to behavioural learning theory) when she states:

> … pleasurable consequences strengthen behavior (reinforce it), whereas unpleasant consequences weaken it. Reinforcers may be food, water, warmth, praise, recognition, grades, or paychecks, varying from one individual to another (p.21).

An important contribution to this area was by Carl Rogers (Hillier, 2002) who developed a theory of personality and behaviour which was evolved from the study of adults in therapy, then sought to apply it to education showing respect for the student. This process led him to conceptualise student-centred teaching as parallel to client-centred therapy. It is important here to recognise the centrality of the student and that the aim of education must be the facilitation of learning in an environment conducive for this to take place.

Relevant education courses for health workers in Australia

Currently, there is very little information covering tertiary courses on men's health. A National Needs Assessment was conducted into men's health education and resource development. From that report, Hardy (2007, p.5) states:

> Currently a Men's Health in Society Distance Education package is being written. First tertiary based postgraduate men's health education course in Australia. Only one university based undergraduate course is available on men's health. This is an elective short course called Men's Health Issues. Most of the participants are nursing and medical students due to the non-existence of men's health in these undergraduate courses. This course is available at the University of SA and has also been delivered at Curtin University in Perth, WA.

There are resources available for health professionals working in men's health. One of these is *Andrology Australia*, the most widely known organisation

working in men's health education. Further in the report, Hardy (2007, p.24) states:

> Numerous resources, booklets, posters, fact sheets are produced on the key areas including some multicultural resources. Andrology Australia has developed online education for GPs with Monash University and GP Online services. Pod casts are also available. They are producing a CDROM with Mensline to give to health professionals on how to deliver a men's health information night. They are already considering the need for mental health resources. All material/programs are evidenced-based and work within a medical model.

Historically, there was only one tertiary course conducted in Australia on men's health, offered by the International Office for Men's Health and Gender Studies, School of Nursing and Public Health, at the Edith Cowan University. The broad aim of this course was to promote men's health and gender studies within the region and internationally at the academic, government and community levels and to establish and manage a base data on men's health issues accessible on the internet in Australia and Asia-Pacific region. This initiative was funded by the Commonwealth Department of Health and Aged Care and accredited by the Royal Australian College of General Practitioners. As an additional outcome, it was required to act as a regional and international resource centre for health professionals **a**nd community groups involved in men's health promotion, teaching, regional development and research (Huggins, 2005).

Post graduate academic courses that are held in Australia are at Australia Asia Pacific Institute for Men's Gender and Health Studies. The three courses offered are the Post Graduate Diploma in Men's Gender Health Studies, the Post Graduate Diploma in Male Adolescent Gender Health and Culture, and the Post Graduate Diploma in Gender Health Studies. These courses are offered in Fremantle and in Manila, Philippines at the Philippines Centre for Men's Gender Health Studies (Australian Asia Pacific Institute Men's gender and health studies, 2009).

The Post Graduate Diploma in Men's Gender Health is directed at medical practitioners, nurses, allied health professionals, health promotion managers, psychologists, counsellors and men involved in men's support groups (Huggins, 2005). Some of the broad aims of the Institute are

- to promote men's health and gender studies nationally regionally and globally;
- To provide university-teaching courses in men's health that are relevant to local community, state, national and international needs, especially in the Australia-Asia-Pacific Region;
- To act in a consultancy capacity in relation to men's health initiatives, as required on a local, national, regional and international basis. (Huggins, 2005).

Another relevant organization is the Men's Health Information and Resource Centre, which is part of the College of Social and Health Sciences at the University of Western Sydney (MHIRC). Chodkiewicz and Morris (2006) describe the role of MHIRC as a group which:

> …designs, develops and supports research and projects which contribute to the enhancement of the health and well-being of men and boys in a variety of contexts: the workplace, family relationships and access to health and social support services (p.10)
> .

Community outreach programs

In Victoria, one of the main thrusts into the community for men's health is through the Centre for Advancement of Men's Health (CAMH) in collaboration with Hepburn Health Service, Daylesford, and the Centre of Research for the Advancement of Rural Health, La Trobe University, Bendigo (Gibson & Denner, 2000). Through this centre, Bernard Denner, founder and projects manager, has adopted programs for men's health workshops, and over the past four years, using the MAN (Men's Awareness Network) model, they have attracted over 8500 men and had considerable success, not only in rural central Victoria, but in communities in South Australia, New South Wales and Queensland (Verrinder & Denner, 2000).

The MAN model firstly identifies health issues important to men and raises the awareness of men and adolescents usually with men's health nights. The model develops health programs in partnership with local health providers and equips them,

particularly GPs, to better relate to men, develop a welcoming physical environment in their practice, and have access to professional development programs for heath practitioners (Gibson & Denner, 2000).

Developed to specifically address the problem of education programs, the model accesses men and encourages them to discuss their health problems in a culturally relevant way. The thought of attending a community health centre does not come naturally to the Australian male, and as noted earlier, men's health programs sometimes have to go to where the men socialise and feel comfortable, whether it is at the football club, hotel or workplace (Verrinder & Denner, 2000).

It has been clearly recognised that, to implement these programs, there are significant cost implications, and there is some debate on where this funding should be found . One perspective is provided by Gibson and Denner (2000), who state:

> …the effectiveness of the program is maximised when communities are required to raise or provide funds themselves so that the agreed program may be effectively implemented. Community involvement and ownership guarantees a far better result into the long term if the community has contributed financially to it and recognises that it is worthwhile, achievable and needed in the community (p.9).

Other support for men comes in many forms and organizations, depending on their needs, and these could represent potential sources of educational funds. Representing homeless men is the Australian Federation of Homelessness Organisations (AFHO), the national peak body advocating for people who are homeless. In Victoria, the Council to Homeless Persons (CHP) – Victoria, established in 1972, represents both individuals and organisations. Mission Australia provides a range of services across Australia for homeless men. St. Vincent de Paul Society is involved with homeless youth, women, men and families in both funding hostels and providing food on the streets. Another federally funded program is the Supported Accommodation Assistance Program (SAAP). Of this latter program, Chodkiewicz and Morris (2006) who organized the directory of organisations, services and resources, noted that:

> … the current five year SAAP Agreement, with an Australian Government contribution of $932 million, took effect on 1 October, 2005. The new agreement

> seeks to improve both short and long-term outcomes for people who are homeless or at risk of homelessness (p.42).

Finally, there has been a growing phenomenon in Australia - and particularly in Victoria - of the concept of men sheds, which is supported by Mensheds Australia. Currently, in 2006 there are nearly 180 men's sheds in Victoria and this number is growing (Hayes & Williamson, 2006). The concept was discussed critically at the third National Men's Health Conference in Alice Springs in 1999, where it was recognised that men needed their own space and an opportunity to meet with other men in an environment other than that of a hotel or sporting venue. In a report prepared for the Office of Senior Victorians, Hayes and Williamson (2006) stated:

> …overall, the sheds were deemed to be important as a place or space for gathering men together (serving a utility function) and for men to gather together (serving a social function). In some cases, this was for the specific purpose of improving health outcomes. However, there are a number of other related responses including: a place to reconnect with community, safe and non-judgmental space, support for disadvantaged men, a place to do "bloke" things, a "man-friendly environment", social support and mateship ….a warm, friendly environment (p. 16).

The growth of men's sheds in Australia is an indication that there is a need in the community, especially amongst older men, for this sort of structure. The men usually run the shed themselves or it is associated with people attached to a community health centre. In September, 2005, 50 sheds were contacted to provide information as to their function, benefits and links to the community. Regarding activities of these sheds, Hayes and Williamson (2006) go on to say that:

> …three-quarters of the sheds canvassed do woodwork specifically. Repair work, metalwork, gardening and other "hands on" and recreational type projects were mentioned. One-quarter of the sheds also have activities relating to cooking and computers. While the men will obviously have many opportunities for socialising through such activities, other men attend sheds specifically to socialise and talk. Importantly, some sheds have a focus on mentoring (p.17).

The rise of this network opens the possibility for the entrée of men's health programs into a non-threatening space where men can more openly and socially engage in education and health promotion activities.

Conclusion

It is clear from the foregoing discussion that there is overwhelming evidence of a serious neglect by Australian men in addressing their health and taking preventative action. There appears to be an entrenched and powerful cultural influence that is gender-based in Australia that repudiates preventative action by men, regular health assessments or sharing of emotions or symptoms that is limiting the longevity and sensitivity to health awareness of the Australian male. The principles of adult education need to be followed and utilised when reaching out to men within any health forum to overcome this reticence and apathy.

In the following chapter, the research methodology which has been used to gather data for the four contributing projects will be detailed. In addition, the theoretical underpinning of the study, expressed in terms of the health belief model will be presented.

Chapter 4

Methodology

Introduction

The objective of this research, which was to consider men's health programs from the perspective of an informal learning context and to find out ways that men were engaged to attend, was strategised by breaking the topic down into four distinct investigations as indicated earlier. This investigation has been designed to identify strategies which can be introduced to attract men to health workshops, to identify issues which create an impact on their health awareness, and to delineate the key factors inherent in a successful workshop or health practice. The main thrust of the research was to access a range of men's perceptions related to factors that initially attracted them to health workshops, and, further, to assess what teaching strategies and methods were employed that appeared to best serve the men's learning needs.

This chapter will provide an overview of how the research was conducted in order to collect the results provided for each of the four contributing projects detailed in the Appendix. Methodology, according to Wellington (2000), is 'the activity or business of choosing, reflecting upon, evaluating and justifying the methods you use' (p.22). For this investigation into the perceptions of a range of men involved with men's health issues, the methodology chosen was ethnography, and data related to the research question was collected by the researcher becoming part of the group as a participant-observer at several men's health-related settings. Consistent with the constructivist nature of this investigation, the sampling process in all four contributing projects involved purposive sampling rather than random sampling in order to access men's perceptions.

The research investigation was divided into four distinct projects, each with its own sub-research question, in order to investigate in more depth the specific perspectives of respondents chosen from four diverse men's groups involved in men's health activities. The studies over the three years 1999-2002 were focused on a rural men's

health workshop, an urban men's health workshop, a shelter for homeless men and the co-ordinators of a range of men's health programs. Before any of the projects began, approval from the university ethics committee was sought and a plain language statement regarding the research given to all the participants as required by the agreed ethics protocols. The research questions related to each of the four contributing projects were as follows:

> Project 1: What factors are necessary for the successful delivery of a men's health workshop on physical health in a rural community, and how do men respond?
> Project 2: What factors are necessary for the successful delivery of a men's health workshop on emotional wellbeing in an urban environment and what are the responses from the men?
> Project 3: What are the essential elements of delivering health information to disadvantaged men in a men's shelter?
> Project 4: How does one develop successful educational approaches to men's health?

In this chapter, the methods and the rationale for using them will be described, together with a discussion of the underlying theoretical constructs that have been used to guide the study. Outlining this approach will allow an appreciation of the particular meanings that will be attached to the research questions: it is not the author's intention to develop generalisations regarding these issues, but rather to provide a range of perspectives, insights and understandings of the learning pedagogies that underlie the men's health programs involved in the study. The researcher is not in search of universal truths, but, rather, relevant contextualised social knowledge which will facilitate a better approach to men's health education.

Such an intention has dictated the methods necessary to obtain information for subsequent analysis. In attempting to ask how we can reach men and deliver effective programs that have an impact on the way they view their health, brings one inevitably to an appreciation of such personal barriers as perceptions of masculinity, Australian culture and peer pressure. The changing of personal behaviour of this type has to come about through men being informed enough to be able to make sensible decisions regarding their attitudes to health behaviour, and developing the social confidence to be able to carry their decisions out. Of relevance here is the observation that although the notion of andragogy and adult education have been explored in the literature review as a possible vector for health education for men, Australian males,

particularly in the environment of health education, seem more aligned to informal and situated learning styles (Laws, 2006). By comparison, formal education seems more of a threat to some Australian men (Hardy, 2007).

As has been indicated in earlier discussion, approaches to men's health that mimic what feminists have done in advancing women's health may not be appropriate. Simply transferring these successful actions and programs and applying them to men does not recognise the different cultural and social contexts within which many Australian men are immersed. While due recognition is given to the achievements of the feminist movement, and that some similarities of intent and approach can be seen, it will not be an avenue to be explored in this dissertation. To superficially include other approaches would make the research too broad. There are complex differences in the way people approach health issues, particularly in the preventative aspects, which is related strongly to gender difference. An appreciation of hegemonic masculinity goes some way in understanding men's approach to their health, which is very different to women. Laws (2006) states, 'there are social practices and behaviours linked to masculinity which predispose men to health problems/injury. Issues arise out of society's expectation of maleness' (p.5), and such a perspective will help to inform the data collection methods.

It was important, during the data collection, to remain focused on what are the research concerns, and that the questions central to the study remained true to these concerns. By assuring this constant focus of the textual data that the four projects generated meant that themes that related to the research questions were able to be identified. The criteria for selection and coding of themes were based on Auerbach and Silverstein's (2003) guidelines of text being closely related to the research concerns, an approach that helps clarify the analysis and to understand the individual participant's perspectives.

Certain themes that were identified from the researcher's participant observation and the literature review became theoretical constructs for the study. According to Auerbach & Silverstein (2003), 'Theoretical constructs move the analysis from the description of subjective experiences found in repeating ideas and themes to a more abstract and theoretical level' (p. 67). During the analysis of the text it was noticed

that repeating ideas were expressed by the participants. Where these ideas were supported by the literature review it was felt that the research could claim to have added validity. In this analytical approach, the theoretical constructs were developed in line with underlying theoretical framework and findings from the literature. Some of the main themes from the specific projects included:

- Rural men viewing health through physical parameters;
- Urban men viewing health primarily through emotional wellbeing;
- Rural men learning by visual/auditory means without taking notes or the use of handouts;
- Women playing an important role in engaging men with health issues; and,
- Health workshops predominantly attracting older men.

Considering the first two themes, it appears that health has different meanings for men in different social contexts. Compounding these differences were differences as to where the emphasis lies within various workshops, and the different influences that coordinators bring as role models.

In parallel with confirming the main themes from the data, it was important to observe the work done by leaders within the health education field and to note any differences in outcome and intent. This investigation was carried out in Project 4. After studying men as participants in health programs and obtaining their perspectives, key workshop leaders were approached in the field of men's health to help to consolidate the findings from the three previous studies.

This consolidation of the work done in the projects that derived from the transcribed text was achieved by the construction of a theoretical narrative. Auerbach and Silverstein (2003) describe this as:

> … the process that the research participants reported in terms of (your) theoretical constructs. It uses (your) theoretical constructs to organise people's subjective experience into a coherent story. It employs people's own language to make their story vivid and real (p.73).

During the analysis and development of the narrative, the prime emphasis was on researcher objectivity, disregarding the tendency to subjectivity, and rejecting what might be an outcome according to the researcher's views. In strengthening the validity

of the data analysis, transparency was enhanced by providing a concept map which breaks the thesis down into stages and what evolved from these stages.

At the theoretical level, because there was no control on the procurement of participants, convenience sampling was the most appropriate method for selection of respondents. Auerbach and Silverstein (2003) justify this method by saying that convenience sampling makes an assumption that by purposefully selecting respondents who have special positions or insights into the area, '…any information obtained … will be informative' (p.96). To complement this sampling approach, the choice of an existing theory, the health belief model was considered useful to inform the data collection and analysis. In this selection of a suitable theory, the comments of Glanz, Lewis and Reimer (2008) regarding four criteria for selection were noted. These include it being: logically related to the context under study; consistent with observations made in its area of interest; similar to those used in successful approaches in similar situations; and supported by the success of the outcomes of past research programs. The health belief model is a well-established theory in the area of health promotion, emphasising the place of the individual as central to the research. For these reasons, this model (Figure 1) was used to underpin the four contributing projects which looked at factors important in health change behaviour.

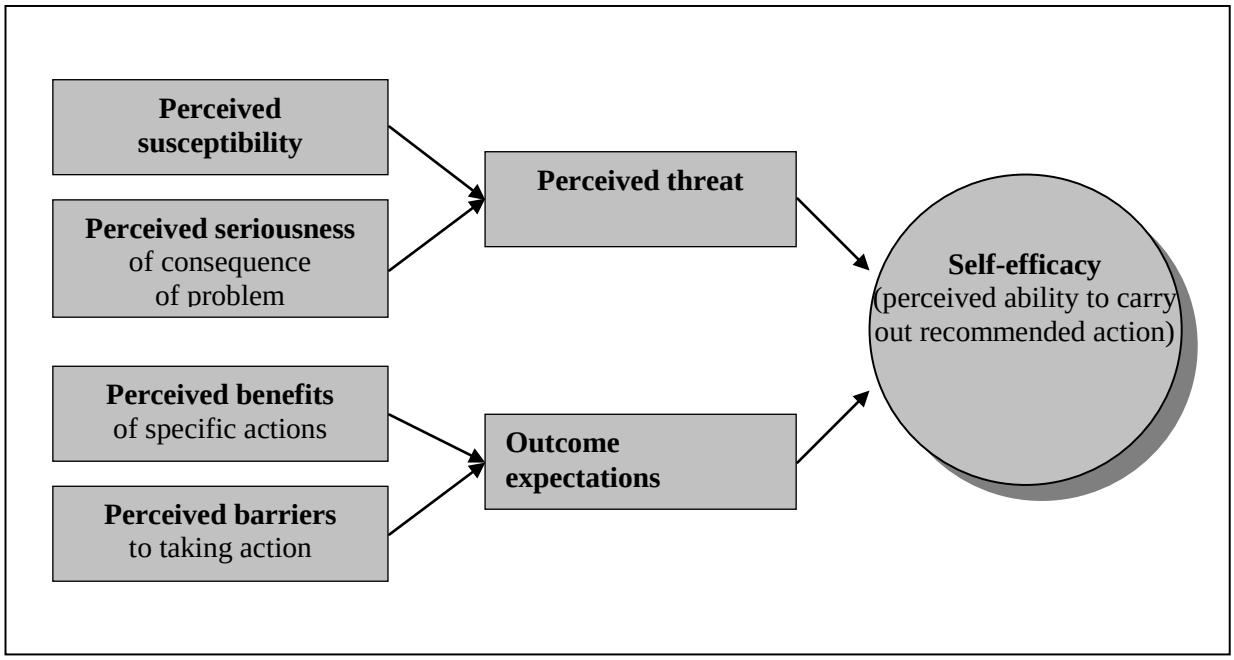

Figure 1. Health belief model: major stages and flow. (Janz & Becker, (1984) cited in Nutbeam & Harris, 1999 p.11).

The component elements of perceived susceptibility, seriousness, benefits and barriers are intimately enmeshed with this study and therefore the model is well suited to assist in the interpretation of resultant findings. In particular, it facilitates insight into issues related to participants' self efficacy and their perceived ability to carry out recommended actions.

The theoretical perspective for this research has been chosen to be symbolic interactionism, and this in turn helps to determine the methodology. Symbolic interactionism is defined by Streubert and Carpenter (1999) as 'a philosophic belief system based on the assumption that humans learn about and define their world through interaction with others' (p.332). It is a particularly useful theoretical perspective to help understand individuals who find themselves in a particular social framework that relies, for its cohesion, upon symbolic exchanges. Germov (2005) states that: 'symbolic interactionism emphasises that health and illness are perceived subjectively, and are social constructions that change over time and vary between cultures' (p.39). Most pertinently for the purposes of this thesis, a symbolic interactionist approach seeks to uncover what individuals see as reality in their situations. There is a set of assumptions brought to these projects that have been developed from the social world of Australian men, which include communication, interrelationships and sense of community, which are ingredients developed over time. Indeed, Handwerker (2001) refers to this situation when he states that:

> …one essential quality of being human is that we cannot escape subjectivity. Research, like all other social activity, entails the construction of culture. At their simplest, explanations are labelled, defined concepts or sets of related concepts that answer questions about what you observe (p.68).

Given that the theoretical framework is embedded in symbolic interactionism, interaction through symbols, understanding of behaviours, gestures and words that are particular to the particular culture become important. This implies that we need to look at respondents to see what individual realities are within a shared culture - in this case, Australian masculinity. Clearly, in this study the notion of masculinity will play an important part in terms of the reticence of men to seek assistance within the health-seeking behaviours of Australian males, and will need to be observed in action with respondents. Whitehead (2002) states that:

> …the relationship between men, masculinities, health and illness connects directly with that of men and ageing. This is especially so inasmuch as men's

> health, both physical and mental, can undermine or reinforce their sense of being men. Deteriorating health can weaken men's association with dominant codes of masculinity, while robust health speaks of men's potency and mastery of situations (p. 202).

Of relevance here is that it is the 'codes of masculinity' that need to be investigated, and to consider how these are currently mitigating against appropriate health-related behaviour, and later, how these notions might be challenged.

The social marketing of men's health has been related to a widespread assumption that masculinity comes under the one banner of 'hegemonic masculinity'. Hegemonic masculinity asserts that there is only one type of masculinity, and it suspected that such an approach has the potential to retard efforts to understand men's needs in particular contexts. In this regard, Smith (2007) urges consideration of:

> … multiple masculinities, in contrast to one dominant form. This opens the door to develop a range of health promotion interventions targeted to specific groups of men, including those that are most marginalised and disadvantaged. In doing so, health inequities among men relating to age, class, sexuality, race and ethnicity can be more purposefully addressed (p.20).

The epistemological perspective adopted for this project is that of constructivism, where the investigation of the personal experiences and understandings of individuals, in terms of the research question, is being sought. Minichiello, Sullivan, Greenwood and Axford (1999) note that:

> …those researchers who adopt a constructivist view of knowledge believe that a process of discovery underpins the research enterprise. From the results of such studies, meaning is described, interpreted and constructed through the eyes of the researcher or the participants in the investigation (p.18).

Clearly, there will be a wide range of personal histories in the lives of the informants involved in the four studies which have contributed to this project. This implies that a single or consistent world-view on a subject as personal as men's health will therefore be unlikely, and that what will come out of the analysis will be broad outcomes based on a range of perspectives. However, what distinguishes this from a subjective standpoint is that within the close knit communities chosen for the study, there are enough shared meanings and symbols which define behaviour and perceptions to develop a consistent and constructed view. This is consistent with the symbolic interactionist approach taken, and allows knowledge claims to be made at the

conclusion of the study which, although not universally generalisable, are useful in a defined context.

Some confirmation of this stance is provided by the observation that other researchers involved in men's health and approaches to education, although in different contexts, have used somewhat similar methodologies. For example, Burns and Grove (2001), who work within a constructivist epistemology, have used symbolic interactionism as the theoretical framework for their studies. They sum up the essence of why this is their preferred framework when they state, 'symbolic interaction theory explores how people define reality and how their beliefs are related to their actions' (p.66). Similarly, Minichiello, Sullivan, Greenwood and Axford (1999) indicate that:

> … symbolic interactionism is based on three premises. Firstly, human beings act towards objects in their environment on the basis of the meaning those objects have for them. Secondly, these meanings are acquired from social interaction between and among individuals. Thirdly, these meanings are established and modified through an interpretive process (p.47).

To realise this approach in practical terms, the perspective of the participants has to be obtained through an appropriate methodology. In this regard, Crotty (1999) notes that:

> …ethnographic inquiry in the spirit of symbolic interactionism seeks to uncover meanings and perceptions on the part of the people participating in the research, viewing these understandings against the backdrop of the people's overall world-view or "culture" (p.7).

Consequently, in this study ethnography has been chosen as the vehicle through which approaches to collecting and understanding data has been carried out, to ensure that information comes from perspectives within the culture, in this case, Australian male masculinity. Minichiello et al. (1999) refer to ethnography as:

> …the study of a group of people whose beliefs, material aspects, actions and artefacts are influenced by their culture's implicit or explicit ways of being. Ethnographic practice is extremely eclectic in that it utilises a wide range of theoretical perspectives, including symbolic interactionism, ethnomethodology, critical and post-modern theories (p.124).

The methods employed in this study have therefore included participant observation of men's engagement within the workshops and shelter, interviews, questionnaires and field notes related to style of teaching content, communication styles and participant's involvement. These methods are traditionally suited to this approach and provide the best way of making sense of the social fabric that involves men's health

and the effectiveness (or otherwise) of the educational approaches directed towards them. Methods can be very diverse and, with these projects both qualitative (descriptive) and to a lesser extent quantitative (numerical), data are presented as part of the multi-method approach.

Within ethnography, various approaches need to be applied in the field. Handwerker (2001) states 'much ethnography entails altering the constructions you take into the field in ways that improve their correspondence with those used by the people in your field setting' (p.13). The use of several methods to gather data is an example of triangulation being multi-focused rather than limited by one method. Triangulation, as Schneider, Elliott, LoBiondo-Wood and Haber (2003) note, is used by many researchers 'to address the issue of validity. The researcher uses different research methods, forms of data and theories to validate (or corroborate) the observations and data gathered' (p.187).

All four projects were carried out in a male environment, that is, where the men gathered, or in the workplace or home of the health care co-ordinators. This could be construed to come under the banner of naturalistic research, which is consistent with ethnographic investigations. Naturalistic research, as defined by Streubert and Carpenter (1999), is 'a research methodology based on a belief in investigating phenomena in their natural setting free of manipulation' (p.331). The researcher needed to be with the men in the same environment they were experiencing, to gain their trust and to provide the opportunity to observe practices and approaches in the workshops. This was done to create a relatively natural environment where participants felt comfortable and knew the researcher. This would not have occurred if the questionnaires distributed at the completion of the workshop had been simply mailed out to the men, with no prior contact with the author.

What now follows is a brief description of each of the contributing projects, highlighting the specific methods and approaches used in data collection.

Rural men's health study

The first project, involving rural men, was based upon a purposive and opportunistic sample of respondents in a small rural community. As indicated earlier, according to Burns and Grove (2001) purposive sampling, 'involves the conscious selection by the researcher of certain subjects or elements to include in the study' (p.376). The participants were recruited spontaneously by the co-ordinator of the program who provided the author's first point of contact in gaining access to these men. The participants for this workshop were mostly recruited after the co-ordinator asked for a list of names of local men from a respected person in the community. While advertisements for the course were placed in the local paper, most of the participants came through word of mouth. The workshop was to be conducted one night per week for five weeks. None of these men were under the age of 40, and the workshop's location in a small rural Victorian town assured the researcher that the sample consisted of rural men who had a focus on their health.

Following the ethnographic approach to data collection, the researcher was able to become involved with the men to understand more completely what they were experiencing. The methods used were participant observation, field notes, questionnaires and interviews which are again consistent with this methodological stance. Minichiello, Sullivan, Greenwood and Axford (1999) state that:

> … participant observation has always been the central technique in a form of social research known as ethnography which, broadly translated, means 'writing about a culture or way of life'….the purpose was to learn how to see another way of life as the members of the community themselves saw it, which meant, among other things, learning the language they spoke (p.432).

Importantly, these data collection methods sit well with the over-arching perspective of symbolic interactionism, where language is a special kind of symbol and is central to the constructed meaning of illness within the particular cultural group.

Having access to the men as a participant-observer was the preferred method by which to build trust and form a relationship with them. Schneider et al. (2003) recognise the importance of this method of data collection, saying, 'in ethnographic research, participation observation is one of the most important data-gathering methods and the researcher is the main instrument of social research' (p.184). As part of the explanation to the group at the beginning of the workshop, it was clearly stated

that one participant was researching the event and would be giving out a questionnaire at its completion. This was done to ensure that correct information was imparted and that informed consent was given by the men. This proved important to the results, since when it came to handing out the questionnaires at the end of the workshop, there was a 100 per cent return rate from the 15 participants confirming that there was a large amount of trust given from the men and a willingness on their part to assist in the research. It would be difficult to imagine such a complete return of questionnaires had they been posted to the co-ordinator and simply handed out to the men on a voluntary basis, particularly with rural men. Many of the participants were farmers and writing down information was observed not to be a prime feature of their learning processes.

As part of the methodology of ethnography, the project used field notes to make immediate observations during the course of the workshop. It was noted on the first day that none of the participants brought pen or paper to the five sessions and at no stage did they write down information given by the co-ordinator. For these men, mainly brought up on farms, looking, listening and doing took precedence over information capture by writing it down and reviewing it later. Because of this, and being part of the group, the researcher waited until after the sessions to write up his field notes comprising fifteen pages. He still had a clear recollection of what had taken place and his field notes soon yielded emerging themes. As a participant-observer, the researcher was able to effectively record and document first-hand the body language the men used, their responses to questions and the teaching strategies utilised during the course of the workshop.

The items on the questionnaire were presented in a way that could be easily understood by the participants (Appendix 1) and were designed to elicit information from the men about how they found out about the workshop, what aspects they liked, their opinion on the teaching strategies used and the effect of the workshop on the way they viewed their health. It was designed so that it would not take too much time, but extra space was available if an extended answer was warranted. There was also provision on the questionnaire for the researcher to ask the men for permission to contact them six months after completion of the workshop. The purpose was to assess what attitudinal changes toward their health had evolved from the workshop and

whether any health or lifestyle habits had altered. Out of the fifteen participants, thirteen consented to a follow-up interview after six months and this gave the researcher a more complete picture as to the influence that the teaching session had had on them as an individual.

The multiple ways data were gathered from field notes, participant observation, interviews and questionnaires, is an example of data triangulation. Triangulation is defined by Wellington (2000) as, 'the business of giving strength or support to findings/conclusions by drawing on evidence from other sources …. Thus, the same area of study is examined from more than one vantage point' (p.201). This was an important strength of this project, since it involved the researcher being there, drawing on the field notes to uncover major themes, interviewing the co-ordinator and utilising the questionnaires. Phone interviews six months later to the thirteen respondents provided a longitudinal perspective on the effect of this workshop on the participants' approach to their health.

Having sat with the participants, the researcher was able to observe that the quality of the data obtained from other methods was appropriate and was in line with observation. Indeed, using participant observation was a useful means of experiencing the content, input and interactions within the sessions on a first-hand basis, thus allowing the researcher to more fully comprehend why men interpreted what they were learning and being taught in different ways. The aspect of trust cannot be underestimated in this exercise: joining in with the men, and being part of the program and socialising afterwards, enabled a more open and trusting relationship to develop.

Urban men's health study

The second research project was a study of a men's health workshop in Melbourne which aimed at comparing the health approaches of urban men with their rural counterparts. The author had no preconceived ideas as to how this would progress or what findings would arise from the study - only that it would focus on a sample size of around fifteen men, similar to that of the rural group. To gain access to this study, a

leader and publisher in the field of men's health was contacted to provide an introduction to a men's health co-ordinator who ran workshops in Melbourne.

The methodology for this second research project mirrored that of the first study and incorporated the same methods. Participant-observation was again a major factor in gaining acceptance to the group when the men were sharing their thoughts, emotions and life experiences. Other research tools included field notes, interviews, a questionnaire and follow-up phone interviews following completion of the workshop. Interestingly however, in this urban setting it was more difficult to gain the men's trust than it had been in the rural-based project. A contributing factor may have been that the co-ordinator was not personally known to the researcher, although the co-ordinator was carefully informed of the objectives of the research and allowed to peruse the plain language statement that had been approved by the university's ethics committee. Unfortunately, at the time of arranging the data collection it was not known that the group sessions were ongoing and not limited to a set time. This had certain ramifications since it may have been possible that significant material used in the workshop or key learning events outside the time spent with the men may have been missed by the researcher.

Most of the participants came to the session through referrals from community health services, *Lifeline* and other agencies. Others came through word of mouth or had seen the contact number in Biddulph's (1995) book *Manhood: a book about setting men free* which included a contact list that led to the co-ordinator. Because of this self-selecting aspect of the group, the urban sample may not therefore represent a true cross-section of society or even a genuine comparison with the rural study, suggesting why these urban men's view of health differed so markedly from the rural men given the different focuses on health issues.

There were clearly two variables in the first two projects that came to light from the participant-observation approach; the rural workshop concentrated on physical health while the urban workshop centred on emotional health. The focus of the urban group was on men's emotional health, their apparent lack of love, loneliness, feelings of guilt, depression, remorsefulness and thoughts of suicide. This was in contrast to the rural men, where the emphasis was on physical well-being and measurable parameters

for health such as body mass index, skin folds, blood pressure, cholesterol levels and blood glucose.

There was also a slight delay before the researcher gained access to and approval from the group to become part of the urban sessions. Because one of the main areas to be covered in the urban workshop was emotional health as opposed to physical health, this appeared to create doubt among some members as to the appropriateness of allowing access to an outsider when sensitive issues were to be discussed. Field notes were taken shortly after the meetings, as there was no writing done within the group as the session was predominantly an expressive forum and a time of counselling support.

Being a comparative study, the questionnaires were the same as for the first workshop. Of the fourteen questionnaires distributed, nine were returned, representing a 60 per cent response rate (see Appendix 2). This again reflected the observation that the trust was more difficult to achieve in the urban setting. Of the nine questionnaires returned, only three indicated that they were prepared to participate in a follow-up interview. Of these, the phone contact given by one was disconnected, which left only two. Whilst this tended to limit the effectiveness of the study, enough information was gleaned from the two informants to make the exercise worthwhile.

By adopting the participation-observation method, the body language of the men could be noted, as could the responses to questions from the co-ordinator and the voluntary verbal expressions of feelings by the participants themselves. Being physically within the group allowed the researcher to gain their trust more readily than an outside observer may have, especially in light of some of the sensitive issues brought forward by the men. Given the serious nature of some of the issues happening in the lives of these men, receiving responses from the participants was most encouraging.

The interview with the co-ordinator was conducted on the last night before the group arrived, the questions closely echoing those employed for the first interview in Project 1. This second interview was taped, with the subject's permission, and notes were taken for later review. The interview environment was familiar to the co-ordinator and

there were no extraneous factors that could have distracted him. Questions asked were open-ended to facilitate expansion of the answers and contribute to the data gained.

Men's shelter study

The data collection for the third project took place in a men's shelter. This necessitated careful planning and meticulous care with the plain language statement, ensuring ethical clearance and approval from the organisation itself, the co-ordinator of the centre and the informal consent of the men who attended. This project was conducted in a major regional town in Victoria at a community health centre which served as a drop-in centre for disadvantaged men under the management of a large charitable organisation. The chosen methodology was principally qualitative, utilising purposive homogenous sampling – that is, selecting a particular group (disadvantaged men) from within a specific environment. The sample was not fixed, but rather transient, with different men attending on different days. There was, however, a core group of regular attendees.

The ethical considerations of this third project were more difficult to meet than with Projects 1 and 2. The nature of the men being observed and questioned with regard to their views about health and their well being, meant the researcher had to be particularly respectful of their predicaments. Many were in dire personal situations and in emotional turmoil, which was symptomatic of the pressures facing these men. Whitehead (2002) writes:

> … modern man has been 'betrayed' by a combination of factors, notably a sexist consumer culture that commodifies and objectifies the male; the loss of economic authority; the weakening and reshaping of men's relationship to the world of work; the public exposure of dominant notions of masculinity to ridicule and censure; and the failure of men, as a gender group, to 'rebel' against their emasculinisation by 'the culture'. Although this process has forced countless numbers of men to reconsider previously held beliefs about male roles and dominant masculinities, it has also, inadvertently, left men with a crisis of confidence (p.48).

The researcher met with the co-ordinator of the drop-in centre and the manager of the community health service before the study commenced to explain the intended data collection process and answer any questions or concerns they may have had. This was only done after project approval had been granted by the university's ethics committee and the plain language statement to the participants had been submitted.

Again, a participant-observation approach was adopted, although this took a somewhat different format to the preceding studies. Being a day centre, there was an open door policy and the centre was opened from 9 am to 4 pm. Most of the men gathered in the mid-morning to late afternoon, taking advantage of the morning tea and lunch that was provided. This presented a difficulty in the sense of gaining trust from the men themselves, since, due to their difficult life circumstances many did not trust outsiders and this was reflected in the poor return rate of questionnaires. Perhaps the use of questionnaires for this project was not the most appropriate method, given the response rate.

Data were collected through participant-observations and notes, conducted over three full days, as well as during previous, shorter visits to meet with administrators. Added to this were interviews with the co-ordinator and an attendant health nurse. Questionnaires were distributed only to the men who voluntarily offered to participate. Of the 30 questionnaires distributed, 18 were returned. From these questionnaires, the key themes that each question addressed were compared with the other returned documents.

There appeared to be little structure to the shelter, which impacted on the conduct of the questionnaires and interview. The co-ordinator and health nurse could experience demands on their time from participants at any time. The interviews with both the co-ordinator and health nurse were recorded with their consent, and from the transcription, certain themes emerged which were included in the discussion and analysis. This was important to the data collection, as brief notes taken during the interview did not fully capture the essence of what was being said.

The environment where the study took place was ideal for naturalistic enquiry. Where the men gathered, daily newspapers were made available as well as card games, table tennis, tea and coffee facilities and shower facilities. The program's assumption was that the lower levels of Maslow's hierarchy of needs (Loh, 2000; Maslow, 1987) would be met before addressing higher level needs. The venue provided warmth, shelter, safety, healthy food and hygiene in the form of hot showers. To be a participant-observer required the researcher to fit into the environment, which meant dressing casually and mixing with the men during the course of the day, talking

informally and observing what was occurring. Health information for these men was disseminated from brochures being available, informal counselling and regular visits by health workers.

Study involving health promotion co-ordinators

The fourth project was designed to target the health promotion co-ordinators who worked with the men in their communities. The aim was to access their views on the main areas of concern in men's health and the most appropriate ways to promote changes of health behaviours, noting ways of engaging men in the workshops and devising appropriate teaching strategies. The interviews were held with key personnel working in the area of men's health following completion of a semi-structured questionnaire.

The target population comprised seven co-ordinators working in this field from both regional Victoria and Melbourne. These respondents were personally approached to take part in this final project, and the relatively small number of participants involved was appropriate for this type of research by an individual researcher. In addition, there are not many practitioners who work in this speciality of men's health, and the involvement of seven of these health professionals represented a reasonable cross-section of the population. They were also chosen to represent a spectrum of the health industry, encompassing the medical fraternity, nursing and community health including social workers, general practitioners and nurses.

The key criterion for inclusion as a men's health worker for the purposes of this study was that the individual was a health care professional employed in the area of health maintenance, diagnosis and counselling, having a focus and current experience with men's health, either on an individual basis or with groups. The question of difference in approaches was broached by Kirby, Carson, Kirby and Farah (2004) who said:

> …each practice will wish to individualise its programme after assessing the health needs of the local population, deciding on the range and location of health services and determining local targets and standards (p.31).

This project, therefore, incorporated homogenous sampling, selecting a particular group so that the members' common experience could be examined in depth. These people were recognised leaders through their research, publications and community

involvement. The purpose of this particular study was to seek information from their experiences that might lead to recommendations for delivering health education programs.

The methodology for Project 4 was a qualitative descriptive research approach using a structured interview technique developed from the findings of previous research studies undertaken by the author. In this regard, Germov (2005) states:

> …people's meanings change with time, and depending on who they are talking to. Qualitative methods try to explicitly engage with the fluidity of meanings and interpretations rather than avoiding them, as is attempted by quantitative research (p.58).

Data collection was designed to describe what occurs in practice and to allow the emergence of new information. The participants were asked if the interview could be recorded, and after consent was given, information from this source consolidated the researcher's field notes.

The writing up for Project 4 took the form of thematic analysis. It attempted to search out meaning and interpret from the available data related to the access for men and teaching strategies within the workshops. This only took place after ethical approval was obtained from the university and after the participants had signed an informed consent to participate.

The questions were designed to address the issues surrounding how men learn about their health. How can that educational process be relevant for the individual and not simply state the obvious, resulting in answers that are genuinely thought out? The co-ordinators were encouraged to offer a more discursive response out of the experiences that had impacted them in their work in the men's health field. The researcher's questions sought to elicit rich stories and situations remembered from the respondents' own experiences and to allow them to freely share their opinions and views in a relaxed and accepting environment.

The opening questions focused on an event or case involving their professional work related to men's health that would be personal, of interest and which might manifest as a common characteristic among the other participants. These questions included,

"Could you tell me about an incident(s) from your experience that highlights the position of men's health in Australia?" and "How have you embedded these experiences into the framework of your program?" As Denzin and Lincoln (2000) note, 'we come to know what has happened partly in terms of what others reveal as their experience' (p.442).

This methodology was influenced by the need to seek out people specifically involved in the formulation and co-ordination of delivering men's health workshops. This necessitated designing a semi-structured questionnaire, allowing for comments to be expanded during a face-to-face interview targeted at seven influential leaders in the community involved in men's health. This direct method of meeting with each participant was preferred over a mail-out to a random, representative sample, as it allowed the researcher to ensure that the questionnaire would be answered in correct sequence and that it would be answered by the person for whom it was intended. Other advantages of this method were that it provided the opportunity to clarify any questions by the participant and to expand on any particular area the respondent felt was important. This condition could not have been achieved through a direct mail-out of questionnaires. As Minichiello, Sullivan, Greenwood and Axford (1999) state, 'These methods provide the opportunity for the interviewer to follow up the responses and to seek either clarification or elaboration from the respondents' (p.369).

The transcript derived from the interviews revealed identifiable views, emerging themes and underlying ideas, using thematic analysis as the analysis method. It is only by sifting through the data gained by the qualitative approach that light can truly be shed on possible forward strategies and other possible answers to the research question. Knight (2002) suggests that this:

> …face to face work offers the chance to change the direction of a whole inquiry to accommodate new insights, comments made by participants, prompts or patter that turn out to work well. They can also jettison things that aren't working (p.50).

The data collection used in this project was in line with trends in interview techniques that move away from tight structures that lock the interviewer into a closely controlled set of questions. The interviewer is seen as an important instrument in this

revised approach, allowing the eliciting of more information than would be produced by a standard questionnaire. Denzin and Lincoln (2000) state that:

> …interviewers are increasingly seen as active participants in interactions with respondents and interviews are seen as negotiated accomplishments of both interviewers and respondents that are shaped by the contexts and situations in which they take place (p.663).

All but one interview (which was conducted by phone) took place at respondents' workplaces or homes, at a time suitable for the participant, and which minimised distractions. The researcher assumed that the familiar environment of the participant's own workplace or home would create a relaxed atmosphere and demonstrate the interviewer's interest in the views of the participant. All the interviews were recorded, and together with field notes, enabled the researcher to review the transcripts developed from the tapes prior to analysis.

The multi-method approach employed with these projects not only enabled the thorough gathering of data, but also enhanced the researcher's understanding of the feelings and position of the men and the strategies they employed for learning about their health.

In the next chapter, the findings of the four projects will be discussed and analysed. The assimilation of information gained by the research methods described earlier will be presented and discussed. It is from these findings that recommendations can be formulated and expressed in realistic and tangible terms.

Chapter 5

Findings

Through the course of this research, several themes have emerged that warrant special attention when looking at the overall results. Each of these themes will be discussed in terms of their relevance and relationship to the subject matter of men's health and informal education, and whether the author's findings support, add to or refute previous literature on the subject. The four projects, each with their own different emphases, contributed to a more comprehensive picture of the strategies required to deal with men's health issues in the community, from the perspectives of both the co-ordinators and the men themselves.

Community health centres: men as outsiders

Assuming that place-based health education is an effective intervention, the first issue is the perennial problem of how to attract men to come to a workshop as opposed to a shelter. Traditionally, it has been assumed that community health centres are the natural venues to host such meetings. However, it emerged from conversations with community health workers and men themselves that these centres are places perceived to be mainly for women and children, and particularly for children's immunisations. From one coordinator:

> Men regard community health centres as having little value for them. It was not a sporting centre or financial institution nor did it offer help with motoring, or tips for working their land.

This was reiterated by another respondent from Project 4 regarding community health centres as places for men to visit:

> ...still a major hurdle, men seem to think of them as places for women or disadvantaged men.

Whilst this attitude may arise out of men's general ignorance regarding places they can access for their health needs and information, it exists as a real barrier that prevents men from accessing workshops. Indeed, it was only after attending the men's health workshop and going back for a physical assessment by the co-ordinator that

many of the participants even realised that opportunities for health education for them were held in the facility. From the men's shelter in Project 3 it was the visiting District Nurse or the coordinator who was the instigator in health treatment or referral, who suggested:

> Because men self medicate – reluctance of doctors to treat these guys. Coordinator often rings doctor on behalf of the men.

Baker (in Davidson & Lloyd, 2001) says, 'finding the right venue for the course was problematic. It had to feel safe as well as being conveniently located' (p.126). In this respect, from a male perspective, the community health centre often appears as a male-unfriendly place. Smith (2007) states:

> The Australian Medical Association, in its position statement on men's health, suggested that strategies such as conveying positive images of men and boys through poster displays and men's health information are considered appropriate methods for encouraging men to access health services. This is an important contribution for promoting men's health in Australia, but differs markedly from what health promotion now constitutes (p.21).

At one such venue, waiting room posters were clearly displayed with such headings as "Intervention order court support service", "Family violence after-hours crisis service", "Men's behaviour change program" and "She has her father's eyes, she'd rather have his ears – Child Protection Week". Whilst each of these programmes have a place in the community and represent important initiatives, their promotion in this area appears to be perceived to have, at worst, an anti-male flavour and, at best, lacking sensitivity for the recognition of men as clients. As two co-ordinators stated:

> I don't think they perceive it as a major role that concerns them. A community centre to them is somewhere you take the kids for their injections. Women might go to know something about family planning background. Men do not access health services unless it's desperate.

This was another comment regarding community health centres:

> Men are suspicious about services, so I suppose there's a need to build a relationship with a man before working with him.

In addition the data suggest that rural men in particular need to be more proactive with their health. As one coordinator noted:

> Typical farming blokes have no idea. They're great with farming machinery, plumbing machinery, great with everything else, but they don't understand or comprehend what their health is or means.

This observation partly explains why community health centres now use outreach models which involve meeting people where they are more at home, including men in the workplace or wherever else they commonly gather. Another comment by a general practitioner in Project 4 also underlines how some men see little benefit for themselves in visiting a community health centre. He noted:

> I think men are not really interested in their health where there are so many issues that they have to undertake, such as paying off the house and helping with their children. There's never enough time to do that if they have children. If they don't have children, building wealth; maybe keeping fit in a sporting sense, because of their competitive nature. Community health is not based on competition; its not based on glamour, not based on production or increased production of their business or workplace, it doesn't help them build their garden, doesn't help build their house, so their interest in community health centres is very low.

An interesting observation made by one of the co-ordinators was that the vast majority of men are not targeted as a group and tend to be forgotten, leading to them only presenting to a health service or hospital after a disease process has extended to such an extent that preventative treatment is not an option. Emslie and Hunt (2009) state 'some men found it difficult to interpret their symptoms, men were more often forced to seek care by relatives than women. Despite severe symptoms, many delayed and endured' (p.169). This observation is consistent with the 'stoic' masculine approach to preventative health discussed earlier. Project 1 gave an indication that knowledge and forewarning could impact on the men's health seeking decisions. As two participants said:

> This course has made me aware of the reasons for many symptoms I have [and]
>
> All men should be aware of issues even if they don't act on them.

As Gray (2005) notes, 'men tend to wait until their symptoms are more concrete, by which time the disease may be more advanced and treatment less effective' (p.3). This co-ordinator further stated that:

> … a lot of money was being spent on domestic violence, drugs and alcohol; lot of money spent on dysfunctional men. General men, with normal issues, are not being given money.

It was intimated by respondents that, politically speaking, men's health does not score many points and is not a vote-catcher among the general public. It was not seen by

participants as good politics to have money directed towards men's health and preventative counselling, and even men themselves sometimes do not see health centres as a high priority in respect of their own well-being.

The way men commonly view community health centres and health services as being inappropriate for them contrasts sharply with women's attitudes. Healey (2008, p.1) alludes to this by saying 'the poor health status of Australian men is complicated by the fact that men are more likely than women to shy away from medical treatment of any kind'. Laws (2006, p.3) says 'women have become more informed about their health and the health of others through recent socialisation'. Women generally appear to be much more attuned to issues related to their health and, further, often try to include their male partners in their own health maintenance. Robertson (2007) states:

> ...the importance for men of 'significant others' in legitimating engagement with services. Many examples were provided by the men of female partners, or mothers, taking responsibility for either encouraging or directly making health service appointments, and this was echoed in the experience of the health professionals (p.139).

An example of this effect has been observed with men who support their wives in attending classes such as post-natal depression support groups. One of the co-ordinators involved in this study actively encouraged these men who come along with their partners to the community health centre to become involved in a separate session consisting of just the men looking at this topic. It was found that, from this small beginning, these men branched out to other topics which subsequently led to further men's classes with their full consent.

This perception of the inappropriateness of health centres for men's needs was a common theme among the respondents of Project 4. One respondent stated:

> … still a major hurdle, men seem to think of them as places for women or disadvantaged men, so it is not accepted.

From this perception emerged the notion that community health centres wanting to engage men in health related issues needed to be mobile - not to rely on men visiting the centre, but for the centre to go out to where men gathered, whether in the workplace, hotels or sporting settings. It is worth noting here that this outreach model

is being used very effectively by the Sustainable Farm Families Program in rural southwestern Victoria initiated and applied for by the men's health coordinator from Project 1 (www.sustainablefarmfamilies.org.au). From Project 3 the coordinator said:

> … men had nowhere to go during the day – not welcome at public areas, malls, shops, beach. There was nowhere they could call their own place.

This is a significant change of access policy, and may encourage more men to be aware and use the service rather than simply waiting for them to come through the community health centre doors. It is suggested that this approach is especially needed in the rural sector, where both accessibility and visibility of health services is more difficult. One coordinator from the rural sector stated:

> … there's really nothing to service these people 50 miles away, so having it mobile, having a service delivered to people rather than having people having to seek services, that's basically what we do.

A remarkable example of this type of approach was given by a respondent from Project 4 who recalled:

> I spoke to a fellow. I can't remember his actual problem, but he said to me his doctor used to visit him in the paddock to take his blood pressure and he was diagnosed from the paddock.

Such a proactive medical regime could significantly alter perceptions of men as to the importance of regular health checks, and might encourage higher participation rates in line with current government policies.

Venues for projects: creating spaces for men

From the above discussion, it is clear that the venues that these men's health workshops use are a crucial factor in their success. In Project 1, the venue was chosen to be the community hostel lounge of the town's hospital which was a convenient central location. In a small rural town, there was not a wide selection of options for a place to hold a substantial workshop, but this facility was a well recognised town landmark. The environment was conducive to a male gathering: it offered a comfortable room temperature, well-positioned chairs (in a semi-circle), an open, well lit area, functional equipment (overhead projector, video machine) and tea and coffee

making facilities. Healey (2008) refers to this from the perspective of medical waiting rooms when he says:

> … this is recognised by GPs at the practice trying to make things more man-friendly – stocking the waiting room with magazines on sport and cars, being proactive with men's health checks, introducing organised reminder systems and allowing appointments in the evenings and Saturday mornings (p.5).

Project 2 was held in the lounge room of the co-ordinator in a suburb of Melbourne. The co-ordinator perceived this as a non-threatening place for men to gather, not being associated with a community health centre or hospital. This urban workshop was focused mainly on emotional health, in contrast to the rural workshop, where the spotlight was exclusively on the physical aspects of health. The environment reflected this different emphasis. Here, the seating was comprised of large bean bags scattered around the room, with every participant having a clear view of the others. There were no teaching aids and the lights were turned down low. In the middle of the room, a rug was placed with a piece of gnarled wood on it. This was referred to as the "talking stick", and whoever picked up the stick could speak to the group and could not be interrupted. Health for these men was emotional health. Important aspects for them is summarised by two of the respondents, who said:

> To have places and groups to talk about their problems and needs, men are in crisis in many areas of their life and have few places to go to talk. They need to be willing also. It's all bottled up. Which leads to many health problems, and the cycle goes on.
>
> The death of the soul through such things as shutting down expression of emotion. The inability or lack of opportunity to share and communicate on a real level with other men; reluctance to confront absent father/male role model/initiation issues.

The experience of this group was that, in many instances, when talking about their emotional journey, the men often needed time to compose their thoughts before expressing them and any interruptions could disrupt their response.

In Project 3, the men's shelter was reasonably central to the town - a community health centre which served as a drop-in centre for men under the guidance of a large voluntary organisation. Due to space restraints, the drop-in centre was forced to operate in a leased area at a senior citizens' club, less than a kilometre from the

principal community centre. Due to the nature of the group of men it was serving, the environment primarily offered safety for its participants. It included a strict rule code for aggressive behaviour, shower and bathroom facilities, nutritious lunches served during the day and appropriate papers, magazines, board games, cards and tea and coffee facilities. It was deliberately set up to be as informal as possible within safety expectations. A district nurse visited regularly, engaging in casual conversations and informally asking the men about any health needs. The District Nurse when asked what convinced her to be involved with the centre stated:

> ...request for district nursing service to sit with target group – didn't understand how to engage health services. Nurses dress formally so they can be recognised – don't play those games of dressing as the group does for acceptance. Doctors come here on a regular basis.

Whilst the three venues in this study needed to cater for different groups of men and thus involved contrasting environments, there was one common denominator between all three sites. In the rural workshop, the urban workshop and the men's shelter, every effort was made to make the environment conducive to the gathering - the right temperature, comfortable seating, access to hot drinks and a co-ordinator/mentor in attendance. In all three projects, the men agreed that the environment was an important component in setting the mood of the group and assisted in the smooth running of the programs.

Indeed, informal spaces and programs in community settings is epitomised by the rise in 'Men's Sheds' in Australia which addresses the environment need for men. Golding, Brown, Foley, Harvey and Gleeson (2007, p.7) state:

> Men's sheds are typically organised by, and legally constituted through, existing community organisations. They usually provide a woodworking workshop space, tools and equipment and an adjacent social area in a public, shed-type setting. Some include a metalwork area and/or an adjacent garden.

Overseas, this is also problematic for men to access community and health facilities especially in the evening. Sixsmith and Boneham (2003, p.382) commented:

> To get involved in community groups for the first time in old age was perhaps predicated on social skills the men had not developed in their younger days. This left the men distanced from their wider community. Some explained their lack of

> involvement in terms of the dominance of older women in community spaces. They referred to the absence of activities or venues which catered to their lifestyles. For instance, local community centres did not allow drinking and smoking. The older men saw the whole community as having become more dangerous, so they did not go out at night, both because they might be vulnerable on the streets and because their homes might be broken into while they were out.

For the drop-in centre, the aspect that ranked as 'most important' in the feedback was that it was a place with a relaxed and safe atmosphere. Statements made by the men included:

> Companionship, sandwiches, soup.
> Happiness, learning to talk to others.
> Quite often I meet unemployed men on the street saying how hard it is to pay rent and food out of their dole. Here, they can have a yarn and a feed and keep out of trouble.

These men had their basic needs met of food safety and shelter which brought them to the shelter and allowed access for health workers to assist in the men's health.

Engagement of men – times

In addition to providing an appropriate environment for the programs, another important factor was the timing of the sessions. What emerged from the discussions with coordinators was the notion that certain times and seasons (especially for the rural men) were better than others for workshop attendance. When planning rural workshops, it must be appreciated that there are certain times when farmers are committed to their farms, and they cannot be absent even for a short period. Times such as shearing, seeding and harvesting mean that farmers are often working on the land well into the night in a small window of opportunity. This is a critical consideration when setting up programs for rural men, especially if they are to be run over a four to five-week period. Very little in the literature refers to the timing of men's health workshops which is unfortunate as this is an essential element in formulating programs for men.

In the current study, both the rural and urban workshops which were the focus of the work were held on a Friday night, chosen presumably as it was the end of the working week. The rural workshop was staged over a five-week period, with a definite start and finishing date, and with men registering for this time. The urban program, on the

other hand, was continuous, apart from Easter and the Christmas break. In addition to the seasonal time considerations mentioned above, these timing decisions also reflected the different agendas of the two workshops, one putting the emphasis on physical health (the rural workshop) and the other on emotional/mental health (the urban workshop). Dealing with men who are going through emotional turmoil cannot be a "quick-fix" situation, completed in a single program or neat package. Indeed, one of the men in the urban group had been a regular participant for the past two years. Many men referred to the group as their support structure and said they looked forward to the meetings.

The men's shelter was also an ongoing project. The main difficulty was staffing the venue for prolonged sessions. At the time of the research, the centre was open for disadvantaged men three times a week from 9.30 am to 3 pm. This enabled the men to shower and attend to hygiene, to access fruit, morning tea and lunch, and have time to play cards, read magazines or have counselling.

Continuation of support and continuity of service: overcoming 'pilotitis'

Once a workshop is completed, it is not in the community's interest to cease interaction with the participants or not to offer new programs. A more valuable approach is to offer follow-up workshops so there can be a regular program of reinforcement and extension available, and new participants can be recruited through reference by past participants or by other health professionals. Clearly, the more men that attend such follow-up workshops, the better will be the overall contribution to community health practices, which will benefit the whole community because of reduced days on sick leave and the reduction in long-term medical conditions. One important perspective in this regard came from a co-ordinator who asserted:

> I think what works is being consistent. If you have the luxury of having a program with the same workers for two or three years, there's that luxury that a good service will have good words said about it. So people will come, not only because of the service, but also because of who runs and organises the service. I think that's really important.

This consistency of service is an important consideration in planning future workshops. In the past, one rural co-ordinator found it necessary to contact influential

and significant men in the community, giving them information about upcoming workshops and personally inviting them to come. However, after instituting a regular service, he observed that:

> Nowadays, I don't do anything. I just say to a group or area, whether it be through a local community service or just an ad in the paper, that men's health is coming to their area and it's fully registered within a week. I originally had to do the footwork, but once it's established they come to you.

Another respondent referred to the reinforcement of information as being critical:

> I think that by seeing them on a regular basis (though not too regular), I remember that it's very difficult for people in middle age to change their ways. I try to create an environment that you're working with them and you understand their difficulties.

The flow-on effect of having regular programs is illustrated by a case in the first rural project in which three of the participants belonged to a particular club. After the completion of the program, the co-ordinator was invited by these participants to speak at a formal meeting of the club, and following this presentation, another workshop was organised for club members in the following year. This experience suggests that not only are participants efficient recruiters of other men in subsequent programs, they can also act as role models for those who may be more reticent to engage with the activities. This needs to be acted on as there is not always funding available for health projects and they may need to be conducted on a user-pays system. One coordinator stated:

> That these programs have been a success is demonstrated by their participation rated. When the first programs were run, there were nine funded group workshops in the state; now there was only one being funded.

Care has to be taken with the limitations mentioned above of the one-off projects that are not sustained or followed through in the same geographical area for men. Kuipers, Humphreys, Wakerman, Wells, Jones and Entwistle (2008, p.17) refer to this when they state:

> ...while disparate trials and pilot interventions are worthwhile, their benefit often only extends to a small group, invariably ceases on completion of the project, and that the lessons learned at times fail to translate beyond the final report to sustainable outcomes. We suggest that this frustration reflects a general feeling within government that there is a need to translate the lessons learned from pilots into key principles, generalisable beyond one or a few pilot projects, to inform policy and health service planning.

Appropriate venues and programs for men have to take account for what has proved successful in earlier projects and this needs to be ongoing and owned by the community.

Incentives and normalising illness for men

With three Projects, tea and coffee making facilities were made available, which it has been found are always essential at any gathering of men. A suggestion was made that if food provision could be extended, men would be even more likely to attend. Indeed, one respondent said that food was always an effective lure for men to attend a health check, workshop or health night - especially if it 'included a barbecue where men could gather'. It was quite clear to the researcher during this project that men appreciated the opportunity to socialise, gather around and talk among themselves.

Although the workshops and programs attended by the researcher had no high-profile sportsperson or media personality in attendance, the co-ordinators did say during their interviews that if some kind of celebrity was present it acted as an incentive for attracting men to come. Verrinder and Denner (2000) when referring to setting up workshops said:

> The strategies used in each of the towns were similar; an initial men's health night was organised to assess interest and celebrity speakers were frequently engaged to encourage attendance. In some cases the local GPs were also involved … Sporting personalities were generally used as drawcards (pp.82-83).

This is especially appropriate when organising a large scale session and works best if on a one-off basis. One co-ordinator stated that:

> Sometimes, we take along a high profile person. If we use a footballer, we get huge numbers. If that footballer has had cancer, that has an enormous impact with the men. I guess that reinforces the idea that he had it and he's OK. Maybe it'll be OK for me.

The reason that sporting heroes, especially high profile footballers, manage to attract so many men to hear them can only be speculated. Possibly, the dangers inherent in a controlled, violent sport such as football or rugby union may be the only socially acceptable way that masculinity in the form of aggression can be demonstrated, and

this notion, coupled with the media controlling the image and popularity of these professionals, may explain why they attract the attention of other men. Many are touted as heroes in the minds of the men, since they face both immediate physical danger and have remarkable demands on their endurance placed on them. It is possibly this combination of attributes may explain why they often appeal to men in today's culture who often feel trapped by the restraints of society. Smith (2007) alludes to another perspective with hegemonic masculinity being a focus and a barrier to normalise illness and says:

> Stereotypical masculine traits, at both an individual and population level, are considered to be detrimental to the health of men, as expressed through engagement in risk-taking behaviours and ignorance towards their health. Not all men, however enact hegemonic masculine behaviours, and I argue that this ought to be a key focus of men's health promotion in Australia. At a starting point, it has been acknowledged that the perpetuation of masculine stereotypes during health encounters is unproductive (p.22).

Pragmatically, for most men's health workshops in small towns, securing celebrities is just not feasible, but if opportunities arise, it could provide an invaluable benefit. Having socially recognised men talking about their own illness 'normalises' it and therefore makes it more acceptable for men to discuss. If a high-profile sportsperson cannot be in attendance for a seminar, an influential person or persons in the community could be approached. If this person is supportive of the program, it can have a great influence on the decisions of other men in the session. In one situation related to the researcher, a coordinator who was provided with a list of names of men who expressed interest in attending rang them personally to answer any questions they may have had, and to personalise the invitation. This effort was one way to avoid a "no-show", which can often happen when there is a lack of a personal approach with the invitation.

Women as health advisors and navigators

Recognising the role of women in attracting men to workshops is a crucial issue. Talking to men during breaks in both the urban and rural programs, it emerged that many had come because their wives had encouraged them to do so. Furthermore, the questionnaires revealed that many men were reliant about their health through their

wives, mothers or partners. One coordinator said he was definite in his belief that men will learn through their wives/partners.

Both the rural workshop and the interviews with co-ordinators underlined the importance of women in influencing men's behaviour, to the extent that the co-ordinator of the successful rural workshop included women in parts of the program. He invited them to the last session which was a visit to the local supermarket. In this session, time was spent looking at foods that families commonly would buy in terms of their nutrient and fat content. Laws (2006, p.40) says: 'twice as many men as women, aged 30-59, chose a family member as a healthier lifestyle advisor'.

Indeed, three of the co-ordinators interviewed said they targeted females as a marketing strategy for their workshops. Their comments included, "the best marketing is talking to the spouse" and "Men's groups are only successful if women are instrumental in getting men to come". When talking about significant others in her research, Butera (2008, p.273) states:

> None of the 15 men in the retirement cohort of this research project spoke of having intimate conversations with other males and only 2 of the 15 referred to openness as an essential element of friendship. They all referred to their wives as their best friend and closest confidante; the only person they would share deeper thoughts and feelings with.

One co-ordinator alluded to the principle that women are prime motivators in getting men to attend and that the marketing of programs is directed at them, asserting:

> Men's groups are only successful if women are instrumental in getting men to come to the workshop. We target women with promotional material, offering a draw at the workshop for a romantic dinner for two or a weekend away. We letter-drop and address it to be read by men only so that wives often open it and read it. In this town, with a population of 500, 120 men turned up.

This emphasises the assertion that women need to become involved if men are going to attend. A doctor who was part of the interviews, now conducts a men's health clinic in a major hospital in Melbourne due to approaches by women who attended a women's clinic opposite his consulting rooms. When asked about marketing, he said:

> We don't advertise at all. I mean, I'm the only one here and we have a personal situation here where there's no room for expansion. What initially started the clinic, ironically enough, was an overflow of demand from the women's clinic. Women were reporting that their partners were having problems with their health and refusing to see someone, so they asked me to come and do a session a week and it went from there. Now it's basically word of mouth. I only see adult men.

Background of participants and reasons for participating

It was important to ascertain from the men themselves what encouraged them to come to the sessions and not simply assume it was primarily because of encouragement from their wives/partners. The rural workshop involved 15 participants. Their occupations are reported in Table 7.

Table 7 Occupation of participants: Project 1

Technical Officer	1	Self-employed	1
Wood mill worker	1	Retired	1
Workshop foreman	1	Tradesman	2
Salesman	2	Dairy farmer	6

These men were asked how they found out about the course, and responses are noted in Table 8.

Table 8 Method of finding out about the workshop

Advertisement	Friend	Spouse	Work	Phone call (co-ordinator)	Other
3	9	0	1	1	1

It is interesting to note that, both in the literature review and the comments from co-ordinators, the importance of wives /partners in influencing men to attend was emphasised, yet not one of these men mentioned women as a factor, although they could have come under the heading of "friend". Possibly, since many of these men came from rural areas, they were typically, fiercely independent. Showing

dependence on, or taking advice from wives was perhaps not something they would admit to readily. The other interesting finding from Table 8 was that more than half of the participants found out about the workshop from a friend. It therefore appears that the best marketing for these programs may be by word of mouth. Past and other participants are clearly an important marketing strategy.

Asked why they registered for the course, most of the men said they were interested in their health and saw this as an opportunity to learn something. Comments such as "improve my health", "concern for good health", "interest in what my health might be like" and "have been interested in my health for a long time, especially since turning 40", demonstrate that men at this age are interested in learning about their health and that learning opportunities like this need to be presented.

The sense of commitment to the workshop was demonstrated by the attendance figures shown in Table 9.

Table 9 Number of weekly sessions attended over four weeks

Sessions attended	1	2	3	4
No. of participants	0	1	5	9

The participant who only made it to two sessions said he would definitely be returning for next year's course. The value of repetition and consistency in providing workshops such as these cannot be underestimated. Table 9 is suggestive that the workshop was deemed worthwhile for these men as was demonstrated by their attendance. In health promotion initiatives aimed at men, Gray (2005, p.7) says:

> … make sure the environment is conducive and safe for men; advertise the service/event extensively; and hold the event in the evening with no appointment needed so men can drop in as best suits them...recognition that the models of maleness that are prevalent at the moment militate against rather than for men's mental health.

The urban workshop used a different arrangement with an ongoing format, since it had neither a set beginning nor a set ending. In the sessions attended by the

researcher, attendance ranged between from nine to 20 participants, the latter being near the maximum number considering the venue. Of 15 questionnaires distributed, nine were returned, representing a 60 per cent response rate. The occupation of participants did not present any clusters, as Table 10 indicates, coming from different backgrounds as opposed to the rural project where the majority were farmers or associated in business related to the land.

Table 10 Occupation of participants: Project 2

Computer support / performer	1	Typesetter / compositor	1
Personal and residential care worker	1	Instructor to autistic adults	1
Pensioner	1	Builder	1
Financial sales	1	Art student	1
Environmental management	1		

The men's impetus for attending this program contrasted sharply to those of the rural men. Four respondents indicated they found the program listed at the back of Steve Biddulph's book, *Manhood* , two mentioned comments by friends, one knew of it by attending private counselling sessions with the co-ordinator, one from an advertisement and the final respondent mentioned "other means" without stipulating what that meant.

The men's reasons for attending were based on predominantly emotional needs. Answers included:

> Personal life hit an all-time low. Important for me to be in the company of men who really talk about themselves. I've shy'd [sic] away from men all my life.
>
> Went on instinct. Bit messed up. Needed long-term support. Needed honesty. To understand the hollow feeling I have been feeling for a long time.
>
> I wanted to experience being in a group of men and to discuss what I felt were 'men only' issues with other men.

These men's perception of health lay in the realm of emotional health, as opposed to the rural workshop, where the participants were strongly focused on physical concerns.

Fees for workshops

The men's shelter was underwritten by a charity, as the men attending usually did not have the means to pay for the service. The other two projects occasioned debate regarding this issue of whether or not payment should be asked of the participants. In the early rural workshops, a payment of $40 was given as an incentive to attend. However, the co-ordinator confessed that this idea failed, with the men handing the money back, preferring it to go into community ventures. These men had the firm expectation that payment should be given for services delivered, not received as an incentive to attend something. The later rural workshops were offered to men at no charge and subsidised by government grants. It was interesting to note, though, that at no stage was the no-cost aspect of the program mentioned by the participants as a reason they were attending. Nor did they ever express any appreciation of this fact.

The outcomes for the urban group were very different. The men paid for each session and, as the program was ongoing, payments were made on a user-pays basis. In this situation, the co-ordinator, who favoured a user-pays system, suggested that payment should be up-front except for the introductory offer of a free first session. He believed men did not respect free sessions, and that by attaching payment to attending, he believed the men felt they had ownership of the program. For the men in the urban group, the question of payments did not arise in their review of the program, suggesting that appropriate payment for programs does not deter men's participation in this setting.

Age of participants

The literature review supports the observations generally that young men do not regard their health maintenance highly and participate readily in risk-taking

behaviours (Noone & Stephens, 2008; Smith, 2007; Laws, 2006; Gray, 2005; Healey, 2008). In this investigation, an examination of the ages of workshop participants again supported this notion. At the rural workshop, no participant was under 40, with the average age being 49 (Table 11).

Table 11 Age of participants: rural workshop

Age	18-30	31-40	41-50	51-60	61+
Participants	0	0	9	4	2

The lack of young men attending sessions is further reinforced in other workshops held throughout Victoria (Project 4, p.10) and illustrates the need for a concerted effort to address this age-related issue. The urban workshop, which dealt more with emotional health issues, saw younger men participating although, still only one male was under 30. Verrinder and Denner (2000) talking about the success of men's health nights, refer to this when they say:

> Men's health nights and sessions apparently appeal to older men who are concerned about their health. The vast majority of participants were in their 50's and 60's. Only 11% were under 40. As well as appealing to older (and more likely to be retired men, the professional groups were also over-represented in the sample and the unemployed were under-represented. This tends to indicate that men's health nights and sessions appeal to groups with higher socioeconomic status (p.85).

Table 12 Age of participants: urban workshop

Age	18-30	31-40	41-50	51-60	61+
Participants	1	6	1	1	0

With the men's shelter project, ages ranged more across the adult age span. This could be understood, given the nature of the centre providing shelter, food and warmth to the disadvantaged of any age. The respondents were evenly spread from 25 to over 65, with no representation of men under 24 years (Table 13).

Table 13 Age of participants: men's shelter

Age	25-30	31-35	36-40	41-45	46-50	51-55	56-60	60-65	65+
Participants	2	2	3	1	2	3	0	3	1

The men's shelter was not age-specific and offered the basic essentials of protection, shelter, food and company for men of all ages. The relevance of what the shelter provides was not lost on its clients as it afforded them the essentials on life and was recognised as a safety net for their situations. This relevance should be marketed more to men similarly disadvantaged in the general community.

Criteria for coordination

Consideration has to be given to the qualifications and other attributes of any potential men's health co-ordinator: the credibility that is given by the men when conducting community health programs is a critical factor in its success. The rural workshop co-ordinator was a registered nurse with qualifications in intensive care and men's health studies and experience in emergency and intensive care at a hospital in a large nearby town. This background gave him tremendous insight into men's health and he was qualified to conduct a physical examination of each participant. Each man had his blood pressure taken, cholesterol and blood glucose levels checked, and weight, height and body mass index (BMI) measured.

This physical examination was an important component to the program and gave each man a starting point as to where he stood in terms of his personal vital statistics. This quick "once-over" allowed early danger signs to be recognised and referrals. More comprehensive tests could be made for men who would not realise that potential problems existed. During the course of this investigation, the co-ordinator actually identified several significant health issues among the participants and further assessment steps were taken. These issues were: (i) three men were asked to have an assessment of worrying skin spots; (ii) two men with apparent chronic indigestion were referred to a GP for assessment and a possible endoscopy; (iii) two men with a family history of bowel cancer were referred for assessment; and (iv) two men with a

history of heart disease and with significant risk factors were referred to their GP for assessment and management. The responsibility to seek further assessment and referral was placed on the individuals counselled, and was not part of the coordinator's role top follow up. This unplanned observation clearly indicates the importance of this initiative.

This initiative is important as without this assessment, these problems would go unnoticed and in our Australian culture, even health care providers construct men as unwilling to seek health. Noone and Stephens (2008, p.713) said:

> Health professionals themselves contribute to the gendered construction of health behaviour ... found that health professionals criticised culturally idealised forms of masculinity for their part in men's reluctance to seek help, but valorised or celebrated them at the same time. Women's problems were constructed as more trivial than men's while men's reluctance to visit the doctor was accepted as amusing.

There is a shifting sense of masculinity resulting in a greater acquiescence in help-seeking, and men are much more prepared to reflect on and discuss their health needs (Davidson & Lloyd, 2001). This tends to risk men's sense of masculinity, hence they do not tend to seek help but conversely the conundrum confronting men is they may feel emasculated in a feminised world and their sense of control is no longer clear.

It has to be noted here that for this rural coordinator, health for men was from the physical viewpoint. At no stage for the rural workshop was the mental or spiritual health of men broached as was the case in Project 2. To look at the health of men holistically, all three areas need to be attended to or given recognition. The coordinator admitted that he did not feel comfortable broaching these other areas and was more familiar with the physical aspects. Butera (2008) refers to this reticence as an adjunct to mateship when she states:

> The practice of mateship requires an unreserved willingness to provide practical support, but emotional support is not overtly offered or requested. The findings of this research show that there is little change to this norm in contemporary practices of mateship (p.275).

This co-ordinator commented during his interview that one of his major concerns was the lack of knowledge men often demonstrated regarding their bodies. He said:

> Research I've done has shown that, on the initial assessment of men, their level of knowledge is shocking regarding simple things like what is cholesterol, what their normal weight should be, what causes a heart attack.

At the beginning of each workshop, this coordinator distributed a short questionnaire asking simple questions about anatomy and physiology, especially in relation to male health issues. Upon collection, it was emphasised that privacy of information would be maintained and only the co-ordinator would have access to their answers. The main aim of this questionnaire was to find out what the men do and do not know so that relevant information could be tailored to meet their needs. Men often were not aware of simple anatomy and physiology and from the pre-workshop test this was made evident and commented on by the coordinator. The results enabled the coordinator to clarify and inform the men during the course of the workshop of specific areas of health, and learning was confirmed with the post-workshop questionnaire. The same questionnaire was given out at the end of the workshop, to find out what learning, if any, had taken place. This is a useful tool for self-assessment for the co-ordinator, in terms of how the informal teaching methods have worked and just how much information the men took in.

The rural co-ordinator's experiences in the health setting made him an ideal person to relate health issues to local conditions. Because he lived in the area and had a small farm further enhanced his close relationship to, and trust from, the men who attended. Generally, establishing one's credentials and relationship to the health program is a crucial concern, and should be carried out before the other sessions commence. A co-ordinator talking about a healthy lifestyle should be a role model himself: he should not be overweight, smoke during breaks or engage in health risk behaviours. Were he to do so, his words would consequently have little impact on lifestyle change and win little credibility from the participants.

The facilitator of the second project, the urban workshop, was instrumental in co-ordinating programs in men's psychological and emotional health. He started working with men's health groups after his first wife, who was an active feminist, began a women's organisation. With training in psychotherapy, he felt he could provide what some men were missing and develop their emotional well-being. The men's shelter in

Project 3 was staffed by support workers who either had qualifications in social work or volunteered their time to assist in the programs. The co-ordinator of the centre had social work qualifications and was a trained counsellor, these attributes combining to give him the credibility and experience that helped in his role with the men.

Relevance to targeted men: overcoming stereotypes

From advice proffered in the literature and from data obtained from the projects, an important issue is that the needs of the men have to be both ascertained and seen to be acted upon, ensuring that the content of the program is relevant to the needs of the particular group of men. It is important to know the target audience including the age group. Brown (in Davidson & Lloyd, 2001) advises, 'when developing your resources you must be clear about identifying your target group. You will then be able to consider effectively issues such as communication'. (p.94).

One of the most successful strategies at the beginning of the rural workshop was to present comparative statistics of morbidity and mortality between rural and urban men. It comes as a surprise to most men that the rural male is more at risk of health problems and suicide than his urban male counterpart. This strategy can be an effective starting point for highlighting health problems in the rural setting. The co-ordinator of this workshop stated that:

> Certainly, with farmers, I focus particularly on farming injuries, farm safety, the use of sprays, chemicals in relation to cancer and other neurological diseases. We do change things around depending on the group that's there. I may go to a dairy area and you have to focus on cholesterol. All dairy cockies love their milk. When I may go to a wheat belt area, I have to talk about hours of work and hydration time, stress and things like that, so it does change.

This statement underlines how critical it is to be adaptable to the needs of the audience and not merely force through an agenda which is not in harmony with what the men require. As another respondent commented:

> I think we need to think quite broadly - there's a whole population of men out there who want a service other than those forced to come in because of child protection or directed because of the system. I think it's really important for us that services are that broad.

When it came to the men from Project 3 (the men's shelter), the health information they needed was given to them through brochures (28%) and informal conversation (72%). These were the only means of communication that the men mentioned – a fact which confirmed the lack of any didactic teaching and the informality of the centre's approach. The most valued aspects of the drop-in centre, as far as the participants were concerned, were (in order of importance): a place with a relaxed atmosphere, acceptance from people involved, interaction with other men, food and drink and community nurse input.

What this centre's clients wanted most was help in accessing community services and assistance with housing and finance. This was an example of how information has to be appropriate to the men the program is seeking to assist. For these men, finance and housing was the information most appropriate to them for their circumstances. It may not be on the radar for health services but a referral service to accommodation services needs to be available for these men. The stress that housing and finance brings is a precursor to adverse health conditions both appearing in physical and mental aberrations.

The most important issues for the rural participants were matters related to exercise and diet. Also important was information relevant to relieving stress, some general health education, and discussion about various forms of cancer and heart disease. One participant said the benefit to him was "incorporating changes for the better into my lifestyle", while another said, "being aware". This last statement symbolically represents the very essence of men's health workshops and illustrates why ways need to be found to combat against ignorance and apathy regarding their own health.

For the men from the urban project, the important aspect of health to them reflected the emphasis of emotional health subscribed to by the co-ordinator. They offered comments which were in stark contrast from the rural workshop such as:

> Cost of counselling, accessibility of male counsellors and validity of men seeking help
> To have places and groups to talk about their problems and needs

> Men are in crisis in many areas of their life and have few places to go to talk. They need to be willing, also. It's all bottled up, which leads to many health problems, and the cycle goes on
> Personal value, self-esteem, personal growth work, hope for healing wounds from the past
> Love – how to ask for it and express it. Anger – what it is and how to use it, communication
> Stress, alienation, lack of purpose, lack of spirituality.

All the answers had similar messages, reflecting the major emotional turmoil in these men's lives. Ironically, it was sometimes difficult to reconcile the loneliness these men expressed with the fact that they were surrounded by so many people in their everyday lives.

The men from the shelter had different priorities from those of the other two groups. The men in the rural and urban groups had their basic needs met (food and shelter), so their perceived needs were higher on Maslow's (1987) hierarchy of needs. In this context, this meant information on exercise and improving their food intake, not simply how to find food. Comments on the question "what do you believe are the most important issues in men's health?" included: "Not dying", "Getting out and meeting people over a cuppa – something to eat", "Low morale, loneliness as a result of unemployment, separation, etc", "Substance abuse, poor nutrition", and "The fact that if he gets sick he has someone to talk to".

These comments indicated that the issues that were of primary concern to these men reflected their more basic needs. They wanted life, not just health. Talking about this point, the relevant co-ordinator said:

> Men walk up to three hours, 15-20 km. One man is up at 6 am and walks 25km, one way, with two dogs. He knew he would get support and food and would be driven back. For the homeless, a lot of men have psychiatric disorders, addictive behaviours, anti-social behaviours and show a reluctance to seek medical attention.

That men appreciate the efforts made to connect with them supports the earlier observation that consistency is important to gain the men's trust not only with the homeless shelter providing basic needs for life, but also consistency with any approach to men's health. There also has to be a consistency with these workshops: it

is best if they are not a once-only occasion, but part of an ongoing holistic health strategy.

Learning styles

One of the foci of this research was on the issue of how men learn and whether that learning style is different to women, for, if there is no difference, there would be little reason for the expense and inconvenience of separate men's health workshops. Suggestions for the importance of having separate men's groups came from a number of quarters in this investigation, including observing the men during the workshops and by asking the co-ordinators for their views.

From the researcher's observations, men in the rural workshops primarily learnt by relying on such senses as hearing and sight. For the duration of the course, not one man brought a pen or paper. Even when these were offered, writing down what was said appeared to be not an option, since for these men, learning took place from observing and listening and not from relying on notes for later recapitulation. This suggests that learning is immediate, and there seems to be little formal reflection on the substance of the workshops. As mentioned earlier, the health education for these men is more in the context of delivering informal learning from a community perspective rather than a formal adult education perspective, which is consistent with the lack of formal note taking observed. Laws (2006, p.40) says 'health promotion messages/leaflets are read by less than 10% of patients in UK GPs waiting rooms' which brings into question the value of written literature distribution especially for men. Recognition is given here to the educational background of men where professional and well educated men may be an exception to this informal way of learning and one cannot make assumptions or generalisations from observing one way of learning from a targeted group.

In order to develop this notion of learning further, one coordinator was asked "From your experiences, do you feel there are differences in the way men learn as compared to women's groups? If so what are they?" This coordinator was specifically asked because alongside the men's health workshop, he was asked to conduct a women's health group. Coincidentally, this request came from the wife of one of the

participants of an earlier program. From this exercise, he perceived that men did indeed learn differently to women. The main difference, he said, was with women there was a greater acceptance of health services and an ability to talk, discuss and share with other women their concepts of health matters. By comparison, he found that hegemonic masculinity in men's groups was a barrier when individuals sought assistance with health matters and tended to restrict the man's ability to share feelings and ask for help. This is supported by Noone and Stephens (2008) who say:

> Our analysis showed that hegemonic masculinity's opposition to the feminine adds dimension to this dilemma because, not only is the seldom-user of health care a masculine subject position, but the virtuous and regular use of health care is a feminine position. This dilemma arises because to admit that one does not seek medical help, risks being positioned as an immoral member of our society. But to identify as a man who is willing to seek help, risks damaging one's masculine identity, as the regular-user position is one they constructed for women (p.8).

This needs to be acknowledged by the health services that men require relevancy and information presented in a way that complements the masculinity factor in both the way information is presented and the shift to 'normalise' illness. The co-ordinator stated:

> Women learn through others and I think they learn by attending and being interested in their health, whereas men, they only learn by possibly fear, possibly the visual shock of the slides, things like that, so that does help with the male learning – I think they're more visual and they're more related to financial income – tell them they are not going to work for six months after a heart attack, bowel cancer, and they'll say, who is going to do the work?

In this respect, Davidson and Lloyd (2001) note that, 'a major consequence of men's reticence and silence is that the gap gets filled by assumptions, prejudices and stereotypes. Men don't talk – so we tend to generalise on the basis of the public front they present' (p.267), which accords with the researcher's observations and the coordinator's perspective discussed above.

Clearly, it appears to be important when delivering a health message to understand that the best way men learn is in an informal style. One co-ordinator reported that:

> Men learn in a more direct fashion - they love being task-oriented. Women, on the other hand, are able to circumnavigate questions and explore the nuances of any particular topic. Women are much more capable of seeing the descriptive side of an argument, whereas men are better at ignoring that and seeking to resolve a problem.

> Therefore, unless there is a targeted end-point in a discussion, men often get bored and don't wish to learn.

This principle was certainly applied in the rural workshop, which featured a clear outline of the objectives for each session, with information reinforced with visuals and minimal handouts. Time was always closely watched and only one session went over the agreed time. On this occasion, the delay was instigated by the men themselves, who were, on this occasion, asking questions at the end of the session on a topic of interest to them. Another coordinator's comment echoed earlier positions:

> Our experiences would be that, men generally are very black and white in their thinking. They don't think in the grey very often; men will want to fix it today. They are changing, though. Men are suspicious about services, so I suppose there's a need to build a relationship with men before working with them.

For informal learning to occur in the field of men's health, a humanistic approach is likely to be the most appropriate. In this approach, the assumption is that the individual is free to choose his own direction and to consequently form his own decisions. Indeed, in all three projects, the talking to the men was done at their level - there were no complicated terms or medical jargon used. Men tend to not like to be lectured to and criticised for their lifestyle, but appreciate information and relevance. Once that is offered, men often have the ability to make informed decisions about their own lifestyles.

Changing fundamental behaviour is very difficult and it may take as much as a near-death experience or the arrival of children to force a change in lifestyle. Some men begin to realise that, because their lifestyle is damaging their health, they may not see their child go to university or get to hold a grandchild. This is illustrated by the comment of one respondent who said: "All men know that smoking is bad for them, so it [is such realisations that] actually makes them decide that they now want to stop. You can't do this by preaching to them or by moralising. It doesn't work."

One of the key observations made at the rural workshop was the men's acceptance that this was not going to be a judgment session and that they would not be made to feel guilty over their lifestyle and health habits. Furber (in Harrison & Dignan, 1999) says, 'health education has historically been criticized because of its victim-blaming

approach' (p.194). Many of these men had grown up in a culture of drinking and instinctively knew the importance of being accepted by their peers in this area. The point to be made here was not that alcohol was the problem, but it is rather the amount that is consumed. This point was illustrated to the men with the simple analogy of assuming a beer was equivalent in food value to a Mars Bar. It was put to them that to have one or two bars a day was not harmful, but eight or nine a day would start to have serious ramifications over time. So it was with alcohol. This simplistic, non-judgmental approach was appropriate for the rural setting. On the last night, to prove the point, beer was offered at the completion of the program along with the normal hot drinks.

Follow up

The follow-up on all three projects yielded some interesting findings. Phone interviews were conducted six months after the completion of the rural workshop (Project 1) and 12 months after observation of a portion of the ongoing urban project. Thirteen men were contacted from Project 1 and all clearly remembered aspects of the workshop. All had acted on them except for one, who said the experience had simply reinforced what he already knew. One man had given up smoking and eight said they had altered their eating habits, which, after six months, suggests a promising trend. Gibson and Denner (2000) stated:

> …men were simply asked whether they were more likely to see a GP after attending a men's health night. On average, 64 per cent indicated they were more likely to see a GP as a result of the information session, while 31 per cent were not' (p.23).

However, from the perspective of one of the GPs questioned in Project 4, this assertion may be difficult to prove. This doctor said that only on very few occasions would a male admit that a workshop had prompted him to make an appointment, though it may have been the trigger. Of his male patients, none could be proven to have come because of this intervention. Despite this reservation, one of the findings to come out of earlier research from the participants themselves was that the health workshop had made the men more inclined to visit their general practitioner earlier or to have a health check.

From the second project, only three of the men would consent to a follow-up interview and one of these was not contactable. This was in contrast to the rural workshop and may be due to the private nature of the urban group, where the men felt secure with the others, but did not want to share outside this environment. Asked if the workshop had affected his health management, respondents answered:

> "Definitely – much greater awareness of how I'm feeling – a wide range of ways to deal with things." "Coming clean with who I am. Situations when I'm not happy, I say so as not before – being able to express exactly where I am at and how."

Asked if the workshop had made him more inclined to talk about his health, one respondent said "Yes, but selective who I share with". When asked about the co-ordinator's teaching methods, one respondent said, "The most important thing is the way the co-ordinator listens and the way the group listens, that no one is interrupted". The other stated, "Owning up to how he is – being on the same level. Saying exactly how it is. Very honest". What the men are alluding to here is not so much the co-ordinator's teaching methods as his counselling techniques. Asked about the best teaching methods to be employed for men's groups, the co-ordinator stated, "How I am myself, in front of men. If I access my inner strength, I'm their father in some sense – present, loving, caring and tender. To be what their fathers weren't. If I was to judge them, they would restrain themselves". One can't help but wonder how this approach would come across in a remote rural setting since the differences were quite marked between the two groups. To these urban men, health was associated with the opportunity for reflection, sharing and emotional stability, but rural men evidenced little open reflection and sharing of views.

The three projects reviewed were all very different whilst all being centrally committed to the health of men. There is evidence here of a more complex relationship between the success of health education strategies and the context within which it is proffered. The workshops and interviews combined to yield a rich supply of data and findings, from which some firm recommendations will be put forward in the next chapter.

Chapter 6

Conclusions and recommendations

This investigation was conducted in an environment where there was a small but growing awareness in the community regarding the issue of men's health. For example by 2009 the Federal Government had initiated a national inaugural men's health policy process. The Australian Government Department of Health and Ageing (2008 p.1) state:

> The Government is undertaking consultations to develop the National Men's Health Policy with consumers, the community, health service providers, and state and territory governments. This is to make sure the Policy meets the varied needs of Australian men – in the cities, in the country, across their lifespan.

This awareness has been stimulated by an increasing body of relevant research and literature, some advertising in the public media, and a move toward providing health sessions and organisations directed specifically for men. In particular, there is a focus of media attention on prostate cancer checks, erectile problems, premature ejaculation and the general benefits of weight loss some of which is advertising related. However, even with this increased attention, the majority of men are still lagging in maintaining good health and taking early action on health problems, a phenomenon which appears to have a direct link to notions of masculinity and the culture of the Australian male (Johnson, 1997; Laws, 2006). It is in this gap that the present project has been located, in an attempt to add further insight into ways in which engagement with men's health programs by a wider population of males can be enhanced.

The structure of this final chapter is embedded in the health belief model which has provided the theoretical basis of this research. This model, presented in Chapter 4, provides the major conceptual elements which will be discussed in relation to this study towards understanding an individual's self efficacy, which is the perceived ability to carry out a recommended action. Nutbeam and Harris (1999, p.21) state that: 'overcoming perceived barriers to successful action was identified as the most important element of the model. Perceived susceptibility and perceived benefits were also important.'

The utilisation of the health belief model has provided a firm platform for the structure and order of this research. The factors that contributed to the perceived threat and outcome expectations leading to the person to be accountable for directive actions within the model corresponded closely to the components of this study. One of the possible limitations is that the model takes an individualistic approach and seems to ignore, amongst other issues, the dominant masculinist culture. The conclusions and recommendations put forward in this chapter align with the structure and elements of the health belief model.

In the four contributing projects to this investigation, there has been a deliberate research design based on a number of approaches to allow any obvious differences in context or circumstance to emerge. Investigations have included observations of rural and urban settings, attention to the emotional and physical content of workshops, the effects of paying and non-paying participation and the efficacy of ongoing versus fixed-term workshops. However, somewhat surprisingly perhaps, even considering the breadth of these alternative contexts and the spread of responses to the research questions, many underlying similarities have emerged. It is this deep level of constancy that has provided a basis for the following recommendations for more effective marketing strategies to attract men to health workshops and ways to heighten the effectiveness of informal learning about health-related issues to men who present with a wide range of personal situations.

In essence, what this investigation has established is that the respondents involved in the various contributing projects were genuinely appreciative of any efforts made to reach them and to connect with them when these approaches were grounded in non-judgmental and non-directive ways. In the following account are observations that have emerged from the investigations on a number of critical areas for consideration by those concerned about the promotion of men's health. For convenience, these

comments have been grouped under the major elements provide by the health belief model[1].

Specific comments under these elements refer to the influence of: age on health promotion behaviour; the environment and location of the workshops; the content of the workshops on the men's responses; the role of women in encouraging men's participation in workshops; the difference in clientele on the conduct of the workshops; the difference in content on the acceptance of the workshops; the timing of workshops; the effect of associated costs on the workshop attendance; the role and influence of the presenter; the importance of follow-up activities; the role of advertising and language on attendance; and the impact of cultural issues on men's attitude to the workshops.

Perceived threats (I)

Perceived personal susceptibility to the problem

The influence of age on health promotion behaviour

Notwithstanding the previous comments about the increasing interest in men's health, it is the case that the men influenced by advertising and attracted to the workshops involved in this study were mainly from older age groups. Indeed, one of the singular facts to come out of this research has been the ineffectiveness of these workshops in attracting young men. Most men in Projects 1 and 2 were over the age of 40, which tends to support this surmise, and while Project 3 (the men's shelter) attracted younger participants, there was still only one participant in the 18-30 age group. This supports and reinforces the findings of Verrinder and Denner (2000) who said 'the vast majority of participants were in their 50s and 60s' (p.85). The broader range of ages represented in Project 3 underscored the shared conception of the basic needs of

[1] **Perceived threats** (Perceived personal susceptibility to the problem; Perceived seriousness of consequences of the problem) and **Outcome expectations** (Perceived benefits of a specified action; Perceived barriers to taking action).

life such as food, shelter and safety major needs that men of more diverse ages saw as being important.

It emerged from this study that men begin to show more appreciation of health-related issues as they become prone to problems as they get older, this certainly being reflected in the attendances seen in Projects 1 and 2. Importantly, it is clear that the physical and obvious manifestation of many serious medical conditions can be late in their development, and opportunities for preventative medication or control are therefore severely reduced. Consequently, one of the primary aims of men's health promotion must be to reach younger men in the population in order to allow screening programs and health promotion advice to be carried out when they are most efficacious. In this regard, aside from health professionals visiting men's workplaces, there seem to be few options available for engaging the attention of young men. This deficiency may need to be addressed as a matter of urgency.

It was suggested by the study that the presence of a professional sportsperson at a health promotion function can be a drawcard and lead to participation by a wider age range of males. As indicated earlier, having a celebrity or sportsman discuss their own health issues can help to legitimise or normalise approaches to illness for many men. However, this can often be difficult to arrange in small towns or by voluntary services, especially if an appearance fee is involved for the speaker. An alternative strategy is to invite influential men or 'gatekeepers' of opinion in the community to participate in the programs, particularly those who relate well to younger men, such as football coaches, youth counsellors, teachers or those involved in leadership roles with young males.

The influence of difference in clientele on the conduct of a workshop

The rural workshop showed that many country men learn by watching and discussing rather than taking notes. It was also observed that the giving out of handouts in rural workshops had a low priority with experienced presenters and probably had limited value, while the notion of asking rural participants to write down information appeared to serve little purpose. What was observed during the investigation, and later confirmed by the recounted experience of the program co-ordinator, was that rural

men responded more to visuals, pictures, facts and figures and anecdotal experiences rather than to learning by writing and receiving printed material. These men, mostly farmers, have spent their lives learning through observing and listening, and this was clearly reflected in their approach to the workshop. Indeed, none of them were observed to bring any writing materials to the sessions.

By contrast, the urban workshop in Project 2 demonstrated that these participants learnt from each other through active sharing of more intimate ideas and perspectives. By opening up to the group, individuals were able to gain constructive feedback and support from both the coordinator and other participants. Also, rather than have a set of pre-prepared criteria which would be followed for each session, the workshop tended to focus upon where the men were emotionally at that particular point in time.

For Project 3 the shelter was designed primarily to meet the most basic needs of the men as the first priority, and any informal education opportunities came later. These men had come from various backgrounds and some, through life circumstances, had found themselves homeless and having to deal with significant emotional and physical stressors. This context was clearly unsuited to the use of written material or formal disquisitions, and the offering of personal support was the most tangible and useful contribution to the participants that the coordinator could provide.

Each project was unique to the men it was servicing, which emphasises the need to tailor workshops to the needs and demographics of the target audience. This needs careful consideration and appropriate planning to produce objectives and outcomes which meet men's health needs and enhances their knowledge of themselves.

Perceived threats (II)

Perceived seriousness of consequences of the problem

The influence of the content on the acceptance of the workshop

It is important to appreciate that all three projects that involved the male clientele had a specific target audience, clearly identifying the special needs of the men they were trying to help. From observations made during the investigation and from

implications drawn from comments made from interviews, it seems that if the content of the first two programs had been interchanged, it is unlikely the men would have attended, as the workshop would not have met their needs. Comments indicated that the rural men studied would have been uncomfortable in sharing their emotional feelings in a group context and indeed emotional issues were never mentioned when they commented on their health. Conversely, for the urban men studied, health was seen to be related to emotional wellness and physical parameters were not introduced in discussions. The men's shelter, by contrast, was specifically designed to meet the men's basic needs, such as physical shelter, warmth and food, and there was no suggestion of formal teaching. An informal approach by the coordinator was seen as being by far the best method for passing on educational, health related information in this environment. Therefore, it appears important that before attempting to conduct a health-related learning session for men, it must be clearly established beforehand what their particular needs are in relation to their health. A presenter should determine the background of the group, and consider what would be the most suitable response to their situation.

In more formal settings, it is common for most men to show little interest in issues related to their bodies or how they function. As a result, it is often useful to give out a pre-workshop and post-workshop questionnaire to assess the men's prior knowledge of topics that will constitute the workshop. This serves two purposes: first, it allows the co-ordinator to tailor the workshop to meet any obvious deficiencies in the participants' knowledge base, and second, the post-test allows the co-ordinator to determine what the men learned from the sessions and whether they have retained and understand the information.

With the men's shelter, health education was carried out on a very informal basis with health practitioners, in particular a District Nurse, having easy access to the men and being available herself if any questions were raised, or if any health problems were apparent such as the need for wound dressings or immunisation.

From these projects it can be seen that appropriate and sensitive input with the men is required if adult men are going to respond to and understand the relevance of what is being done on both a physical and emotional level. Attention has to be given to the

stage that the men are at with their knowledge of health (which is the purpose of the pre-test), and more importantly to the relevance of the service to their needs, keeping in mind the structure, content and nature of the health professionals involved in the programs.

The influence of the presenter on the acceptance of the workshops

Presenting an effective and stimulating workshop does not lie solely in the program and how it is conducted, but is also determined by the abilities and reputation of the presenter. For the men involved in this research, it appears that the credibility of the presenter is a critical factor influencing attendance. The presenter (male or female) who conducts sessions must have a wide background in health and, more importantly, be able to relate to the men. If a workshop is focusing on physical rather than emotional issues, then it is recommended that the men be given a physical assessment from suitably qualified health professionals. This could include measurement of blood pressure, weight, body mass index, blood glucose and cholesterol levels, pulse rate and lung spirometry variables, together with documenting their medical history, which will help to give the men an understanding of their current health status. If this work is carried out sensitively, it can encourage men to seek further health assessment which will provide an important opportunity for men to connect on a long term basis with their local doctors.

In addition, the investigation showed that it is advantageous if the presenter represents a physical role model for the messages that are being delivered. He or she needs to display a healthy lifestyle, to be neither obese nor skeletal, a non-smoker and one who is careful about dietary intake. This study indicated that men tend to only take notice of, and respect, the health advice and information being offered, if it comes from someone who transparently lives and reflects their message.

The coordinator in Project 2, the urban workshop, was a trained counsellor and this background was found to be extremely useful during the sessions due to the differing psychological needs of the clientele. He perceived the emotional needs of the men and allowed time for thoughts to be gathered and expressed in the clearest way possible.

For the men's shelter, the coordinator had skills in counselling, was a qualified social worker and had a personal manner which was appropriate for engaging the target population. The one major impression of this coordinator was that he had a broad range of social views and had a wide experience of varying life conditions, and attributes that meant he could relate well to disadvantaged men. Responses from participants indicated that he could confidently speak the language of the group and could effectively but appropriately enforce the rules of the shelter when necessary. Given the context, this ability was particularly important when considering safety issues.

The influence of the role of advertising and language on attendance

Some participants have indicated that the term 'men's health' may, *per se*, be actually a 'turn-off' factor for most men and this is now being more widely recognised. Men's perceptions of masculinity often dictates that they should take an outwardly cavalier attitude to their health, and be discouraged from engaging with health promotion activities simply because of the name. This is having significant and irretrievable consequences for some men. As a consequence, it appears that the creation of a fresh term for this activity may go some way in defusing this prejudice. Indeed, coordinators suggest that men's health workshops are now being given terms such as 'men's tune-up sessions' or 'pit stop workshops', which have a metaphorical cultural relationship to areas many men recognise as being relevant and acceptable to them. Their comments gives credence to authors such as Smith (2007) who says:

> Health information and counselling phone lines (such as Mensline) have been established...the gutbusters waist-loss program...was hailed a great success. Pit Stop, a health screening and referral program has become a common feature at field days and community events (p.21).

An extreme example of this approach was a research project aimed at men's health which was renamed the 'Sustainable Dairy Farming Project', which clearly did not mention men's health. The two key words in the title of the project immediately gained interest from funding bodies, and the terms "dairy" and "family", also attracted the attention of a rural audience. This underlines the fact that the term "men's health" has little impact on government who primarily control funding, unless it is included in

a wider spectrum, and that it should be represented as an acceptable focus for a meeting for men to attend.

For the rural workshop, advertising strategies were mainly focused on finding influential men in the community and having their support with names supplied and having personal contact to each of the men prior to the workshop. As indicated by a number of participants during informal communications, the use of fliers or posters at the community health centre was not recognised as an effective advertising tool for men. Seemingly paradoxically, although not registered in the formal questionnaire data, the influence that women have was deemed by both coordinators and participants to be important in advertising both the rural and urban workshops. Wives are generally the primary source that men turn to for health matters because of their traditional caring role (Emslie & Hunt, 2009). This reflects the notion that women more readily recognise the importance of health-related activities. It was therefore important to access their support for men's programs through advertising. In contrast, for Project 3, where the target clientele did not have significant female figures in their lives, advertising was restricted to word of mouth and from crisis centres where men could be referred to the shelter.

Outcome expectations (I)

Perceived benefits of a specified action

The influence of follow-up activities on the success of the workshops

One of the strengths of the rural project was that the co-ordinator lived and worked in the area which enabled him to conduct further workshops for men who may have been unable to attend initial sessions and to provide follow-up activities when necessary. It was both the quality of the presentations and the personal availability of the presenter that ensured there was an on-going demand for more workshops in the area. This combination therefore needs to be taken into consideration when running rural health workshops. Workshops ought not to be merely one-off events and programs not designed to be repeated, since this loses the opportunity to do follow-up evaluations of the effectiveness of the program, and there is no chance to monitor the long-term progress of participants. Transferring lessons learned from traditional systematic

reviews into key principles is at times non-existent or extremely limited (Kuipers et al., 2008).

For the urban workshop, this was not really a consideration as the sessions were ongoing and based on a user-pays system. There was no set start or finish date so the men had the opportunity at any time to return to the meetings. Follow up at this workshop was not a designed part of the program because of the seamless nature of the gatherings.

With the men's shelter, there was follow-up only if this was indicated by the physical or mental state of individuals in the client group, and then it would be acted upon by the appropriate agency. Using information from informal health assessments made by the staff and through the work of the attendant District Nurse, appointments were made on the men's behalf for any General Practitioner consultations, or arrangements made for immunisations or dressings to be done at the Centre.

Whilst each of these three projects was concerned with men's health, they differed markedly both in content emphasis, mode of presentation, timing and whether there was a user-pays system attached to the service. These factors are all related to the nature of the target audience, and whether men wanted to take ownership of their development through the service provided.

The influence of the role of women in encouraging men's participation in workshops

One important recommendation that came from respondents, and indeed many community health centres probably claim they already do this, is, wherever possible, is to encourage women who attend the Centre's programs to include their husbands and partners in their activities. For example, if women can bring their partners to evening ante-natal classes, the opportunity is there for those men to be invited to join a separate men's group. The strategy of having men accompany their wives or partners to such events is a way to break the initial barrier to engagement, and consequently sessions can be expanded to include specific men's issues once they feel comfortable in the new environment.

It has been suggested that hospitals that provide women's clinics should do the same for men. Whilst this is an important and valuable suggestion, it must be stressed that to replicate the success and influence attached to women's health is not simply a matter of replicating women's services and programs. Most men do not respond the same ways as women when it comes to making health-related decisions. What needs to be recognised, though, is the importance of women in the lives of their men and the extent of their influence on men's health-seeking behaviour. Women need to be specifically included in any marketing strategy for men's health programs because of their position of influence and their interlocutory role in promoting health-related behaviour in families.

Outcome expectations (II)

Perceived barriers to taking action

The influence of the environment and location of the workshops

The study indicated that the location where a workshop or seminar is held is very influential on the success of the program. Men do not necessarily see community health centres as appropriate or desirable places to visit, or as potential sources of men's health advice. They see them rather as places for addressing issues pertaining to women and children. To make these centres a more effective vector for disseminating health promotion advice and consequently to more efficiently utilise community health resources, they must be made more innately attractive to men and make men feel at home.

One possible approach to this process is through education sessions that, from a young age, stress the importance of the inclusiveness of community health centres, emphasising that their services are provided for all members of the community, regardless of their gender, ethnicity or age. To promote this notion amongst men, some waiting rooms may need to be made user-friendly for both genders. Responses from participants suggest that any strong anti-male slogans or posters containing innuendoes against males have been recognised as unhelpful for prospective male clients and their removal or more strategic positioning should be arranged. Further,

some community centres may need to look at extending their opening hours for men who work full day jobs or who need to travel from a remote rural area.

It was further suggested that the function venue must also satisfy some basic attractiveness criteria, including a comfortable room temperature, good lighting, adequate seating and all audiovisuals in working order and easily seen. Feedback from the three projects involving groups of male clients indicated that tea and coffee was seen as essential, and this is consistent with messages from the literature which indicate that free barbecues and refreshments are a very effective attendance incentive and they work as a good icebreaker. Men generally like to gather in informal groups and discuss issues of interest and the provision of food or access to tea, coffee and biscuits are likely to facilitate this process and appear to be an essential feature of any men's program.

Building strong relationships with the local hospital is an area which has long been neglected and the two services, both hospitals and community health centres have, for too long, been separate identities and having separate agendas. Linking community health centres with hospitals and not just geographically but also as a referral option, might prove to be a crucial step in this process, with dispersed community health centres being used for follow-up treatments and for providing effective health education options. In addition to allowing more convenient access for male clients, it will confer a more 'acceptable' status on health centres since they will be 'legitimised' by being seen as residing under the aegis of the hospital system.

An alternative strategy in regard to location that is currently proving most effective is to take health centre activities to places that men normally congregate rather than requiring men to gather in unfamiliar surroundings. The success of this measure was affirmed by all the co-ordinators interviewed. Many community health centres, with the support of employers and unions, have experimented with the presentation of their programs in male-friendly workplaces and areas such as hotels and the local football club. Respondents in this study have indicated that this has been a successful initiative, resulting in the involvement of more men in health programs and widening the overall catchment for the initiative.

This move is paralleled by the notion that a community centre must be generally more mobile and visible in the community. There have been attempts for community centres to have a presence in shopping centres, workplaces and community functions, where free blood pressure testing and advice is offered, but to date responses suggest that this has not proved to be entirely adequate.

The influence of the timing of workshops

Timing of the workshops is another important consideration that impinges upon attendance. For example, farming is very seasonal, and often men can be involved with shift work far into the night. Such seasonal occurrences must be factored into program offerings, because they will fail if they coincide with these important times. In this respect, the overall length of the workshop must be considered. Project 1 (rural) ran for five weeks with a starting and finishing date to fit between season commitments, while Project 2 (urban) was ongoing, and urban men could come as long as they felt it was worthwhile since they had more regular work times.

Both Projects 1 and 2 ran for two hours, followed by refreshments, which appears to be an appropriate length for an evening session. Coordinators suggested that three hours for an evening workshop for men may be expecting too much, especially after a busy day. The men's shelter, which had quite different aims, was only open three days a week and then only for a limited time during the day. It covered the period from morning tea to mid-afternoon, these restricted hours being primarily due to staffing problems and the lack of a suitable evening venue. Choice of days was difficult for a once a week commitment, but Friday seems to be a common day. Being the end of the week, for many men it seemed to be a good time to socialise. These recommendations are made on the basis of responses from typical participants in these workshops, and it is anticipated that these attendance characteristics will remain fairly stable over the foreseeable future.

The influence of associated costs on the workshop attendance

Costs for the surveyed workshops included instances where there was non-payment for services to initiatives where there was a fixed price for attendance. The rural

workshop was provided at no cost to the men, being subsidised by current State Government initiatives in men's health. By contrast, the urban workshop was conducted as a user-pays service on a weekly basis. The homeless men's shelter was provided at no cost to the attending men, which was quite understandable due to the obvious difficulties of these men to meet any financial imposition. In this case, the financial burden was offset by a branch of a large charitable organisation.

Interestingly, this research showed that, the shelter aside, cost was not a determining factor in men's attendance and that for many men, having a subsidised or free workshop did not significantly influence their decision to attend. Indeed, of relevance here is that it has been argued (Robertson, 2007) that to participate in anything worthwhile requires ownership, and this implies that a small fee might be levied on participants which would make men feel that they are getting value for money. However, notwithstanding this notion of user-pays, it must be acknowledged that there are legitimate arguments advanced by proponents of both sides of this debate, and it continues to be a contested issue. In the light of the experience of this investigation it is nevertheless recommended that whilst fees may be heavily subsidised through community or business sources, there still needs to be some cost to participants, to legitimise the perceived value of the activity and to develop a sense of ownership for the activity.

The influence of cultural issues on men's attitude to the workshops

With the continuing poor performance of men in general in regard to their health behaviour, it would be easy to dismiss this problem as simply 'too much testosterone', or it is just 'Australian masculinity'. This is the 'boys will be boys' mentality consistent with the notion that it is too hard to break existing cultural norms. However, this investigation has unearthed some simple techniques and practices, based broadly on the elements of the health belief model that may be used to change behaviour among men in Australia. The approaches, drawn from the preceding discussions that seem to offer promise include: the development of more effective marketing strategies which target men's female partners; providing food and drinks at workshop venues; putting more emphasis upon knowing the needs and sensitivities of the audience; working with influential members of the community in a facilitation

role; inviting well-known personalities to be in attendance; and being more visible in the workplace and at venues where men congregate.

In the workshops, educational techniques that appear to be most useful include: relating visually to the male adult learner with graphics; short and up to date presentations, and recognising from the study that country men tend not to take notes or collect handouts, through being more visual and kinaesthetic learners. From a more long-term perspective, there is a need for men to be comfortable with, and knowledgeable about, their bodies and with bodily functions. This can be facilitated by a focus upon boys' education at primary and secondary school level, and by providing access to community health workers to the school system. Another promising proactive strategy that has been attracting much interest is the infusion into school programs of issues about men's health and the foregrounding of positive, non-hegemonic examples of masculinity (Bissett, 2008). Indeed, respondents have suggested that such initiatives have the potential to develop a gradual change in the mindset of young males to help balance the personal difficulties and peer pressures they will likely face later.

Finally, the investigation suggests that it is not productive to make men feel guilty about their drinking habits or to dwell on past records of poor health maintenance. A wide measure of acceptance of individuals on their own terms, coupled with the ability to meet the men at their own level of comfort using a non-judgmental approach, seems paramount in helping to develop good self esteem and a positive approach to health. It has been observed that what needs to happen before most men appreciate the benefits of engendering better health is not to be talked to, berated, or lectured but, like their cars or motorbikes, encouraged to institute regular service and maintenance schedules for their physical, emotional and spiritual needs, recognising that all three areas are important to good health.

Limitations

There are a number of unavoidable limitations inherent in this type of study, and these are noted here. These may be broadly associated with the chosen theoretical stance;

being a qualitative research design rather than quantitative, gives rise to possible criticisms of lack of generality, but, on the other hand, affords greater insight into the specific areas investigated, especially from the sociological perspective. However, due to the wide diversity of men and the many facets of health problems across the community generally, it was not possible to focus upon specific self interest groups of Australian men such as homosexuals, Indigenous Australians or men in workplace settings.

One of the key limitations of this project lies in its scope: there was only one workshop in a rural setting and one in an urban setting, together with a study located in a men's shelter, therefore the study was not able to utilise multiple settings. The environment for the projects was restricted to Victoria due to time and cost restraints, and consequently the numbers of participants was relatively small. Whilst it may be assumed that information gleaned from these two workshops, which produced quite contrasting results, can be broadened to give an overall, general impression or defensible comparison, the participants in the program were selected differently, making direct comparisons impossible.

As indicated earlier, the use of participant-observation, involving partial immersion into the culture of the groups contributing to the projects, enabled a degree of trust to be formed with the participants. Whilst this method allowed an openness and veracity of responses which was manifest in the workshops and in the high percentage of returned questionnaires, it is recognised that the researcher's presence and status may have affected the participants' responses. It is hoped that any bias of the researcher has not been transferred, since it was intended to be deliberately non-judgemental and objective in observing and recording data.

Summary

In summary, this investigation has suggested that, with appropriate educational strategies and the choice of a suitable venue and support, men can be reached in increasing numbers and given a chance to correct poor health decisions. This research demonstrated that with the use of appropriate strategies, men will respond well to, and

appreciate, any attempt to bring health information to them, particularly in the case of men who traditionally would normally not seek professional health advice.

However, the projects have highlighted how, while differing approaches to men in varying circumstances need to be instituted, there are some underlying principles that should inform future initiatives in this area. If further research is carried out, these variables of age and gender need to be addressed. Notwithstanding the particular situation and circumstances of the men who need help in developing more appropriate health promotion behaviour, it has been seen that men like to gather and socialise in familiar areas, they are open to genuine efforts to improve the health decisions if done with an open, respectful and non-blaming approach, and that for long-term change to this area, health promotion needs to be done in a context that does not challenge male culture, but rather integrate its notions and language, using them to promote messages in accessible and acceptable contexts, settings and format.

This thesis has related to the deeper issues within men's health, and placed them in an appropriate framework of heath education and androgogy. What has been indicated by the responses to this investigation is that a more determined systematic and collective effort from government, councils, health institutions, schools and community centres is needed to create a suitable platform for a change in men's health promotion behaviours. Further, to achieve maximum effectiveness, such initiatives must be handled in a positive and enlightened fashion to address what has been, and remains, a deeply rooted problem in men's psyche which acts to prevent a responsible and accountable approach to their health.

References

Abraham, I.L. & Krowchuk, H.V. (1996). Unemployment and health: Health promotion for the jobless male. *Nursing Clinics of North America,* March, Vol. 21, no.1, pp. 37- 45.

Adams, L., Amos, M. & Munro, J. (2002). *Promoting health. Politics and practice.* London: Sage Publications.

Allen, G., Bastiani, J., Martin, I. & Richards, K. (Eds.) (1987). *Community education: An agenda for educational reform.* Stony Stratford: Open University Press.

Ambert, A. (1998). *The web of poverty. Psychosocial perspectives*. Binghamton: The Haworth Press.

Auerbach, C. & Silverstein, L. (2003). *Qualitative data. An introduction to coding and analysis.* New York: New York University Press.

Australian Bureau of Statistics (2009). Causes of death, Australia 2007. (Cat no. 3303.0) Retrieved from www.abs.gov.au , 21 July 2009.

Australian Institute of Health and Welfare (1996). *Australia's health 1996*. Canberra: Australian Government Publishing Service.

Australian Institute of Health and Welfare (1998). *Australia's health 1998*. Canberra: Australian Government Publishing Service.

Australian Institute of Health and Welfare (2004). *Australia's health 2004*. Canberra: Australian Government Publishing Service.

Australian Institute of Health and Welfare (2006). *Australia's health 2006.* Canberra: Australian Government Publishing Service.

Australian Institute of Health and Welfare (2008). *Australia's health 2008*. Canberra: Australian Government Publishing Service.

Australian Asia Pacific Institute Men's gender and health studies. (2009). *Academic Courses Postgraduate.* Retrieved May 31, 2009, from http://mensgender-health.com.au/postgrad.htm

Australian Government. Department of Health and Ageing. (2008). *Developing a men's health policy for Australia. Setting the scene.* Retrieved December 4, 2008 from Www.health.gov.au/internet/main/publishing.nsf/content/mens-developing.pdf

Barton, A. (2000). Men's health: A cause for concern. *Nursing Standard,* vol.15 no.10, pp. 47-52.

Bassey, M. (1999). *Case study research in educational settings*. Buckingham: Open University Press.

Baum, F. (2002). *The new public health* (2nd ed.). South Melbourne: Oxford University Press.

Baum, N. (2003). The male way of mourning divorce: When What and How. *Clinical Social Work Journal*, vol 31, no. 1, March, pp. 37-50.

Bayram, C., Britt, H., Kelly, Z. & Valenti, L. (2003). *Male consultations in general practice in Australia 1999-00.* A.I.H.W. General Practice Series No. 11 (February).

Bensley, R. & Brookins-Fisher, J. (2003). *Community health education methods: A practical guide.* Sudbury, MA: Jones and Bartlett.

Best, J.W. & Kahn, J.V. (1998). *Research in education* (8th ed.). Boston: Allyn & Bacon.

Biddulph, S. (1995). *Manhood. An action plan for changing men's lives*. Sydney: Finch Publishing.

Bissett, K. (2008). Boys don't cry. *Men's health and wellbeing. Issues in society*. Vol. 274, pp.3-5.

Buchbinder, D. (1994). *Masculinities and identities*. Carlton: Melbourne Uni. Press.

Buckley, D. & Lower, T. (2002). Factors influencing the utilisation of health services by rural men. *The Journal of the Australian Healthcare Association,* vol. 25, no. 2, pp.11-15.

Bunton, R. & Macdonald, G. (2002). *Health promotion. Disciplines, diversity and developments* (2nd ed.). London: Routledge Taylor and Francis Group.

Burns, R. (2002). *The adult learner at work. The challenges of life-long education in the new millennium*. (2nd ed.) Warriewood, NSW: Business and Publishing.

Burns, S. (2003). *Artistry in training thinking differently about the way you help people to learn.* Warriewood, NSW: Woodslane.

Burns, N. & Grove, S. (2001). *The practice of nursing research. Conduct, critique, & utilization* (4th ed.). Philadelphia: W.B. Saunders.

Butera, K. (2008). 'Neo-mateship' in the 21st century: Changes in the performance of Australian masculinity. *Journal of Sociology,* vol. 44, no. 3, pp. 265-281.

Case, B. (1996). Breathing AIR into adult learning. *Journal of Continuing Education in Nursing,* vol. 27, no. 4, pp.148-158.

Chodkiewicz, A. & Morris, R. (2006). *Older men's health and well being: A directory of organisations, services and resources.* Sydney: COTA (NSW) Inc.

Crotty, M. (1999). *Phenomenology and nursing research.* South Melbourne: Churchill Livingstone.

Daniels, A. (2001) *Men's health – a mortality check.* Pharmaceutical Society of Australia. Retrieved September 8, 2005, from http://www.psa.org.au/ecms.cfm?id=140

Davidson, N, & Lloyd, T. (2001). *Promoting men's health. A guide for practitioners.* London: Harcourt.

De Krester, D. (1996). Declining sperm counts. *British Medical Journal,* vol. 312, no.2, pp. 457-458.

Denzin, N. & Lincoln, Y. (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks: Sage Publications.

Department of Human Services. (2007). *Your health. A report on the health of Victorians*. Melbourne: Impact Printing (Vic).

Dilworth, R. & Willis, V. (2003). *Action learning: Images and pathways.* Florida: Krieger Publishing.

Duckett, S.J. (2004). *The Australian health care* (2nd ed.). South Melbourne: Oxford University Press.

Emslie, C. & Hunt, K. (2009). Men, masculinities and heart disease. A systematic review of the qualitative literature. *Current Sociology,* vol.57, no. 2, pp.155-191.

Ewles, L. & Simnett, I. (2003). *Promoting health. A practical guide*. (5th ed.). London: Bailliere Tindall.

Fincher, R, & Saunders, P. (Eds.) (2001). *Creating unequal futures? Rethinking poverty, inequality and disadvantaged.* Crows Nest: Allen & Unwin.

Galbraith, M. (2004). *Adult learning methods: a guide for effective instruction.* Malabar, Fla: Krieger Pub. Co.

Galgut, C. (2007). Men and therapy – is it time for men to come out of the closet? *Healthcare Counselling and Psychotherapy Journal, vol.* 7, no.3, pp. 14-17.

Gardner, H. & Barraclough, S. (Eds.) (2002). *Health policy in Australia* (2nd ed.). South Melbourne: Oxford University Press.

Geertz, C. (1975). *The Interpretation of Cultures*. London: Hutchinson and Co.

Germov, J. (2005). *Second opinion: An introduction to health sociology.* South Melbourne: Oxford University Press.

Gibson, M. & Denner, B. (2000) *Men's health report 2000.* Bendigo: La Trobe Uni.

Giglio, M. & Tobler, H. (2003). Ignorance is bliss for young men drinking to their health. *The Australian.* Feb. 19th p.5.

Gillon, E. (2007). Gender differences in help seeking. *Healthcare Counselling and Psychotherapy Journal.* Vol. 7, no.3, pp.10–13.

Glanz, K. Lewis, F. & Rimer, B. (2008). *Health behaviour and health education: Theory, research and practice.* (3rd ed.). San Francisco: Jossey-Bass.

Golding, B. Brown, M., Foley, A., Harvey, J., & Gleeson, L. (2007). *Men's sheds in Australia. Learning through community contexts.* Adelaide: National Centre for Vocational Education.

Gray, M. (2005). *Fundamental aspects of men's health*. London: MA Healthcare Limited.

Grbich, C. (2004). *Health in Australia*. Sydney: Longman.

Hamilton, C. (1993). *Men's health*. Sydney: Pan Books.

Hamilton, J. (1994). Male mid-life crisis. *Conscious living*. Sept/Oct. p. 59.

Handwerker, W. (2001). *Quick ethnography*. Alta Mira Press: California.

Hardy, S. (2007). *Men's health education and resource development.* Report prepared for Foundation 49, May 2007.

Harris, P., Nagy, S.& Vardaxis, N. (2006). *Mosby's dictionary of medicine, nursing & health professions.* Sydney: Mosby-Elsevier.

Harrison, T. & Dignan, K. (Eds.) (1999*). Men's health. An introduction for nurses and health professionals.* London: Churchill Livingstone.

Hayes, A. (2006). *Teaching Adults*. London: Continuum International Publishing Group.

Hayes, R. & Williamson, M. (2006). *Evidence-based, best practice guidelines for Victorian men's sheds.* Bundoora: LaTrobe University.

Healey, J. (Ed.) (2008). Men's health and wellbeing. *Issues in society*, Vol. 274. Thirroul NSW: Spinney Press, pp. 26-29.

Healey, J. (Ed.) (2008). Separation and divorce. *Issues in society,* Vol. 282. Thirroul NSW: Spinney Press.

Healey, K. (Ed.) (1995). A man's world. *Issues for the nineties*, Vol. 34. Balmain: Spinney Press.

Hillier, Y. (2002). *Reflective teaching in further and adult education.* London: Continuum.

Hinchliff, S. (Ed.). (1999). *The practitioner as a teacher* (2nd ed.). London: Bailliere Tindall.

Hoare, T. (1993). Men staying healthy: Working with or in spite of biology. *In men's health the forgotten issue.* Melbourne: Ausmed Publications. pp. 63-69.

Hockenbury, D. & Hockenbury, S. (2000). *Psychology* (2nd ed.). New York: Worth Publishers.

Huggins, A. (2005). Vision 2005 and beyond. Australia-Asia-Pacific Institute for Men's Gender and Health Studies: MensOwn Pty. Ltd. Retrieved September 19, 2007. http://www.mensgenderhealth.com.au/postgrad.htm

Huggins, A., Somerford, P. & Rouse, I. (1996*). A report on men's health W.A. Men's health teaching and research consortium*. School of Public Health, Curtin Uni.

International Office for Men's Health and Gender Studies. (2000). *Prospectus 2000.* Churchlands, Western Australia: School of Nursing and Public Health, Edith Cowan University.

James, A. (2007). *Teaching the male brain: how boys think, feel and learn in school.* Thousand Oaks: Corwin Press.

Janz, N. & Becker, M. (1984). The health belief model: a decade later. *Health Education Quarterly*, vol. 11, pp. 1-47.

Johnson, T. (1997). *No man's land.* Rushcutters Bay: Halstead Press Publishers Pty. Ltd.

Jones, J. (2000). *An exploratory study into selective health protective behaviours of rural and urban men in north and north-west Queensland.* James Cook University. (Thesis/dissertation).

Joyce, B. & Weil, M. (1986). *Models of teaching* (3rd ed.). New Jersey: Prentice-Hall International.

Keleher, H. & Murphy, B. (Eds.) (2005). *Understanding health. A determinants approach.* South Melbourne: Oxford University Press.

Kiger, A. (1997). *Teaching for health*. London: Churchill Livingstone.

Kirby, R., Carson, C., Kirby, M. & Farah, R. (2004). *Men's health* (2nd ed.). London: Taylor & Francis.

Knight, P. (2002). *Small-scale research.* London: Sage Publications.

Knowles, M., Holton. E. & Swanson, R. (1998). *The adult learner* (5th ed.). Houston: Gulf Publishing Company.

Kuipers, P., Humphreys, J., Wakerman, J., Wells, R., Jones, J. & Entwistle, P. (2008). Collaborative review of pilot projects to inform policy: A methodological

remedy for pilotitis? *Australia and New Zealand health Policy*, Vol 2, No. 17.

Laura, R.S. (1998). *Men's health: How men can live longer and fuller lives*. East Roseville: Simon and Schuster Australia.

Laws, T. (Ed.) (1998). *Promoting men's health.* Ascot Vale: Ausmed Publications.

Laws, T. (2006). *A handbook of men's health*. London: Churchill Livingstone.

Lee, C. & Owens, G. (2002). *The psychology of men's health.* Buckingham: Open University Press.

Loh, D. (2000). *The Maslow revival: Maslow's hierarchy of needs as a motivational theory*. Caulfield, Victoria: Monash University.

Long, H. (2002). *Teaching for learning.* Florida: Krieger Publishing Company.

Luck, M., Bamford, M. & Williamson, P. (2000). *Men's health. perspectives, diversity and paradox.* Blackwell Science Ltd: Oxford, England.

Macnamara, J. (2004). *Representations of men and male identities in Australian mass media.* PhD. Thesis: University of Western Sydney.

Malouf, D. (1994). *How to teach adults in a fun and exciting way.* Chatswood N.S.W.: Business and Professional Publishing.

Marcus, B. & Forsyth, L. (2003). *Motivating people to be physically active.* Illinois: Human Kinetics.

Maslow, A. (1987). *Motivation and personality*. (3rd ed.). New York: Harper and Rowe Publishers Inc.

Mathers, C. (1995). Health differentials between Australian males and females: A statistical profile. *Paper presented at the 1st National Men's Health Conference, Melbourne* 10-11 August 1995.

McGrane,T. & Patience, A. (1993). Masculinity: Implications for adolescent sexuality in Australia. *In men's health, the forgotten issue*. Melbourne: Ausmed Publications, pp.35- 46.

McLennan W. (2000) *Year Book Australia*. Canberra: Australian Bureau of Statistics.

McMillan, J.H. & Schumacher, S. (1984). *Research in education.* Boston: Little, Brown and Company.

Men's Awareness Network. (2006). Retrieved July 5, 2006, from http://www.mannet.com.au/gmm/index.htm Centre for Advancement of Men's Health (CAMH).

Merriam, S. & Brockett, R. (1997). *The profession and practice of adult education*. San Francisco: Jossey-Bass Inc.

Miller-Keane. (1997). *Encyclopedia and dictionary of medical, nursing and allied health* (6th ed.). Philadelphia: W.B. Saunders Company.

Minichiello, V., Sullivan, G., Greenwood, K. & Axford, R. (1999). *Handbook for research methods in health sciences.* Sydney: Pearson Education Australia.

Minzey, J. & LeTarte, C. (1973). *Community education: From program to process.* Michigan: Pendell Publishing Company.

Monaem, A., MacDonald, J., Woods, M., Hughes, R., Orchard, M. & Jasprizza, E. (2008). A proposed longitudinal study of boys' and men's health and well being in Greater Sydney, Australia. *International Journal of men's health*, vol 7, no. 2, pp.192-200.

Monash University Centre for Rural Health (2000). *Promoting rural health: A bibliography with international coverage.* Traralgon, Victoria: Monash University Centre for Rural Health.

Moran, J. (1997). *Assessing adult learning. A guide for practitioners*. Malabar: Krieger Publishing Company.

Morton, T. (1997). *Altered mates. The man question*. St. Leonards: Allen and Unwin.

Napthine, R. (1998). Men's magazines-educating the 'wusses'. *Australian Nursing Journal*, vol.5, no.9, p. 32.

N.S.W. Health. (1999). *Moving forward in Men's Health* (online). Retrieved July 22, 2002, from http://www.health.n.s.w.gov.au/health-public-affairs/men'shealth/

Noone , J. & Stephens, C. (2008). Men, masculine identities and health care utilisation. *Society of health and illness*, vol. 30, no. 5. pp.711-725.

Nutbeam, D. & Harris, E. (1999). *Theory in a nutshell. A guide to health promotion theory*. Sydney: McGraw-Hill Australia.

Ots, J. (1996). Maintaining the momentum of men's health. Standing beside and leading the way. *Conference paper presented at Men's Health and Family preservation*. November, 1996. Melbourne: Ausmed Publications.

Pattison, A. (1998). *The M factor: Men and their health*. East Roseville: Simon and Schuster Australia.

Petersen, A. (1998). *Unmasking the masculine.* London: Sage Publications.

Radican, N. (1995). Helping men help themselves. *The essentials for health and fitness*, Feb/Mar, p. 32.

Rankin, S. & Stallings, K. (1996). *Patient education. issues, Principles and practice*. (3rd ed.). Philadelphia: Lippincott.

Redman, B.K. (2001). *The practice of patient education*. (9th ed.) St. Louis: Mosby.

Renaurd, Jr., W. (1993). The embattled American male. *Nutrition Health Review. The Consumers Medical Journal.* Issue 65. p.2.

Reid, J. & Trompf, P. (1994). *The health of Aboriginal Australia*. Marrickville,

NSW: Harcourt Brace & Company.

Robertson, S. (2007). *Understanding men and health. Masculinities, identity and well-being.* Berkshire, England: Open University Press.

Roxon, N. (2008). Media release. First ever national men's health policy. www.health.gov.au/menshealthpolicy accessed Jan 2009.

Sabo, D. & Gordon, D.F. (1995). *Men's health and illness. Gender, power and the body.* Thousand Oaks, Ca: Sage Publications.

Scanlan, D. (2003). *Everything men should know about health*. Burleigh, Queensland: Zeus Publications Australia.

Schneider, Z., Elliott, D., LoBiondo-Wood, G. & Haber, J. (2003). *Nursing research. Methods, critical appraisal and utilisation*. (2nd ed.) Marrickville: Elsevier (Australia) Pty. Ltd.

Schwandt, T. (1997). *Qualitative Inquiry: a dictionary of terms*. Thousand Oaks: Sage Publications.

Scraggs, J. (1985). *Key ideas in personality theory*. St. Paul: West Publishing Company.

Sillitoe, J. (2007). *Process 2: Finding a theory*. The Graduate Centre Seminar Program: University of Ballarat.

Sixsmith, J. & Boneham, M. (2003). Older men's participation in community life: Notions of social capital, health and empowerment. *Ageing International,* vol. 28, no. 4, pp. 372-388.

Smeltzer, S. & Bare, B. (2000). *Textbook of medical-surgical nursing.* Philadelphia: Lippincott.

Smith, J. (2007). Beyond masculine stereotypes: moving men's health promotion forward in Australia. *Health Promotion Journal of Australia*. 2007. Apr: vol.18 no.1, pp. 20-5.

Smith, J., Braunack-Mayer, A., Wittert, G. & Warin, M. (2006). Qualities men value when communicating with general practitioners: implications for primary care settings. *Medical Journal of Australia* vol.189 no.11/12, pp. 618-621.

Smith, J., Braunack-Mayer A. & Wittert, G. (2006). What do we know about men's help-seeking and health service use? *Medical Journal of Australia*, vol.184, no.2, pp. 81-83.

Smith, R. (1994). The weaker sex – born male: It's the biggest health hazard of all. *Time Magazine.* Dec.

Streubert, H. & Carpenter, D. (1999). *Qualitative research in nursing. Advancing the humanistic imperative.* Philadelphia: Lippincott.

Taber, A. (2001). Ask men's health, *Men's Health*, vol. 16, no. 7, p.20.

Taylor, K., Marienau, C. & Fiddler, M. (2000). *Developing adult learners.* San Francisco: Jossey-Bass.

Tight, M. (1996). *Key concepts in adult education and training*. New York: Routledge.

Verrinder, A. & Denner, B. (2000). The success of men's health nights and health sessions. *Australian Journal of Rural Health, vol.* 8, pp. 81-86.

Ward, R. (1966). *The Australian legend*. Melbourne: Oxford University Press.

Weisner, D. (1993). Save the males. *XY: Men, sex, politics, vol.* 2, no.1, pp. 17-18.

Wellington, J. (2000). *Educational research. Contemporary issues and practical approaches*. London: Continuum.

Whitehead, S. (2002). *Men and masculinities: Key themes and new directions*. Cornwall: MPG Books Ltd.

Willder, S. (2000). *Men's health education report*. Western District Health Service: Community Services.

Appendices

Appendix 1

Project 1

Men's Rural Health Education Workshop

Introduction

In order to make a case study of some of the issues raised in the literature related to the state of men's health, such as men's approach to their health and their reluctance to utilise health care services, a research study using a case study approach was carried out in a men's health workshop conducted over five weeks in a small town in rural Victoria. The aim of this study was to identify the marketing strategies adopted to attract participants, the style of educational approaches undertaken when delivering the health care program to men from the local rural area and the effect this interaction had on their approach to their health.

This research project, in essence, is an attempt by the author to understand better how men think about their health in an actual working environment within a rural setting. The researcher in this study spent a considerable time in the natural setting of the study in contact with the participants.

The incentive for research into rural men's health was to understand the different teaching strategies adopted when delivering health care programs to men and to consider the question of whether Australian men are, in that locality, reticent in preventative health care, resulting in poor health outcomes and higher mortality rates. The researcher's role in health education and access to health services, his visits to hospitals to assist nursing students on clinical placement, his years involved in hospital care as a registered nurse – all these made it even clearer to him that Australian men were suffering from higher rates of preventable diseases than their female counterparts. When the researcher's cousin, who was a farmer in South Australia, committed suicide in 1998, this tragic event emphasised and personalised the growing problem of men's health in the rural sector - not only from a physical perspective, but also a psycho-social one. Laws (1998) cited Krupinski, Tiller, Burrows and Hallenstein (1994), as saying:

> One of the most touted indicators of wellbeing amongst young men is the suicide rate. Overall, males aged between 15 and 44 have a higher rate of death from suicide than do females. There has been a steady increase in youth suicide across Australia since 1960 in males but not in females. Male suicide rates are higher in non-metropolitan areas and areas of high youth unemployment (p.124).

The data analysis of this study is qualitative and results are presented in a descriptive-analytical approach. Why worry about men's health? The statistics published in the past five to 10 years are cause for alarm and an impetus for further research and funding. The following (Pattison, 1998, p.13) is a brief synopsis of the problems besetting Australian men in regard to their health.

The average life expectancy of men is 75 years. For women, it is 81 years. Male deaths are greater at all ages and the discrepancy begins from infancy. Up to the age of 14, boys are at least *twice* as likely as girls to die from accidental injury – for instance, in motor vehicle accidents and from drowning. In the 15-24 years age group, males are three times more likely to die from motor vehicle accidents and four times more likely to commit suicide. The overall death rate for males in this age group is 2.65 times that of females. In the 25-64 years age group, they are four times more likely to die from coronary artery disease and have significantly higher death rates from conditions such as stroke and diabetes. They are twice as likely to die from cancer – especially lung cancer, stomach cancer, throat cancer and melanoma. Men in this age group have a higher incidence of obesity, smoking, high blood pressure and elevated blood cholesterol levels. They are more likely to use illicit drugs and are at least three times more likely to die from alcoholic liver disease. In the workplace, there are more than 400 deaths each year in Australia. Men account for more than 93% of these deaths, yet they constitute about 56% of the workforce. The average life expectancy of Aboriginal males is about 58 years, around 17 years less than non-Aboriginal males. In the 35-44 years age group, the death rate of Aboriginal males is 11 times than that of non-Aboriginals. About 40 per cent of Australian marriages end in divorce. Of these, 80 per cent are initiated by women. Ninety per cent of those convicted for acts of violence are males. Eighty per cent of the victims of violence are men. In Australian schools, 90 per cent of children with documented behavioural problems are boys. These statements are clearly evidenced by the statistics. In all major areas of risk-taking behaviour and disease, the male of the species is clearly more at risk of earlier death.

Table 1: Australian Bureau of Statistics 1998: Deaths in context: (p.23)

	Male	Female
Accidental drowning	187	58
Suicide	2,150	533
Motor vehicle accidents	1,224	507
Respiratory disease	3,628	2,486
Chronic liver disease	725	293
Ischemic heart disease	15,024	12,801
Lung cancer	4,821	2,053

The objectives of the workshop, in the words of the co-ordinator, were to:

a) access and educate significant men within the community on the status of rural men's health.
b) develop a peer education model for the education of men.
c) increase the awareness of men to health issues.
d) develop a network for the service of the men's health educator. (Men's health education report, 1999).

The project is not intended to study the types of health problems encountered, but to see how information regarding these threats is disseminated to the participants, effectively resulting in changed lifestyle habits and increased health awareness. It will also examine the marketing strategies involved in promoting the workshop and

establishing the participants for the workshop to proceed. The co-ordinator, who was employed by the community health centre, had previously conducted several successful workshops in the area and had attracted funding from the State Government as a result of the leadership he had shown in this aspect of health. From this experience, it is hoped that valuable information and teaching strategies can be extracted from the workshop, to put forward recommendations when analysing the case study.

Purpose

The purpose of the study (given the background described in the literature) is to observe as a participant a rural men's health workshop to consider why men came to this particular course, to monitor teaching strategies that were employed and the effectiveness of this approach for the participants. The opportunity to attend the workshop presented itself and, through this case study, would be a starting point to answering some of the questions raised in the literature search. That is, how to attract men to attend a health workshop, to study effective teaching strategies directed at men and the impact these have on them. It is hoped that the data gained from this study through the use of field notes, observation, questionnaires and follow-up interviews will enable the researcher to develop appropriate models of teaching in the area of men's health to the Australian male.

Method

The approach to this project by the researcher holds no preconceived views or hypotheses other than the fact that men are reticent with their health, which is supported by the literature. Nor does it intend to code the data using numerical means, but rather, plans to look at personal experiences and gain information from participant-observation by the researcher.

This format places the form of research into a qualitative design case study, incorporating quotes from participants, interviews, questionnaires and field note observations.

Due to the fact that no men took any notes for the duration of the workshop, all field notes were written immediately following the sessions. Field notes from participant-observation formed a major part and returned questionnaire comments were scrutinised and reported, extracting any significant statements. The information gained from the interview with the co-ordinator was analysed and important themes were reported and described. Follow-up of participants who consented to a taped phone interview was carried out approximately six months following completion of the workshop, as a measurement of the impact the workshop had brought on lifestyle choices.

The researcher adopted a case study approach to this study that entailed being a participant in a men's health workshop as the most appropriate method for the aims of this research. Case studies are different from other forms of qualitative research in that they are descriptions in depth and analysis of a single entity such as a group,

event, program or individual (Merriam, 1998). Case study research, according to Burns and Grove (2001), ensures:

> a variety of sources of information can be collected on each concept of interest through the use of different data collection methods. This approach allows detailed study of all aspects of a single case (p.255).

This case study involved participant-observation, interviews and questionnaires. The researcher attended all sessions, participating in discussions and being subject to the physical examination given to each participant. The researcher also took an ethnographic approach, by participating in and observing the lived experience of the participants, and translated this into a written report. It is this lived experience of the participants that gives meaning to the men's own perceptions of a particular phenomenon and is influenced by everything internal and external to the individual. In the case of these rural men - many of them farmers - environmental factors external to them provided a large influence in their approach to the workshop. These factors involved the distance to attend the centre, time frames for their farming responsibilities and if there was any support from their wives or partners.

The interview questions are an important component to the case study approach, using triangulation methods to enhance the collected data to ensure a more complete analysis is gained. The open-ended questions are designed to elicit descriptions of their experiences of the workshop, sharing thoughts, perceptions and views. The questions are worded in such a manner that the participants should understand what is required clearly and there is no misunderstanding or conflicting messages in the question structure. Use of medical or research terminology is kept to a minimum to allow for greater understanding and clarity.

The development of the questionnaire was primarily aimed at eliciting from these men who participated the reasons why they attended, what teaching strategies assisted in their learning, if the content was meeting their needs and pertinent and what effect the workshop had had on their own health lifestyle. These were the core areas that the researcher wanted to explore which would assist in identifying the teaching models and health theories most suited to men's health education.

The researcher put aside any preconceived ideas or beliefs about what was being studied and looked at the data without prejudice. At times, this can be difficult when confronted with views and lifestyles different to one's own. However, after many years in the health service industry, the researcher has become accustomed to seeing negative health changes brought about by poor lifestyle choices without passing judgment. Part of this reductive process is called "bracketing". Having a health background, it was important for the researcher not to bring preconceived ideas or value judgments to this forum. The researcher had to "bracket" these thoughts and feelings, any prior knowledge or assumptions and any perceptions to observe impartially. This term is used in phenomenology and the principle is that it will allow the reader of the research to take this into consideration, although it should encompass all forms of research. An example of this is that for many of these men, drinking beer was an important social custom and smoking was prevalent. This preference was ascertained from comments made by the men and from personal observation. The

researcher's view - a different one - had to be put aside by "bracketing" it. Crotty (1999) defines bracketing as:

> a sincere endeavour not to allow one's beliefs and assumptions to shape the data collection process and a persistent effort not to impose one's own understandings and constructions on the data (p.20).

Streubert and Carpenter (1999) describe bracketing as:

> … the cognitive process of putting aside one's own beliefs, not making judgments about what one has observed or heard and remaining open to data as they are revealed (p.21).

In reality it would be impossible not to have gained views, opinions and a theoretical framework based on a working life in the health profession. Even embarking on a project such as this is proof that there is a specific need in men's health that the researcher has already recognised.

According to Minichiello, Sullivan, Greenwood and Axford (1999), the issue of validity, 'in the sense of an accurate understanding and representation of what is being investigated, has concerned many authors' (p.44), is an integral part of the research process. Validity in this investigation comes from cross-checking different sources of data - in this case analysing the questionnaire response, interviewing the co-ordinator and personal observation using a triangulation approach. As a strategy, triangulation has been chosen to provide further understanding and depth to the project, approaching the targeted event from multiple perspectives. Streubert and Carpenter (1999) refer to this when they state:

> … qualitative researchers may choose to use triangulation as a strategy in any investigation when their goal is to provide understanding or to obtain completeness and confirmation (p.300).

This could also be perceived to simply be an obvious approach to gather rich data incorporating three different strategies from which recommendations can be made.

Through all the sessions, the researcher was not a passive observer, but was included in the group and took an active role in discussions, participation and socialising before and following the workshops with the men. This created an acceptance from the men as a fellow member of the group and established a relationship of trust which allowed for greater ease in gathering questionnaire data and interview access. The subject matter of health was familiar to the researcher and, as a registered nurse, there were already professional as well as personal concerns for men.

Background

This report relates to a men's health workshop conducted in a small rural town in south-west Victoria. The education sessions were conducted over a five-week period in the community hostel lounge of the town's District Memorial Hospital from October 20 – November 17, 1999. This town was chosen because it was primarily a

small rural community and access to men from this area would enable the researcher to ascertain what particular problems men in rural areas had in relation to their health. The town is approximately 50km from the nearest hospital with emergency facilities - also a factor for the researcher when looking at the rural aspect of men's health, given the distances rural men are from any existing health services. The position of the town was important to the study, as it would reflect and be a representative group for other wider Victorian rural communities. Fifteen men attended the sessions over the five weeks.

The course was initiated by the unit manager of a community centre after funding was gained from the State Government. The men's health educator for a provincial health service community service conducted the program.

The researcher's access to the group required the approval of both the co-ordinator and participants. Best and Kahn (1998) summarise this by saying 'the relationship of researchers to their subjects is based on trust and confidence. Researchers do not allow themselves to be aligned with either the authority figures or the subjects. A position of neutrality is essential to objective participant observation' (p.252).

It was necessary to meet the co-ordinator before the group commenced to state the intention of the study, the confidentiality procedures in place and how the information gained from the sessions would be used. In such a study, gaining entry into the field requires establishing good relations with all individuals in the host institution and the researcher's skill is reflected in whether the participants see him as an interested, respectful, non-judgmental observer who maintains confidentiality. Minichiello et al (1999) stated:

> ... an investment of time and effort must be given to building a trustworthy relationship with gatekeepers to ensure that they understand fully what the research project entails and feel comfortable with the research being undertaken (p.414).

The co-ordinator did say that there were times when it was difficult to attract men to workshops - this has been a major topic at recent men's health conferences. This time, the co-ordinator ensured his success by personally phoning each individual, clarifying any questions. In the interview, he said:

> I make the effort. Even if it does take me another hour or two hours of work time, I ring each man and talk to him so he has a full understanding of the program before he even gets any mail from me. Then I ring them again. I think that is why they come. Certainly, if they ask who else is coming, I give them a couple of names. They are more than happy to come then. Over 180 men and I have only had 10 say no.

This strengthens the researcher's belief that a personal approach to men is more effective than a mailout or posters, which are often ignored. However, when looking at Table 4, on how the men found out about the course, it is noteworthy that only one responded to a phone call.

The researcher shared some of the characteristics of the men, which assisted in gaining acceptance in the group. The main factor was the level of acceptance shown by the co-ordinator and the personal introduction he provided. Secondly, the researcher was at every meeting these men attended, including the breaks and supper following. Being a participant allowed the men to get to know the author not as an outsider, but as one of them. The researcher's personal interest – evidenced by his participation and readiness to travel five hours to attend each workshop - was appreciated by the men. Being a participant-observer encouraged a high questionnaire response rate from the participants and every person offered to be involved in a follow-up phone interview. The informal style of clothes worn was also seen as an important factor in this study, which was the standard dress code of the participants.

The group/participants

This was an opportunistic random sample for this study, as the site was selected to be from a small rural community – so satisfying the criteria for men who were from the country as opposed to their urban counterparts. The workshop's location and purpose assured the researcher of a sample of rural men and the focus on health. The sample group of men was not chosen by the researcher, but was those who voluntarily attended this men's health workshop. To begin the process of attracting men to the workshop, the co-ordinator asked for a list of names of potential participants from a respected person in the community. The co-ordinator believed this method to be more effective than recruiting at random or simply using posters around the community. The fact that the mayor of the township was involved encouraged others to join. The initial list of 18 names yielded a final enrolment of 15 men from a range of occupations (see Table 4) in addition to the co-ordinator and researcher, with an average age of 49 years.

The age of the participants was interesting in that younger men were not represented at the workshop. None was under 40 years, with an average participants' age of 49 years. Men in the 20-39 age bracket are grossly under – represented, a fact which reinforces the researcher's findings (see Table 2) that this is an issue needing to be addressed.

Table 2: Age of participants

Age	18-30	31-40	41-50	51-60	61+
Number	0	0	9	4	2

The fact that younger men typically do not attend health workshops can be confirmed by statistics from other workshops held in Victoria (Gibson & Denner, 2000). Young men may not perceive these workshops to be important or necessarily relevant to them (see Table 3).

Table 3: Age Profile of Men in Victoria (Per cent)

H&CS Region	Town	16-20	20-29	30-39	40-49	50-59	60+	Total
Grampians	Creswick	0	0	11	39	19	31	100
	Daylesford	0	0	2	26	39	24	101
	Warracknabeal	0	4	13	31	29	25	102
Loddon Mallee	Castlemaine	0	0	0	18	22	60	100
	Gisborne	2	2	0	26	44	56	126
	Ouyen	2	4	18	31	24	22	101
Southern Metro	Mordialloc	1	4	18	25	53	0	101
Eastern Metro	Manningham	2	8	11	19	36	26	102

Source: Age Distribution of Men Attending Men's Health Nights/Sessions in Victoria, 1994. (Gibson & Denner, 2000, p.14).

Table 4: Participants by occupation

Technical Officer	1
Self-employed	1
Woodmill worker	1
Retired	1
Workshop foreman	1
Tradesman	2
Salesman	2
Dairy farmer	6

Before the course, most participants were presumed to be from farms in the area. Since hay cutting was in progress at this time, attendances were expected to vary. The content of the workshop should reflect what was perceived as relevant and applicable to men in the area. Davidson and Lloyd (2001) state, 'we would advise anybody who wants to initiate and to develop work around men's health to look at the local perception of health needs in their community' (p.128). Harrison and Dignan (1999) confirm this when they say that:

> ...it is important when designing health promotion strategies, to ascertain the perception of health in the population being targeted, as men are more likely to respond to those who match their opinion of what will be beneficial (p.193).

One way to address this need is a test of the men's knowledge of certain health issues. From this, the co-ordinator can explore areas where knowledge is limited and compare learning capacities by conducting the same test afterwards.

One of the weaknesses in this study could be seen to be the sample size of 15 men from a limited range of professions. The "sample" number is, however, an acceptable cross-section due to the small population of the town where the research was carried out and statistical significance is not an issue in a study of this kind. The "sample" is assumed to be indicative of rural men across the state and views indicated will strongly reflect the wider rural community. The men who attended the course came

voluntarily. In addition, a larger number of men in the sample population would have created a strain on resources due to lack of funding, time and assistance.

When asked how each man found out about the course, the distribution in Table 5 was noted.

Table 5: Awareness of workshop

Advertisement	Friend	Spouse	Work	Phone call	Other
3	9	0	1	1	1

Fifteen men attended the first night. Prior to this, the room was set up carefully, ensuring the right temperature was maintained with comfortable chairs, whiteboard, overhead projector, video and tea/coffee facilities. All equipment was checked before commencement. No name-tags were worn or individual introductions given. Most of the men knew each other, coming from the same local community, and the mood was relaxed and friendly. For these workshops to be user-friendly and to create the appropriate environment, the need for informality is essential, especially for working with rural men from the same area. Nametags were unnecessary. It is important in setting up such workshops to acknowledge the culture of men. Davidson and Lloyd (2001) state that:

> ...merely designing programs and processes to operate in parallel with those developed to promote women's health will not deliver the results we need to tackle a pervasive "variation in health" (p.60).

Merely duplicating women's information sessions for men will not achieve the same success rate due to differing needs and learning styles; similarly, a forum for men from an urban area may not necessarily work for their rural counterparts.

Asked why they signed up, most of the men said they were interested in their health and saw this as an opportunity to learn something. Comments such as:

> improve my health
> concern for good health,
> interest in what my health might be like
> have been interested in my health for a long time, especially since turning 40

substantiated this observation.

Table 6: Number of sessions attended

Sessions attended (4)	1	2	3	4
No. of participants:	0	1	5	9

The participant who indicated two sessions said that he would be in next year's course. From Table 6, it can be assumed that the majority of men found the workshop worthwhile and deserving of their attendance.

Workshop Overview

The following reflects the structure and function of the course in a weekly sequence to give the reader an overview of the workshop.

Week 1

The introduction stated the reason for, and outline of, the workshop, then stated to the men that medical jargon would not be used, with simplicity being emphasised. Questions would be welcomed, no matter how irrelevant they seemed, which was important to the men - all enquiries by the participants would be treated with respect. Statistics of health status were shown from National Health Authority material, highlighting main areas of concern in men's health and demonstrating that rural constituents were worse off statistically than their urban counterparts. This came as a surprise to most and provoked their interest in finding out the reasons. The co-ordinator spoke in terms familiar to the men and related examples to farm experiences, reaching the men at their level and applying a collaborative style of teaching.

None of the men brought paper and pen and no notes were taken during the session. This pattern continued for the entire course. This was an interesting observation to the researcher: it showed that to these rural men, many of whom were farmers, learning takes place immediately by the senses rather than through writing information down for later review. Taking a folder, paper and pen to the session by the researcher was not continued as, in the role of participant-observer, this would have been distracting to the other men, if only one member was writing during the sessions. In the first session, participants were given a questionnaire (see Note 2) regarding health and diet. This enabled the co-ordinator to ascertain their level of understanding concerning health issues. The same questionnaire was given out on the completion of week four, as a comparative analysis of the learning that had taken place. This is an important component for workshops: it gives the co-ordinator an awareness of how much learning has taken place and what information has been retained.

The co-ordinator went through the content of the course over the four weeks so that the men knew what areas would be covered. The fifth week dealt with dietary needs, which included a visit to the local supermarket with the men's wives and partners to select food normally eaten and to look at fat and calorie content, as it was recognised from the group that the women often did the shopping. The men were told they would have a physical assessment done before classes over the following two weeks, so arrangements were made to slot the men into 10-minute segments.

Week 2

Week two saw nine men coming earlier to have the health check. This included having their blood pressure, cholesterol levels, blood glucose, weight, height and waist-hip measurement checked. This only took approximately five minutes for each man due to the professional approach of the co-ordinator, who was proficient in taking these measurements due to his health professional experience.

Again, none of the men brought writing materials or any literature to the class. The session started with a brief overview of what had been covered in the first week to reinforce learning.

A short video on heart disease was shown. This contained interviews with heart attack victims and health practitioners. All videos in the sessions were recent, produced in Australia and of good quality. The co-ordinator focused on coronary disease and looked at risk factors that lead to heart attacks, including obesity, stress, genetics and cholesterol. Mention of cholesterol and glucose in the blood could be appreciated by the men, as they had just had their levels taken and it had been reinforced in the video in addition to the fact that they were aware of their own personal readings. Again, the use of practical demonstrations reinforced the men's knowledge and finding out their own levels of blood glucose, cholesterol and blood pressure gave them a platform which they could build on and lead them to an increased self-awareness.

That week, there were more questions asked of the co-ordinator and the men seemed more relaxed with the proceedings. Following the session, more men stayed behind for coffee and discussion. Most of the conversation centred around what had been spoken about in class and what health problems they could see in other men. This showed the session had succeeded in stimulating thought. It is important that men can exchange ideas and experiences and look at their challenges in a wider spectrum (Davidson & Lloyd, 2001).

Week 3

Week three was directed at looking at different types of cancer - signs and symptoms, treatment and statistics. This was supplemented by videos (Australian) that showed common diagnostic treatment, surgery and the latest in radiotherapy techniques. The visual reinforcement that reiterated the co-ordinator's words served to emphasise the important points. During discussion, the co-ordinator used a whiteboard to reinforce key points. Examples were a diagram of the large bowel, what happens with a colostomy, where the colonoscope goes when diagnosing and a short video of surgery of the bowel. Each subject was clearly explained and followed the same order of condition, signs and symptoms, diagnosis and treatment, with preventative care included. Reinforcement, and clarification that the message has been received, are important in community teaching. Communication is enhanced when reinforcement of the message is given and feedback confirms this (Kiger, 1997).

The co-ordinator used terminology that was not medical, but at a level the men understood, with examples familiar to farmers. This ensured that the men could relate to health problems from a personal perspective. The co-ordinator supplemented a talk on skin cancer with slides of different cases, including basal cell, simple squamous and melanomas. These dramatic images reinforced the importance of having changes of skin tissue checked. The slides used were not from books or cases worldwide, but from local people who had presented to the hospital. No faces or names were shown for confidentiality reasons. At the end of the session, the co-ordinator moved on to farm injuries. This was supplemented by more slides, again from local cases. These included amputations, deep lacerations, dog bites and machinery injuries which were easily recognisable and related to most of the men's work. The message conveyed by these pictures had a stronger impact than any book or spoken word. In teaching, it is

important to present visual cues so that sight has a major place in the learning process - not just listening (Kiger, 1997).

This session was extremely interesting, evidenced by the participation and questions from the men. They were more relaxed in discussing their own problems or physical examinations they had undertaken, including procedures which normally would not have been disclosed. This openness was encouraged by the co-ordinator, who shared experiences from his own family, some personal health-related issues, together with his professional background of dealing with health emergencies. Due to the nature of the session and the interest generated, especially by the graphic slides, the session went overtime by 20 minutes. Again, no notes were taken – by now, this was the standard approach to the men's learning. Supper was declined, perhaps because of the late finish and the need for an early start the next day for the farmers in the group.

Week 4

Week four covered impotence and its causes, indigestion and ulcers, back care (which included exercises to strengthen the back), stress management, alcohol intake and dietary needs. The two-hour session did not include a break, but this was not an issue. The men did not appear to lose concentration due to the diversity of, and personal interest in, the topics. Time was set aside toward the end for the questionnaire forms to be distributed (see Appendix B). The participatory approach by the researcher was assumed to be responsible for the 100% return rate. Time was also taken to clarify what was required for week five - with the visit to the supermarket with wives and partners to look at the types of food consumed and their health value.

Week 5

This final week was an opportunity for the men to bring their wives, girlfriends and mothers to meet at the local supermarket to assess nutritional facts and the types of food usually purchased. This involved a guided supermarket tour and dietary education on reading food labels, special dietary requirements, fat, fibre and daily allowance guide. Many of the men had not considered these parameters before, relying only on preference and food bulk.

Data collection

Data collection was achieved by participation and observation of the workshop adopting the participant-observer approach. Best and Kahn (1998) state, 'when observation is used in qualitative research, it usually consists of detailed notation of behaviours, events and the contexts surrounding the events and behaviours' (p.253). The co-ordinator was interviewed by the researcher and audio-taped, with this being transcribed. Significant statements were extracted, followed by a questionnaire for all participants at the conclusion of the workshop. Approximately six months after the course, the researcher phoned each participant who had indicated they would be available for follow-up. The aim was to clarify the research findings and check what effect this workshop experience had impacted on these men in regard to their health and daily lives.

Data analysis

During the period of this workshop, the researcher was not a neutral participant but an active member of the group. As a nursing lecturer, he had professional as well as personal concerns regarding this topic. This critical thinking component, interwoven into the research project, is referred to as reflexivity, a dynamic interaction between the self and the data occurring during analysis (Burns and Grove, 2001). Having encountered men in a health setting where often it was because of preventable illness due to neglect of their health, this workshop for men and its analysis took on special significance. It is recognised that there are preconceived ideas, beliefs and assumptions for the researcher which only give a rationale for pursuing this topic and will be cause for self reflection and external assessment.

Field notes were written immediately following the workshop while it was still fresh in the researcher's mind and key concepts were noted. These notes recorded the processes that took place in the running of the workshop. Transcripts were written up from recorded interviews with the co-ordinator and follow-up phone interviews with the participants. From these, major themes were noted and reported on.

Findings

To these men, in their view, the most important issues in men's health were exercise and diet, followed by stress and education. However, other issues included cancers and heart disease with one respondent stating "incorporating changes for the better into my lifestyle" and another, "being aware". This last response is significant in that it encapsulates what many men don't realise and that is the importance of being aware of their health and the consequences of negative or irresponsible health behaviour. This may be due to the fact that they may have limited knowledge on the subject or not had the opportunity (as distinct from interest) before.

When asked what were the four most important things they learnt from class that they were not aware of before, most responded to this question by mentioning the importance of exercise and its relationship to the heart (10), then on cholesterol and diet (8). Others mentioned stress (3), types of cancers (3), effects of smoking (1), alcohol (1), bad statistics for this area (1) and causes of impotence (1). This suggested to the researcher that there is a neglect of men to not look after their health, primarily through the lack of recognition of diet and exercise in relation to cholesterol levels and cardiovascular disease. This was confirmed by 13 of the men indicating that dietary intake was the main area of their lifestyle that they would consider changing, with 10 respondents saying exercise and only one mentioning to stop smoking.

From the learning viewpoint of the workshop, when the men were asked about the most important aspect of the sessions they learnt from, a resounding 13 of the participants pointed to the teaching style of the co-ordinator, followed by choice of topics. Only one mentioned the handout material and one said 'interaction with other men'. This supported the researcher's observation that these rural men did not require handouts or taking notes during the sessions; rather, their learning style was based more on visuals and observational learning.

Five of the men responded that they found all the topics most informative, with four others stating heart disease and two said cancer, with single responses for prostate, diet, stress and treatment of back pain. This is also dependent on the style and teaching methods of the particular co-ordinator, combined with relevant knowledge in these areas when exploring this information to apply to other men's health workshops. When asked what topics they would like to know more about, only seven men responded, with three indicating heart, two for cancers, one said diet and another said "referral to a doctor", but did not elaborate.

One of the best marketing strategies of any course is the students themselves who have completed the course. Fourteen out of the 15 participants said they would recommend the workshop to other men, which would indicate an easier time to fill places in any future workshops due to having men in the community who had already completed the course once.

Some of the responses are listed below, the following reflecting an awareness of the men to this area:

> The course has made me aware of the reasons for many symptoms I have.
> All men should be aware of issues even if they don't act on them.
> Most men do not realise that you need to be more than fit, you need to exercise the heart.

Others commented on the importance of the workshop by saying:

> This is the first time we have had this sort of program. Full marks.
> It is important for men to learn more about themselves.

Others reflected the researcher's own view that for marketing, the men are the major factor:

> Try to get others to come.
> Yes, will recommend it to all. Very helpful.

Others referred back to the actual course by saying:

> Well organised and informative.
> Good fun…, well presented.

What has emerged from the questionnaires, interviews and observations is that men's health workshops can be run successfully with the appropriate approach and a style of teaching tailored for adults. One of the main concerns with men's health workshops was attaining adequate numbers of men to warrant conducting a program. Contrary to some reports of lack of interest from men, the apparent key in this case study is to approach significant figures in the community first. The co-ordinator put it this way:

> ...look through the phone book and find the local CFA group, maybe the SES, the volunteer ambos (sic), a major employer…and just try to access them through that. I have never had any trouble getting numbers for a group anyway.

In this case, it was recognised that men needed to be influenced by a leader in their community, one who had responsibility and a position of leadership to assist in their decision to attend.

The credentials of the co-ordinator are important, as he has to be a role model for the men in regard to health. This means that the co-ordinators who are overweight, smoke or are seen to have poor health habits themselves have little credibility with men and, consequently, will have little impact on lifestyle change. This is a key point to teaching health to men: that the co-ordinator has to exemplify the qualities of a healthy lifestyle and gain the trust of the men in the early stages, establishing credibility amongst the participants.

During the course, it was reinforced that beer drinking was not harmful, but rather the extent of it. A simple analogy was put to the men: think of one stubby of beer as the equivalent of one Mars Bar. Consuming one or two of these bars is not harmful, but eating five or six a day could lead to unhealthy results. So it is with beer. This is an important finding: that to be successful with getting the health message across, it will do damage if any lifestyle (such as drinking alcohol) is criticised. By acknowledging the acceptance of consuming alcohol, this presents the information in a way the men will listen to rather than by their feeling vilified. After showing acceptance of this, the point can then be made of taking this to extremes, and the negative effects associated with binge or excessive drinking.

Being able to carry out a health assessment on the men was extremely beneficial. It legitimised the workshop and gave the men the opportunity, in an accepting environment, to have their cholesterol, blood pressure, pulse, weight, blood glucose and skinfold checked before any dangerous symptoms were manifested. In interview, the co-ordinator did raise one concern - the lack of knowledge men have of their own bodies. “Research I’ve done has shown that, on the initial assessment of men, their level of knowledge is shocking regarding simple things like what is cholesterol, what their normal weight should be, what causes a heart attack and what is a heart attack,” he said. This emphasises the need to know your audience and the areas they are unsure of and need education with. It also provides the co-ordinator with an awareness of the quality of learning and how much the men understood from the workshop by conducting the post-test.

Teaching approaches using the adult teaching model and participative learning (Knowles et al., 1998) are essential for men to reach their potential when delivering workshops such as these. The co-ordinator was asked whether he could isolate the essential factors that made the workshop on men’s health special. He responded that the talk had to be at the right level, without confusing medical terminology. Technically, these terms are correct, but to these men, who are not in the health profession, understanding of key principles may be lost when these terms are implemented. He said:

> If you talk at a high level and they cannot understand, you will lose them. The other thing is to change your tack every ten to 15 minutes so you know; make sure we have a change of topics, so we have lots of videos in there, lots of visual things. The guys are very visual. So they want a lot of interaction.

The phone interviews conducted six months after the course emphasised the impact of the workshop on each individual. All the men contacted clearly remembered aspects of the workshop and had acted on them, apart from one who said it simply reinforced

what he already knew. One man had given up smoking and eight said they had altered their eating habits. Three men who belonged to the local Lions club asked the co-ordinator to speak at a Lions meeting. Following that, 20 club members participated in a men's health workshop in February, 2000. The 13 men contacted by phone all said they could now talk to others more freely about health issues. Again, every man felt the workshop to have been extremely valuable. They said it was delivered in a way they could understand, it was related to their own situation and they appreciated the fact that it was organised for them in their rural town.

Since this particular workshop finished, the co-ordinator has conducted four more courses in the town for local men. This indicates just how well received his efforts have been and the perceived value the men thought of the program. The co-ordinator identified several significant health issues among the participants and further assessment steps were taken. He reported:

> Three men were asked to have an assessment of worrying skin spots.
> Two men with apparent chronic indigestion were referred to a G.P. for assessment and a possible endoscopy.
> One man with a family history of bowel cancer was referred for assessment.
> Two men with a family history of heart disease and with significant risk factors were referred to their G.P. for assessment and management (Willder, 2000).

The question of payment for these workshops elicits differing responses. For some co-ordinators, the best approach (as in this case) is to have funding available so there is minimal (or no) cost to the participant. Others believe a fee should be charged so that the men prove their commitment and have some ownership of the course.

There is a potential for theory to be linked to developing programs such as these in the area of health promotion. One of the main theories that can be applied to this case study is the health belief model. What has been observed from this study is that, in many instances, men are just not aware of important factors that dictate their health and are unaware or naive when it comes to being in touch with their bodies and correct maintenance. This model is based on the men taking some form of action to protect their health when presented with the advantages of changed health behaviour. Nutbeam and Harris (1999) state:

> … the model predicts that individuals will take action to protect or promote health if they perceive themselves to be susceptible to a condition or problem and if they believe it will have potentially serious consequences: the perceived threat … and that the benefits of taking action outweigh the costs or barriers' (p.19).

This model has been used in predicting why individuals took up different health behaviours, or failed to, and is useful when setting up health workshops for men. This model worked well with the men who took action following the workshop in seeking medical advice regarding their condition (which was ignored before) or changing their dietary intake after being informed of consequences.

The transtheoretical (stages of change) model developed by Prochaska is another health theory that can be applied to this case study. This purports that an individual

will go through stages of change and it is not just an event (Rankin and Stallings, 1996). Nutbeam and Harris (1999) describe this as:

> ... precontemplation: this describes individuals who are not even considering changing behaviour, or are consciously intending not to change; contemplation: the stage at which a person considers making a change to a specific behaviour; determination, or preparation: the stage at which a person makes a serious commitment to change; action: the stage at which behaviour change is initiated; and maintenance: sustaining the change and achievement of predictable health gains. Relapse may also be the fifth stage (p.27).

When relating this theory to the workshop, the first stage would be when setting up the program and organising participation. Stages 2, 3, and 4 could be initiated during the workshop or immediately following and the final stage would be long-term and recognised in any follow-up to the workshop participants. This final stage was recognised in several of the participants during the follow-up calls made approximately six months following the completion of the workshop.

The outcome of the analysis of the data is varied and can be summarised as follows: in rural areas, participation at men's health workshops is greater if recognised leaders in the community are approached and they participate. Men often need an excuse to attend, an opportunity given that they may not have had before. A financial inducement to attend is not recommended and, indeed, can be a turn-off for many men, eroding the value of the course.

If a course, such as this one is to be related to the physical parameters, then a pre- and post-test is useful and complemented with a health assessment. For this to be effective, the co-ordinator needs to be a role model and familiar with the health industry and health needs of men. When discussing health, care needs to be given to not adopting a victim-blaming approach, but demonstrating sensitivity and awareness to these health issues. The presentation needs to be pitched to the men at their level, avoiding excessive terminology, idealistic views and textbook regurgitation, but including real life testimonies.

One of the strong observations to have come out is how the men like to socialise, gathering around to talk among themselves before and after the workshop. Provision of refreshments even if it is just tea and coffee, will encourage this and enhance the time together. It is important to remember that, although the workshop is for men, recognition needs to be given to the women in the lives of these men. They need to be recognised as it is often they who prompt the men to come - and in this case, were included in the final session.

There is a need for further studies to be done in the rural area. This was considered a standard trial for rural men's health workshops, but certainly not a template, as there are various considerations to be taken into account for other areas depending on the marketing styles, co-ordinators, teaching styles and background of the men attending.

Following on from this study, the natural progression is to conduct a comparative study of a men's health workshop in an urban setting to see how these are conducted, the teaching approach and what subject matter is discussed.

Conclusion

Community education is an evolving process which does not happen in a short space of time. Programs need to be carefully formulated and marketed to the community in a format that is attractive and achievable for men. Their implementation needs to be flexible and affordable, with a curriculum and delivery that is dynamic and sensitive to the needs of the Australian male. There must be a concerted effort to change the way Australian men think about their health on the part of health professionals, teachers, politicians and policy-makers. Programs in adult education such as these need the support of the community if they are to have an impact on the lifestyle of Australian men.

This case study gave an important insight into health education for men, including successful teaching strategies, men's health needs and marketing tools. There is no uniform model that can be applied to every men's health workshop but, rather, sensitivity to the environment, needs and educational background of the men have to be considered.

Notes

1. Workshop program details

Week One

Comparison of metropolitan, rural and remote rural statistics related to men's disease and death rates.
Video on men at work and play and the risks to their lives they take, but do not alter.
Why men die eight to10 years younger than women do.
Diabetes understanding of risk factors, symptoms, causes and treatment.
The problem with men.

Week Two

Heart disease and all the risk factors of heart disease.
Medications.
The genetic link of heart disease and how it really is in the family.
Prevention of heart disease.
How heart disease is treated.
Latest trends in health care and the minimisation of heart disease in men.

Week Three

Cancer and the detection process.
Treatment of cancer.
Skin cancer, bowel cancer, lung, liver, stomach and testicular.
Videos and slides on the detection, removal and treatment of all cancers.
How we get cancer.
Farm injury statistics and slide presentation of injuries common on the farm.
Prostate cancer treatment, detection and surgery.

Week Four

Impotence and the causes and non-medical assessment of it.
Indigestion and ulcers.
Back care.
Stress management. Exercise and their needs.
Pain relief and basic first aid.
Alcohol and drug effects.
Cholesterol and dietary advice.

Week Five

Dietician education and supermarket tour.
This involves the men's partners' involvement with a guided supermarket tour and dietary education on label reading, dietary requirements, fat, fibre and daily allowance guide.
Throughout the sessions, men are invited to undergo a full physical evaluation with an additional 30-minute assessment on a one-to-one basis. The assessment covers the following information.

Cholesterol level.
Blood sugar level.
Weight-for-height assessment.
Skin fold test.
Body mass index.
Waist-hip ratio.
Blood pressure.
Heart sounds.
Respiratory assessment.
Dietary assessment.
Sexual advice.
Heart disease assessment.
Assessment of hearing and stress test available.
Referral to medical attention and investigations are encouraged.
First aid education may also be included as education.
(Men's health education report 2000, p.5).

2. Questionnaire

Please complete the following and place in the box provided on completion.

Questionnaire: Men's Health

Please circle appropriate age:

AGE: 18-30 31-40 41-50 51-60 61+

Occupation……

Postcode of your residential address…….……

1. How did you find out about this course?
   advertisement
   friend
   spouse
   other means

……
……
……

2. Why did you decide to attend?

……
……
……
……

3. Did you attend all the sessions?

……
……

If not, how many were attended?

……

4. What do you believe are the most important issues in men's health?

……
……
……
……
…….

4. Briefly state the four most important things you learnt from this class that you were not aware of before.

……
……
……

5. Indicate one or two areas (if any) that you may consider changing in your lifestyle.

……
……
……
……

6. From the following, circle the two most important aspects of the sessions that you learnt most from?
   a. Teaching style of co-ordinator
   b. Videos
   c. Handout material
   d. Interaction with other men
   e. Choice of topics
   f. Other (please name)

……
……
……

……
……

7. a) Which topics did you find most informative from these sessions?

……
……
……

b) What topics would you like to know more about?

……
……
……

9 a) After completing this course, will you recommend it to other men?

Please tick appropriate response:

Yes…… No…… Maybe……

b) Briefly explain your answer.

……
……
……

10 Any other comments regarding the workshop?

……
……
……

Thank you,

Neil Gracie.

3. Pre and post-test questionnaire

1. a) Please list what you think to be the major causes of heart disease.
   b) How is a heart attack treated in hospital?
   c) How can heart disease be prevented?
   d) What are the signs and symptoms of a heart attack?

2. a) What is cholesterol?
   b) How do you know if food has cholesterol in it?

3. a) What are the signs and symptoms of an enlarged prostate?
   b) What tests are available to detect prostate cancer?
   c) What are the causes of impotence?
   d) How can impotence be treated?

4. What causes a stroke?

5. What are the major risk factors for diabetes?

6. a) How much exercise does the average male need?
   b) What is the best form of exercise?
   Why is aspirin useful?

7. What is blood pressure?

8. a) How is colon cancer detected?
   b) How is colon cancer treated?

   c) What are some of the causes of colon cancer?

4. Phone interview questions

1. From the workshop, has the experience affected the way you manage your own health? If yes, in what way?
2. Would you be more inclined to talk to people about your health following this workshop?
3. What do you remember from the workshop that influenced you the most in regards to your workshop?
4. Did you think the workshop was worthwhile in hindsight? Would you attend another?

References

Bassey, M. (1999). *Case study research in educational settings.* Buckingham: Open University Press.

Burns, N. & Grove, S. (2001).*The practice of nursing research, Conduct, critique & utilization* (4th ed.). Philadelphia: W.B. Saunders Company.

Best, J. & Kahn, J. (1998). *Research in education* (8th ed.). Boston: Allyn & Bacon.

Biddulph, S. (1995). *Manhood. An action plan for changing men's lives*. Sydney: Finch Publishing.

Crotty, M. (1999). *Phenomenology and Nursing research*. South Melbourne: Churchill Livingstone.

Davidson, N. & Lloyd, T. (2001). *Promoting men's health. A guide for practitioners.* London: Harcourt Publishers Limited.

Gibson, M. & Denner, B. (2000). *Men's health report 2000*. Bendigo: La Trobe University.

Harrison, T. & Dignan, K. (1999). *Men's health: An introduction for nurses and health professionals*. London: Churchill Livingston.

Kiger, A. (1997). *Teaching for health.* London: Churchill Livingstone.

Knowles, M., Holton, E. & Swanson, R. (1998). *The adult learner* (5th ed.). Houston: Gulf Publishing Company.

Krupinski, J., Tiller, J., Burrows, D. & Hallenstein, H. (1994). Youth suicide in Victoria: A retrospective study. *The Medical Journal of Australia, vol.* 160, February: pp. 113-116. In T. Laws (ed.). (1998). *Promoting men's health – an essential book for nurses*. Ascot Vale: Ausmed Publications.

Merriam, S. (1998). *Qualitative research and case study applications in education*. San Francisco: Jossey-Bass Publishers.

Minichiello, V., Sullivan, G., Greenwood, K., & Axford, R. (Eds.) (1999). *Handbook for research methods in health sciences*. Sydney: Addison Wesley Longman Pty. Limited.
Nutbeam, D. & Harris, E. (1999). *Theory in a nutshell: A guide to health promotion theory*. Sydney: McGraw-Hill Australia.
Pattison, A. (1998). *The M factor: Men and their health*. East Roseville: Simon and Schuster Australia.
Rankin, S. & Stallings, K. (1996). *Patient education: Issues, principles, practices* (3rd ed.). Philadelphia: Lippincott.
Schwandt, T. (1997). *Qualitative Inquiry: A Dictionary of Terms*. Thousand Oaks: Sage Publications.
Streubert, H. & Carpenter, D. (1999). *Qualitative research in nursing: Advancing the human imperative*. Philadelphia: Lippincott.
Willder, S. (2000) *Men's Health education report*. Western District health Service: Community Services.

Appendix 2

Project 2

Men's health workshop Melbourne

This workshop was attended by the author as a comparative exercise against the rural workshop previously detailed in Project 1. It was felt that the difference in environment between country and city dwelling would give rise to different stressors, circumstances and lifestyle amongst men living in both these areas. This would require a separate study of a men's health workshop that was held in the suburbs of Melbourne, comparing teaching strategies, marketing and information covered for the men. The obvious differences in the health of men in rural and urban environments are demonstrated in the national statistics. The Australian Institute of Health and Welfare (1998) states:

> ... death rates for all causes combined for the period 1991-1995 are greater among people living in rural and remote areas of Australia than for those living in metropolitan areas. Rates in the remote zone are highest, with those among males and females in "other remote areas" 22% and 32% higher respectively than males and females in capital cities (1998, p.40).

Projects 1 and 2 were designed to look at the needs and approaches of a men's health workshop in both of these areas. The facilitator of the second project city workshop was the founder of the Melbourne Men's Centre and instrumental in co-ordinating programs in men's psychological and emotional health.

Method

As a comparative study, the method needed to follow the same approach as Project 1 and that was to conduct the research through a case study. In this project, a men's health workshop was held in Melbourne over a similar time frame with meetings occurring weekly. The researcher decided for true conformity, in that he would be a participant-observer at the group meetings similar to the previous studies and would gather data through this means, by interviewing the facilitator, utilising a questionnaire and doing follow-up phone interviews with participants.

Prior to the meeting, the researcher spoke with the co-ordinator over a meal to introduce himself and to glean background information regarding the men's health workshop. Delays with ethical clearance meant the first three weeks of the course were missed, but it was not until later that it was realised that the workshops were ongoing meetings, with participants choosing when to attend on a continuing pay basis. The co-ordinator said the men came to the workshop through referrals from Lifeline, community health services and other agencies. This indicated that the sample of men who came may have a different level of needs to the first study: if they were referred by these organizations, many of the participants may be in need of psychological counselling and may be more prone to bouts of depression. Garvey (in Healey, 1995) says:

> … therapists and counselors say that men are often unwilling to make the first move to help … increasingly, men are propelled by events around them - the threat of divorce, access to children - to seek professional help (p.28).

The researcher was warned that there could be some areas of the meeting that might unsettle him and that it was acceptable not to participate if this was the case. The example was given that some men had initially come to the workshops, but had not continued, as they may have felt uncomfortable at certain aspects of the meetings. These areas were indicated to be the use of touch, chanting as a group and sometimes the private thoughts expressed within the group. The following is a descriptive analysis of how these meetings were conducted.

Nine men attended the meeting in a northern suburb of Melbourne, held in the home of the facilitator as part of a six-week course. The venue was, appropriately, the home of the co-ordinator, who mentioned that the men who came to the sessions felt this was a non-threatening venue. They quickly became comfortable in these surroundings, as opposed to a community health centre. Gibson and Denner (2000) state that:

> ...community health centres are not seen as appropriate venues for health care by men, who can present a problem of access in towns where GPs have their practice in a health centre (p.24).

A private home may have been seen as a conducive environment for men to gather: it is perceived to be non-threatening and not associated with a community health centre or hospital. Kiger (1997) says:

> ...the psychological setting is as important as the physical setting. In group settings, it may be useful to arrange furniture so that people can see each other. That way, no one feels peripheral to the activity, and no hierarchy is established by virtue of positioning (p.194).

There was a range of tea and coffee served before the meeting, for the men who came early and who participated in social engagement for approximately 15 to 30 minutes. The meeting was held in the lounge room of the house, with a gold velvet rug laid out in the middle and a large candle at the centre. There were small cymbals, a bell with a wooden striker and the lights were turned down low. Also placed on the rug was a piece of gnarled wood. This was a symbol for whoever held it. When a man took this wood, he held the floor and could talk to the group without being interrupted. The co-ordinator reminded the men that this was an ancient custom when men came together. Each man was invited to participate as he felt the need. It was obvious that the environment was in stark contrast to the workshop held for the rural men.

The co-ordinator started by playing the didgeridoo, then read a couple of esoteric poems (several of the men referred to these in later discussion). It was clear to the researcher that this gathering was focused on emotional health and mental well-being, rather than the physical and lifestyle challenges of the first workshop. This different approach was in stark contrast to the previous research in a rural area and would have created certain difficulties to participate within this environment for the previous group of men. Baum (2002) says:

> ...recent years have seen discussion of "new men" who are more in touch with their feelings and who would be happier to seek help. If this is a sustainable and real trend, it might contribute to reducing male mortality rates in the future (p245).

Each man in this group was allowed to have his turn to say what was happening in his life and how he was feeling.

Some of the men obviously had large issues in their lives, but they clearly felt comfortable sharing these, thanks to a trust that had been developed within the group. Davidson and Lloyd (2001) state:

> ...men have traditionally been suspicious and unsure of those working in health-related services and trust may have to be built up with particular groups of men, especially those with little or no history of contact with traditional health settings (p.271).

Three of the men had been on a retreat with others, facilitated by the co-ordinator, and this had impacted their lives through its male bonding, games and a release of tension through group dynamics. It was noticed that the men were positive to each other and any comments made, if responding to a situation raised, were done in a conciliatory manner. Physical contact between the men was accepted and there were often hugs given, especially at the completion of the session.

One of the men who said he was "incredibly sad" sought comfort from the group in the form of being touched after the co-ordinator asked him how the group could help him in his personal struggle. How this was done was to lift him up from the floor and raise him above the group, at the same time saying words of encouragement, specifically stating his name and chanting, which was led by the co-ordinator. Later, the man sat in the middle of the circle and acknowledged each person in the group. After this exercise, the individual appeared more relaxed and was certainly grateful to the group for the gesture of support.

Following this, another participant with some frustration in his life asked for help. He was surrounded by the group and pushed around, symbolising his trust that he would be supported and protected by others.

The meeting was symbolic in nature, ritualistic at times and carried out in an atmosphere of acceptance. It was obvious to the researcher that prior to coming, the men would have had reservations had someone come into the group purely to observe – some of the issues raised were very personal. It was important that the men see the researcher as a participant as well as an observer and, on that basis, the acceptance came quickly.

The researcher was allowed time to speak to the men regarding why he was there and the purpose of the study. This was done early in the session so the men could feel more comfortable and get to know the researcher as a participant. Following the conclusion of the meeting, the men were slow to leave, having another hot drink and talking among themselves. They spoke with the researcher easily and asked if he would be back the next week. Two expressed surprise at the perceived distance the researcher had travelled to attend the meeting.

The second session the researcher attended was held in the same setting, the lounge room of the home of the facilitator in a quiet street of suburban Melbourne.
There were 15 men this time, including the facilitator. The format was similar to the first meeting, but differences were evident. After welcoming the men, the facilitator asked them to form a tight group with arms around each other and to start chanting. This had clearly been done before and all the men joined in. There was no explanation by the co-ordinator as to the purpose of this chanting, what the words meant or what purpose they served. To the researcher, it was obvious that this had become a regular feature of the meetings and that the men who participated in this were aware of the reasons, which would have been outlined at earlier meetings. After approximately five minutes, the men took their places on the floor, sitting on cushions with the gold rug in position and the large candle in the centre with the bell and striker. One of the men asked for the lights to be turned down. Environment had clearly become an important issue to many of these men.

The facilitator read a short story which concerned an old man climbing a tree and reflecting on how he would bring the tree down without damaging a nearby fence. Then the men were invited to pick up the piece of wood and share with others how they were feeling and what their week had been like. They were reminded to say their names, as if they were doing it for the first time - to release the old and add a freshness to their thinking. One person, early in the meeting, referred to one of two sandboxes at the end of the room which contained porcelain figures depicting various people and animals placed in the sand. The sandboxes explained the diverse array of figurines displayed on shelving around two of the walls, depicting all types of characters, male and female, fiction and non-fiction, together with different types of animals. These are used in personal counselling sessions by the co-ordinator, who invites his clients to place in the sandbox various figurines representing people, fears or situations in their lives in a way that closely portrays what they are feeling and how they view the world. There were several men in the group who came to the facilitator for private counselling at other times.

A common theme among the men (disturbing to the researcher) was an overwhelming feeling of hopelessness and poor self-concept. This could be a sign that many of these men had been referred to this group due to loneliness, depression or poor self-concept. Some found it difficult to express themselves and shared with the group that they were struggling in mind and body. A couple finished their time of talking with the comment: “I’m just so full of ….” This reinforced the researcher’s impression that many of these men felt alone and not wanted. They therefore valued the time with other men, where they were listened to, given affirmation and generally supported in a warm and accepting environment. The message from this indicated that, although the men lived in close proximity to other people in a heavily built-up urban area, there was still an immense feeling of loneliness and low self-esteem.

During the course of the evening, while the men in the circle shared with the group, there were often extended periods of silence - even when someone was holding the wood. These silences were permitted by the facilitator and appeared to help the men gather their thoughts without interruption.

The men's background varied immensely, from businessmen to unemployed and homeless. One spoke of feelings of depression, suicide ideation and wandering the streets, but said he felt stronger by belonging to the group. At the completion of the session, the facilitator offered this person the chance of an affirmation exercise similar to the previous week. He lay down, the others laid hands on him and lifted him above the group. During this time, the others were encouraged to chant and give energy around the person. Later, the man seemed more relaxed and content. He commented that, as he was being lowered, he felt as though he was being raised higher.

This exercise was repeated with another man who had shared with the group about his ongoing battle with drugs. Again, the individual stated he felt acceptance, love, warmth and support from the group. The lifting exercise appears to be a valuable one for the men.

With the larger numbers, the meeting was extended by 20 minutes, although this did not deter the men from staying after and socialising with each other over coffee and tea provided. This was supposed to be the final night of the course before the end-of-year break, but the facilitator proposed that the group continue for one more week with an affirmation theme, honouring each other and the following week to have a group dinner with a brief meeting to follow.

This session was the final full meeting from the year, apart from the concluding meal break-up the following week. Eleven men attended on this final night. After the initial social gathering, the co-ordinator spent a couple of minutes playing the didgeridoo while the men found cushions and sat around in a circle. The large candle was placed centrally, situated in the middle of an empty sandbox.

The men were invited to stand up and form a close circle with arms around each other, then to start chanting. This was done in unison, using the same pattern as in previous weeks. The co-ordinator asked each person to close his eyes, to push any dark thoughts through his body and out through his feet into the ground and to replace this with light coming in through the top of his head. After a few minutes, the men were asked to sit down while the co-ordinator read a short story.

Each man was then asked to consider what the group had meant to him and to choose one of the many figurines to symbolise this that were on the shelving. The researcher found this difficult, but finally selected a juggler, to depict the many demands in life that need to be handled and to acknowledge the group as helping to keep the balls in motion.

When he felt ready, each man addressed the group on how he was feeling and why he had chosen his particular figure. Many referred to the group as their support and said they looked forward to its meetings. One man stated that he had been coming for nearly two years, which indicated that these sessions were ongoing and men could come at any time. The value of the sessions had to be questioned in this instance when experiencing his perception of life after this period of counselling. This brings into question the fragile line between education and therapy. There appears to be minimal impact in this instance in what the sessions have created: instead of a freedom experienced through education, there is a dependency on the facilitator and the other men involved in this workshop.

The men spent considerable time gathering their thoughts and silence was a major feature. It appeared that as the "talking stick" was passed around, it took longer for the men to address the group after a period of increasing silence. After someone had his turn, the stick was passed on to another person in the group and not placed back in the centre.

A common theme among the men was a lack of self-confidence. A couple of participants saw themselves as "children" compared with the other men and others said they lacked confidence in themselves. All acknowledged the benefit of the group and said they felt accepted and listened to. One participant shared that it was the only real time in the week that he felt people had time to listen to what he had to say.

This feedback from the group took most of the time. Afterwards, the co-ordinator asked the men to say something positive to one individual, "honouring" him, as he had indicated he would not be attending the final dinner. This was done and each man was thanked by the man concerned. Following this, the person proceeded to share a dream with the group which was very real and meaningful to him. Then there was an outpouring of emotion, after which the co-ordinator referred to the dream as a major issue in his earlier life.

After a few minutes, the meeting was adjourned with the men gathering in a tight circle. Confirmation of next week's meeting place and time was given. A few of the men returned their questionnaires in sealed envelopes and placed them in the box provided. Several men spoke to the researcher before and after the session, indicating his acceptance into the group and their genuine friendship. Four of them asked the researcher whether he was going to the final dinner and one wanted to be sure that clear directions to the hotel had been given.

On the final night of the year, the researcher arrived earlier and utilised this time to interview the co-ordinator in the meeting room. The interview went well, with no interruptions. The co-ordinator felt relaxed about talking on this topic, one in which he had a long standing interest.

In the event, the planned venue was booked out, so the final session was held in the home of the co-ordinator. Each of the 12 men attending brought a plate and drinks. The first part of the evening was a shared barbecue meal, with light beer supplied by the co-ordinator. The men related well to each other and the group included a member who had been to the group meetings earlier in the year. After the meal, the co-ordinator invited the men in for the final meeting, which began with a tight circle and chanting. The men were told to close their eyes and, when the chant finished, to open them when ready and look at each of the other members in acknowledgment.

The remainder of the evening was devoted to each man receiving validation from the group, but only by those who wanted to. Each individual was given a special place to sit, with the group in a half-circle around it. The man who sat there was told not to talk, but to hold the "talking stick" and accept positive comments from other members of the group. The co-ordinator used terms such as "honour" and "bless", which were repeated by the participants. One man, when given positive feedback, started to cry and this exercise aroused certain emotions in others. There was a time limit imposed

by the co-ordinator, who used the bell. Then the involved participant was asked to pass the stick to another member who then took his place. This exercise was a particularly pleasant one for the men because of the positive feedback and one which they clearly appreciated. The researcher - who had been in the group for four weeks - was the last man to be handed the stick. This could have been coincidental, or symbolic of the fact that the men saw the researcher as an outsider and did not consider him part of the group. This was quickly dispelled as eight of the men immediately gave positive feedback on the strengths that they perceived. They said the researcher would be missed in the group, but would be welcomed back at any time. The coordinator then clarified details for the following year and reminded the men that it was important to secure a place in the meeting.

Any doubt that the researcher's place in the group was accepted was dispelled when one of the men who had been talking to the Co-ordinator before the meeting wanted the group to do something for him as a token of appreciation. This was agreed by the men, who formed two lines and placed their hands on the researcher as he walked slowly through them with eyes closed. A couple called this the "tunnel of love". There was a sincerity in the way this was done which indicated to the researcher that these men did care for each other and had included the researcher in the group. To the researcher, this was an uncomfortable time but due to the participation observer methodology, refusal was not an option. One assumes that, for many of these men, the act of touch and confirmation of them as males had been missing in their lives and that this group was one way of reclaiming that void.

Results

The questionnaire distributed to the men was essentially the same as the one used at the rural men's health workshop. The purpose was to provide a close comparative study of the perceptions of men regarding their health in both rural and urban settings. There were 15 questionnaires distributed and nine returned, representing a 60 per cent return rate. The men were told that they could participate in the study only if they wanted to and that it was purely voluntary.

The respondents were primarily in the 31 to 40-year-old age group, with one indicating 18-30, one 41-50, and one 51-60. All were from Melbourne, except for one respondent from Bacchus Marsh. There were no similarities in occupation, as the following indicates.

1. Computer support / performer.
2. Typesetter / compositor.
3. Personal and residential care worker.
4. Instructor to autistic adults.
5. Pensioner.
6. Builder.
7. Financial Sales.
8. Art student.
9. Environmental management.

When the men were asked how they found out about the course, four indicated that they found the resource at the back of Steve Biddulph's book, *Manhood.* Two mentioned comments by friends, one knew of it from attending private counselling sessions with the co-ordinator, one from an advertisement and the final respondent mentioned "other means," without stipulating what that meant. The reasons for attending were similar and included predominantly emotional needs. Answers included:

> Went on instinct. Bit messed up. Needed long-term support. Needed honesty.
> Personal life hit an all-time low.
> Important for me to be in the company of men who really talk about themselves.
> I've shy'd (sic) away from men all my life.
> To understand the hollow feeling I have been feeling for a long time.
> Had belonged to a group before and was new to Melbourne. A good point of contact with other similar-minded men and for friendship and support.
> Stopped going to a different group … and felt the need for another support group which accepted me.
> I wanted to experience being in a group of men and to discuss what I felt were 'men only' issues with other men.

The question which asked the men whether they had attended all the sessions was a little ambiguous – this course was a six-week block, but the co-ordinator's work was ongoing, with one respondent saying he had been attending for the past two-and-a-half years. The fact that he was still attending after this amount of time suggests there is a dependency in the group that has not been addressed. Five said they had attended all the sessions, one had attended two of them, one about two-thirds of the sessions. Another stated:

> I've been attending the group for 18 months. I stopped going after the first block for three months, but haven't missed too many sessions in the last 18 months.

The final respondent did not answer that question.

"What do you believe are the important issues in men's health?" was a question that elicited responses that shared in the same requirements for the men that is, to be heard, to have a place to meet with other men and to feel valued. The following comments are in direct contrast to the response of the men from the first case study:

> Cost of counselling, accessibility of male counsellors, validity of men seeking help.
> To have places and groups to talk about their problems and needs. Men are in crisis in many areas of their life and have few places to go to talk. They need to be willing, also. It's all bottled up, which leads to many health problems, and the cycle goes on.
> Personal value, self-esteem, personal growth work, hope for healing wounds from the past.
> Love – how to ask for it and express it. Anger – what it is and how to use it".
> Communication.
> Honesty.
> Stress, alienation, lack of purpose, lack of spirituality.
> Depression/suicide, life coping skills, changing life roles, acting out through alcohol and danger, mental fall-out from pursuit of unattainable life goals.

To be listened to, affirmed, contact with other like-minded people rather than isolation.
The death of the soul through such things as shutting down expression of emotion; inability/lack of opportunity to share and communicate on a real level with other men; reluctance to confront absent father/male role model/ initiation issues.

These answers clearly reflected the views these men had about health, being psychological; and not one referred to any physical ailments, which was in direct contrast to the rural men. The fact that neither co-ordinator included either physical or psychological in their respective workshops, it seems this was accepted by the men that their health was unilateral.

When asked to state the four most important things men learnt from this class that they were not aware of before, some of the answers were:

The importance of being still with yourself.
I've learnt to relate to men – safe to talk about feelings, to be supported and validated by men is a great thing. Developing self-belief and confidence is huge for me.
Other men share their personal pain and emotional growth, their development and honesty, my own belief in identity, in who I am and where I am going".
How special I am.
That we are all connected somehow. Somebody's truth can be linked to another.
To stand back from what I feel and just watch, not judge. To accept myself.
I have a good future if I want it. I am a sensitive man. I can face the world and people in an honest, up-front way. There are many other men like me.
The number of time-bomb men ready to explode isn't getting less. Weekly groups don't change much. Our journeys are not the same. We are all in pain – some hide it better than others.
To be listened to is vital, to listen to others.
The power of my own masculinity, power of affection (non-sexual) between men, and that it is possible.
The depth of my soul, the love and compassion I have for other men".

When asked what one or two areas the men may consider changing in their lifestyle the answers were varied;

I wish to devote time to something for myself, like a hobby.
Stay aware. Keep things simple. Water the good thoughts, not the destructive ones.
Not always being in control of events. Giving and receiving affirmation of my own worth.
Intimate relationship needs change – which I'm doing. Relationship with son is much better and I'm much better with ex-partner, which has been an extreme source of frustration and turmoil.
Leaving relationship and job.
Seek and appreciate the good and true in men that I would normally not enjoy being with.
Dependent on my wife and father for money – I will start working and earn some money for me. I will continue to think more positively and act more positively in my life.
Being genuine and real in my male friendships.

All of these replies emphasise the need for the men to feel valued and listened to, something that appears to be lacking in their lives outside of this group.

The most important aspects that the men learnt most from were the "teaching style of co-ordinator" and "interaction with other men". Other things some men liked were "choice of topics". One respondent liked "the ritualistic nature of the sessions, which relates strongly to [the teaching style above]".

The next question asked which topics the men found most informative from these sessions? - was not appropriate to the context of the meeting, as it was more a disclosure and sharing of self. As one respondent answered, "sharing in the group and being real and listened to and validation". Another responded: "speaking up, listening and participating honestly with other men". Another validated this observation by stating: "we don't really work to 'topics'".

"After completing this course, will you recommend it to other men?"
Yes……7
No…….1
Maybe……...1

Only one respondent failed to comment when asked to explain his answer. The person who replied "maybe" stated, "if someone expresses an interest in doing something like this, I would recommend this group highly. However, it's not for everyone." Other responses were as follows:

> I feel it's the best way to 'go down' to the fundamentals. Its painful to go down into certain parts of us, but you gain strength when you go through it, specially with the guidance and support of other men.
> Having experienced personal groups and what men's groups can be to our own personal journey and development – being able to be heard in silence without shame.
> I now really am seeing the great work done in the group and tremendous benefits for each man: although subtle, its very powerful. Also form friendships and other resources.
> Each group is different – the men in this one seek a father-like leader and being told. Generally, I would recommend it as a point of departure for further self-awareness.
> I have struggled at times to talk about the men's group with other men. I have told many men about it over the years and recommended that they give it a try.

The respondent who circled "no" stated:

> I don't know many men in Melbourne. I also believe it's best to allow these things to happen when they are right.

Three respondents did not write in the section "any other comments". Of the others, their responses were:

> This is an ongoing men's group, so either group or one-to-one has been very good and encouraging. We had a good (co-ordinator) who is connected and very in touch.

> (Co-ordinator's) style is very nurturing, allowing, not demanding anything – very safe place.
> I would prefer more structure, half session of talking and half session focused discussion.
> If a group does not meet your needs, put your hand up and ask for it, or find another group.
> Excellent workshop. I feel I have made huge progress emotionally and practically in the short time I have been attending. Highly recommend it to anyone seeking a better understanding of themselves and a better life.
> Men's group is challenging for me. I feel part of a brotherhood of men and what I bring to the group is important and valued and received by other men.

Interview with the co-ordinator

This was done on the final night before the men were due to arrive and originally was planned for the same venue as the original meeting with the co-ordinator before participation in the workshop by the researcher. Due to being booked out for Christmas, this meeting was held in the lounge room of the coordinator's home, the same room as the men's workshop. The first question related to what the co-ordinator saw as the main issues in men's health. He identified emotional, psychological and spiritual "lostness". He stated:

> the father may provide things, but not caring. The garden is barren. There's a scariness about being a man – usually in midlife time.

He believed men didn't seek health advice earlier because of a lack of trust and not being able to talk to men in a real way. There was a sense of isolation, a lack of the father being there. One of the main reasons men came to his workshops was to set all that right. "To provide a forum and provide an environment where the group can discuss and recover their inner life – there is no sense of well-being". The co-ordinator started working with men's health groups after his first wife, who was a strong feminist, began a women's movement. With training in psychotherapy, he felt he could provide the missing experience for men and develop male community. When asked about the essential factors that made a workshop successful, the co-ordinator said:

> ...working on self – creating an environment that works is an environment of safety - invite men to risk new beginnings and invitation to risk new beginnings and reference their inner life-talking about 'I' statements. The less the group does, the better, such as the quality of listening.

The difficulty running these workshops is to make it as easy as possible for men to attend consistently. He believed in a user-pays system and that this payment should be up-front, except for the introductory offer of a free first session. It is his belief that men did not respect free sessions, but needed an ownership of the program by having to pay for it. The motivating factors for men to improve their health were the group itself and the dynamics within that group. The opening up of one man can motivate others to share amongst the group to a higher level than they would otherwise do. Asked for the best teaching methods employed for men's groups, the co-ordinator stated:

> How I am myself – in front of men, if I access my inner strength. I'm their father in some sense – present, loving, caring and tender. To be what their father wasn't. If I was to judge them, they would restrain themselves.

Follow-up of the group was carried out 12 months after the researcher's involvement. Of the group, only three men had indicated they would consent to a follow-up interview and, of these, one was not contactable. As a result, only two men were willing to be contacted. This was in stark contrast to the men attending the country workshop, where the overwhelming majority consented to a further interview by phone. This may be as a result of the men only feeling safe in the group environment and not wanting to be contacted outside of this group and reflecting the very private nature of their thoughts.

Asked whether the workshop had affected the way he managed his own health, one respondent said:

> ...definitely – much greater awareness of how I'm feeling – a wide range of ways to dealing with things.

Another stated:

> ...coming clean with who I am. Situations when I'm not happy, I say so as not before – being able to express exactly where I am at and how.

There was some reticence about the next question: "following your experience of the workshop, would you be more inclined to talk about your health?" One man said:

> ...yes, but selective with whom I share.

Another question: "what do you remember from the workshop that influenced you most in regards to your health?" One man said:

> ...sense of fellowship, level of trust between the men – power of that circle.

The other participant stated:

> being in touch with the here and now – tendency to have your mind elsewhere – how you feel right now.

A further question focused on the teaching methods used by the co-ordinator. Comments from two men included:

> The most important thing is the way the co-ordinator listens and the way the group listens
> That no one is interrupted, owning up to how he is – being on the same level. Saying exactly how it is. Very honest.

Both men were affirmative when asked if they thought the workshop was worthwhile and said they would recommend it to other men or attend another.

Discussion

The responses of these two men were very different to those from the rural workshop. The two had a different view of what constituted health; theirs was based on emotions, as against the physical approach of their country counterparts. To these men, health was associated with the opportunity for reflection, sharing and emotional stability. All involved in the Melbourne course believed interaction with other men was the most important aspect, which suggests many men feel the need for company and to be listened to by other men. This was confirmed with the follow-up interviews where being accepted and listened to were the overriding ingredients the men appreciated with the teaching strategy within the workshop.

Parts of the feedback reflected on the style of leadership shown and the format of the meetings, which was about unconditional acceptance and the opportunity for each man to share his feelings. That approach - and the lack of input on physical health – meant the men equated health with emotional and mental stability. Some of what the co-ordinator said was repeated by individuals in their questionnaires, which demonstrated the leader's impact and the influence the Co-ordinator had within the group. One man mentioned the watering of his garden, which was barren in parts, to the group using the same analogy used by the co-ordinator. On a couple of occasions, the co-ordinator referred to himself as "the gardener" tending to his plants, digging here, taking out weeds there, applying fertiliser and watching the garden grow. One respondent referred to the co-ordinator as a "father figure" Due to many men having difficulties with their father, or the absence of a father, this could be almost seen as a replacement figure for many of these men who seek security from the group and to have someone they can share with.

Another difference between the city and country groups was the use of touch between the men and the perceived need for touch and to be accepted by other men. There were frequent hugs as a form of greeting and touch as affirmation, which was encouraged by the co-ordinator in the group settings. In this way, by participating in these exercises, the men found touch to be therapeutic and it became normal in their social practices with each other. The lack of touch was very evident in the previous study and it is surmised that the men from the rural area would not respond positively to this approach initially.

As mentioned earlier (but needs to be included in the discussion), there was a difference between the two groups in the area of funding the meetings This project was done on a user-pays basis, while the rural project was fully funded and at no cost to the participants. Either way did not appear to be an issue with the men, as this aspect did not arise in any of the discussions or in the questionnaires. The benefits perceived by the participants attending the user-pays sessions appeared to be worth the cost involved.

One of the main themes to come out of this project centred on how men responded to the leading of the co-ordinator and how their own health was influenced by outside factors. The second group's emphasis on mental health, as opposed to the physical, was a stark contrast to the previous rural project. It was clear from the researcher's participation and interviews with these men that, although living in a metropolitan area, surrounded by people, loneliness and insecurity were an undeniable force in

their lives. For many of them, the opportunity just to talk and be in an accepting environment was why they came and were prepared to pay for the experience. The education in this setting was attained by learning from others' experiences and the self- disclosure that followed with learning taking place in the form of self-actualisation and a deeper understanding of who they were as men.

Conclusion

Before commencing this project, there were no expectations of how the workshop would be conducted or the profile of the participants, only that it was a men's health workshop conducted in a Melbourne suburb for urban men which would provide a comparative study to the previous rural workshop for men. The differences encountered by the researcher with this study were in stark contrast to those of first study and counterbalanced the physical approach with psychological health. Key findings in this study were that men deeply need to feel wanted and valued by others and that loneliness, isolation, low self-esteem and depression can occur in urban areas and is a major issue amongst men living in the city.

The rules of engagement were clearly set out by the co-ordinator and rules implicit within the meeting, such as holding the talking stick, were clearly adhered to. The emphasis on emotional health was such that the men spoke in terms of feelings and emotions when asked about their health, which reflected this culture. The question is, could this form of a men's health workshop/meeting be easily transferred to the country for the rural males in the same format as it is currently conducted, and if the reverse could be true?

References

Australian Institute of Health and Welfare (1998). *Australia's health 1998*. Canberra: Australian Government Publishing Service.

Baum, F. (2002). *The new public health* (2nd ed.). South Melbourne: Oxford University Press.

Davidson, N. & Lloyd, T. (2001). *Promoting men's health: A guide for practitioners.* London: Bailliere Tindall.

Gibson, M. and Denner, B. (2000). *Men's health report.* Bendigo: LaTrobe University.

Healey, K. (Ed.) (1995). A man's world. *Issues for the nineties*, vol 34. Balmain: The Spinney Press, pp.26-29.

Kiger, A. (1997). *Teaching for health*. Edinburgh: Churchill Livingstone.

Appendix 3
Project 3
A Study of Education Approaches in Programs for Men with Special Needs at a Day Centre in a Regional City

Introduction

This project follows on from two studies completed researching men participating in health workshops in rural and urban areas respectively. The focus of this study is a program directed at another group of men in society, those who have been displaced and marginalised, and at risk of poor health as a result. The program, in the Geelong area, commenced in 1996 and is co-ordinated by the St. Laurence Community Services men's program. The purpose of this project is to study the program and the role played within it by the Barwon Health District Nurses, from an educational perspective. The way the program has developed, and the range of agencies that have contributed to it, will also be of particular interest. The theoretical foundations of the study will be drawn from adult and community education.

The role of the researcher will be based on structured observation. A tentative set of domains of observation will be developed and subsequently tested during initial visits for their capacity to provide an effective framework for observation and analysis. A similar framework will be developed to guide interviews and conversations with key people in the program, including participants. The researcher's main question will concern effective ways of delivering health education to men in such circumstances and settings. Initial conversations with the general manager of St. Laurence Family Services, indicated that he would provide a positive and supportive role in this project.

The qualitative study will provide an important component for the researcher's overall program concerning men's health education. Ethical approval will routinely be applied for from the University of Ballarat human ethics committee prior to commencing the project, following all necessary approvals from the external agencies involved in the study.

This study follows a natural progression from earlier studies conducted by the author on identifying and describing educational strategies used by health educators to assist men to access health care facilities and enhance their understanding of health issues. The purpose of this study was to investigate a unique group of men targeted because of their needs and circumstances quite different to those investigated previously. Education and needs (both physical and emotional) were addressed there in semi-structured and more formal settings. The current approach studied here, however, is based on trust and caring, offered in an unstructured, informal setting to tend to basic support needs. The participants in the current study are men who come from a disadvantaged background and who are marginalised and therefore vulnerable in today's society.

The first two projects were directed at men's health workshops conducted in a rural and urban setting respectively. This current project is investigating another aspect of men's health, namely in a drop-in centre for men who may have a disadvantaged background and where the educational approach is informal and non-structured. The drop-in centre is located in a large regional Victorian town. The centre has set hours, is open over three days a week and caters to men who attend on a voluntary basis. This third project examines an informal educational approach and compares it to the more formal approaches of the previous two studies using diverse strategies. These men would not attend a more formal health education workshop due to their circumstances.

Following on from studies conducted with men in semi-formal settings situated in both rural and urban areas, this study looks at men who attend a drop-in centre on a purely voluntary basis at no cost to them. The centre is staffed by support workers who either have qualifications in social work or volunteer their time to assist in the programs from a major community service organisation. These participating men come from various backgrounds, but most are disadvantaged and unemployed. The number attending varied depending on the day, but, on average, about 25 individuals participated.

Literature review

Before continuing, the term "community education" must be explained. From the literature, there have been many attempts to define this term with varying degrees of success. One of the most accurate definitions comes from Minzey and LeTarte (1973), who claim that:

> … community education is a philosophical concept which serves the entire community by providing for all of the educational needs of all of its community members. It uses the local school to serve as the catalyst for bringing community resources to bear on community problems in an effort to develop a positive sense of community, improve community living and develop the community process toward the end of self-actualization (p. 19).

In a sense, this definition highlights the importance of using what is already in the community for the betterment of others. The community needs to take ownership of both the programs it offers, then individuals need to have the opportunity of partaking in education and areas that will develop their potential. Maslow says self-actualisation:

> ...may be loosely described as the full use and exploitation of talents, capacities, potentialities …. such people seem to be fulfilling themselves and to be doing the best that they are capable of doing …. They are people who have developed or are developing to the full stature of which they are capable (Hockenbury & Hockenbury, 2000, p.310).

This need for self-actualisation, or achieving one's full potential, can only come about when the more basic physiological needs, such as food, shelter and warmth, have been met, as is demonstrated at this shelter. Hockenbury and Hockenbury (2000) states:

> Maslow believed that people are innately motivated to satisfy a progression of needs. Once the needs at a particular level are satisfied, the individual is motivated to satisfy the needs at the next level, steadily progressing upward. The ultimate goal is self-actualisation, the realisation of personal potential (p.309).

Education can only begin when an individual has achieved the more basic level of needs and has a positive self-concept. Scraggs (1985) puts it this way, 'if all the lower needs are gratified, the need for self-actualisation emerges' (p.277).

Until these needs are met, the motivation to learn will not be present, therefore an environment conducive to learning must be established. Case (1996) refers to this by saying:

> ...learning becomes relevant when it connects with and satisfies the needs and wants, or motivations, of the individual … not only do individuals differ from one another in their motives, but an individual's motives differ in time and circumstances, as some needs are met and other needs and priorities emerge (p.157).

Education in the community must relate to the needs of the men participating and not an agenda thought to be in the best interests from the organiser's perspective. Clark (in Allen, Bastiani, Martin and Richards, 1987) states:

> it is more appropriate to see community education as drawing on a range of educational approaches which can co-exist within the aim of enriching community life. Indeed, if communal maturity is a developmental process, different educational approaches will be necessary at different stages of the journey (p.64).

With regard to community health education, the primary goal in this community environment is primary prevention - strategies aimed at the prevention of disease or disability before it occurs. Kiger, (1995) states, 'influencing the patterns of health in given communities is achieved in a variety of ways, including environmental control, nutritional policy, immunisation, screening and health education' (p.7). Teaching men in a community setting acknowledges the fact that eradication of many chronic conditions can be achieved if approached early. There must be equal access to comprehensive health services. Rankin and Stallings, (1996) refer to this by saying:

> ...poor health habits, chronic illness and disability pose major challenges and cost communities in terms of lost work and school days, financing of health care and service agencies and unnecessary suffering; primary prevention is therefore considered the best way to preserve the health of any community (p.246).

Access to health services and education regarding the health of these disadvantaged men takes a higher priority when looking at the increased risks associated with this low socio-economic group. Hunter & Boyd (in Fincher and Saunders, 2001) state:

> ...there is a strong correlation between socio-economic status, income and health outcomes for other Australians. The high levels of risk factors, such as smoking, alcohol, sedentary behaviour and obesity, among low-income families appear to result in much higher rates of chronic illness than among more affluent Australians (p.152).

There is a high level of research evidence that highlights the fact that disadvantaged backgrounds lead to an increased incidence of stress and serious illnesses. The immune capacity diminishes when individuals lead a stressful life. These stressors can include financial insecurity, unemployment, domestic problems, malnutrition and unsafe neighbourhoods (Ambert, 1998).

The community organisation referred to here provides services to people who have complex or multiple needs, live in low-cost accommodation or are homeless or at risk of recurring homelessness. It also offers men limited access to emergency accommodation through a voucher scheme operating in conjunction with local hotels and caravan parks. In addition, the community service also offers general support and counselling services for issues of health, finance and addiction. Referrals to the community support program can only be made by a Centrelink office, following a special needs assessment.

To maintain the confidentiality of the men who attend the drop-in centre, any names that would identify the community service have been deleted from this report.

> The objectives of this community service are:
> 1. To carry on certain activities …. in the provision of care and services for the aged.
> 2. To work for the well-being and empowerment of people who are disadvantaged, including those who are poor, aged or infirm, and to enable those people to achieve their full potential.
> 3. To develop and maintain services which address contemporary social issue and needs in innovative and creative ways, to be an advocate for positive social change and to support the community to work together to find solutions to problems experienced by people who are disadvantaged.
> 4. To undertake, carry on or carry out any other charitable activity having a wider regional focus.
>
> (St. Laurence Annual Report 1996-7, p.7)

Sabo and Gordon (1995) state:

> ...there is little, if anything, we can do about the biological factors that influence longevity. We must, however, recognise that when an organism, plant or animal appears to be at biological risk, rational caregivers will attempt to create an environment that will nurture that organism and provide it the safest and most fertile climate in which to grow and flourish (p.63).

Methodology

Data was collected through participant-observations conducted over three days, as well as during previous shorter visits to meet with administrators. The researcher gained ethics approval and written confirmation of his involvement in the program from the co-ordinator of the organisation involved. Data was also collected by means of a questionnaire and separate interviews. In addition to participant-observation and a structured questionnaire for the men, an interview was conducted with the co-ordinator of the centre and the health nurse on separate occasions (see Note2). These consisted of open-ended questions that allowed for more informed responses, with every question answered in sequence.

The study was conducted in a major regional town in Victoria at a community health centre which served as a drop-in centre for men under the guidance of a large voluntary organisation. Because of space restraints, the drop-in centre operated at a leased site within a senior citizens' club less than a kilometre from the principal community centre. The methodology was principally a qualitative study using homogenous sampling - that is, selecting a particular group (disadvantaged men) from within a specific environment.

The ethical considerations of this study involved the use of informed consent procedures for the co-ordinator, participants and health practitioners following approval from the university's human research ethics committee. The researcher met with the co-ordinator of the drop-in centre and the manager of the community health service before the study commenced to explain the study and how it would be conducted. This was also an opportunity for the researcher to answer questions and address any concerns raised by the participating men involved in the study. Their response was positive and the structured questionnaire was deliberately objective, written in plain language and clearly non-threatening to the participants (See Note 3). Due to the purposeful sampling technique used, the questionnaire was structured so that questions were easily understood, did not contain any jargon or medical terminology and allowed space for any extended comments. The contents were checked by the co-ordinator of the centre before distribution.

The researcher visited the day centre on several occasions as an active participant. Participants were told that a questionnaire was to be distributed on a certain date. This was to be entirely voluntary and there was no obligation to complete it. As in previous studies, it is interesting to note that returns were greater when the respondents were known to the researcher before questionnaires were distributed. This may be an advantage of the participant-observer approach when dealing with qualitative research of this nature.

Results

Of the questionnaires distributed to the men there were 18 returned questionnaires, including one handed in that was blank. This was included in the data results - by not responding to the questionnaire, the individual concerned was still making a statement.

Table 1: Ages

25 - 30	31 – 35	36 – 40	41 – 45	46 – 50	51 – 55	56 – 60	60 – 65	65 +
2	2	3	1	2	3	0	3	1

The respondents were evenly spread across the age span from 25 to over 65, with no concentrated group in any area, although there was no representation in the 16-24 bracket. The majority (72%) of the respondents indicated that they found out about the drop-in centre from a friend. The remainder came from welfare agency referrals, drug volunteer work and one from an advertisement. Interestingly, the co-ordinator had said they did not advertise.

A principal purpose of this study was to find out why the men attended, as this is an important question in all the previous projects. Most indicated it was for company and as a social outlet (71%), while others said “just something to do”. One said he wanted treatment for his swollen leg. Another stated, “so I could have people around me”. That comment was typical of the replies and indicated the loneliness these men experienced.

Attendance at the centre was varied, with five attending one day a week, seven coming two days and four attending three days. One participant responded that he attended only rarely. The informal approach of the drop-in centre was perceived as a strength, with no expectation the men would attend. The respondents offered no insight into what they saw as the most important issues in men’s health. Two mentioned the heart, others stated happiness, getting together, emotional support, flu injections and poor nutrition. This correlated closely to their own perception of the situation they were experiencing and reflected their own needs.

From the educational perspective, the men indicated that the most important information they received from attending this centre was how to access community services and assistance with housing and finance. Three mentioned help with their health and stabilisation of their situations.

According to the returned questionnaires, the information they wanted was given to them through brochures (28%) and informal conversation (72%). These were the only means the men mentioned – a fact which confirmed the lack of any didactic teaching and the informality of the centre’s approach. Presentation of the information was considered the most effective way by 93% of the respondents.

The most important aspects of the drop-in centre, as far as the participants were concerned (with number of respondents indicated in brackets), were: a place with a relaxed atmosphere (five), acceptance from people involved (four) interaction with other men (four), food and drink (two) and community nurse input (one). Areas of health covered and information disseminated, according to them, were on diabetes, heart, hypertension, flu vaccinations, stroke and where to go for assessment.

There were only three responses to question 10, which asked the men to indicate one or two areas (if any) that you may consider changing in your lifestyle. Two stated housing and the third said that he seemed to be permanently unhappy with his life. The low response to this section may indicate that the men did not want to be transparent and that any indication for a change in their lifestyle may disclose a weakness within self.

Of the 16 responses to the question “will you recommend the centre to other men?”, fifteen answered in the affirmative and one said maybe, with none of the men saying no. When asked to explain their answer, the outstanding theme to come out of the answers was the fact that they enjoyed the company, could gain assistance with housing and health problems and that it was an accepting place with no formal links with a relaxed atmosphere. This theme was confirmed during the interview with the co-ordinator - that a major factor in men coming to the centre was a sense of belonging and having company.

Discussion

The men attend three times a week at a leased community hall with bathroom and kitchen facilities on Tuesday 9 am-2 pm, Thursday 9 am-12 midday and Friday from 9 am till 2.30 pm, with no attendance criteria and open to any male from any situation. The approach when setting up this centre was deliberately unstructured and informal, creating an accepting, non-judgmental and safe environment for participants. Staff in the community health centre recognised that there was a need in the area for men to have a place to go to. As the co-ordinator stated:

> ...men had nowhere to go during the day – not welcome at public areas, malls, shops, beach. There was nowhere they could call their own place.

Education programs involved at the day program for men is unstructured and informal and includes regular health input usually on a daily basis while the centre is opened from district nurses from the major health services, as well as a twice-yearly health check by medical practitioners.

Activities are generally decided by the men with minimal equipment available, but the centre provides a safe environment where men can gather and communicate with others from similar backgrounds. *The Age* newspaper is provided on these days and, in addition, the men bring along their own papers. Card games are often played, there is a small library of books that is available to the men, and morning tea and lunch are served to the men on these days. The co-ordinator at the centre, a social worker and trained counsellor, receives assistance from two other workers from the community service, volunteers trained in food handling who assist in preparing meals and volunteers who have a genuine interest in these men who interact with the participants. The meals consisted of healthy sandwiches served almost continually throughout the morning, soup and a variety of fruit. This in itself contributed enormously to the health of these men, whose dietary intake without this would be dubious It satisfied individuals' basic needs before they could move to the next level applying Maslow's hierarchy of needs. The co-ordinator recognised that the most important issue with these men was that there was poor nutrition and the men did not eat correctly – compounded, in many cases, by an alcohol problem.

This endorses the fact that health is very dependant on the environment that the individual is in. Davidson and Lloyd (2001) state:

> ...although individual determinants such as genetic and behavioural characteristics are important, the environment in which people live has a key influence on their health (p.36).

Health teaching for men can simply be presenting them with a well balanced nutritious assortment of food and ensuring they are distributed. Education in this context is based on the premise that the individual will learn when they are ready and there has to be an environment of trust and acceptance, with basic needs satisfied, before the individual can progress.

Health teaching was not overt and took the form of regular visits from the district nurse, who was available for any health questions and from the counsellors available

at the centre for emotional health. This was taken up by several of the men with the centre's men's program support worker, who is a qualified social worker/counsellor. Education took the form of learning life skills, adapting back into the community and learning to relate socially with other participants. The co-ordinator, talking about teaching methods utilised, stated that intensive initial support with what needs to be dealt with, followed up by ever-decreasing levels of support quickly with the individual and groups was best.

The rules at the centre are minimal but firmly enforced. No alcohol is permitted on the property and any aggression directed to any participant will not be tolerated. This may result in time out or a period of non-participation at the centre for the individual. This criteria appears to be easily accepted by the men and during the time of observation no incidents related to either criteria was apparent. The men knew each other and conversed easily with each other in small groups. Several of the men were smokers and this was allowed outside the building, where further conversations took place.

During the days that the centre was open, the district nurse from Barwon Health Services visited the centre and this is a way whereby health issues can be raised and also minor medical treatments carried out. At the time of the observation, one man was having his leg ulcer dressed and this venue was preferred, rather than at his place. The nurse was accepted by the men and was included in activities such as playing cards and sharing a meal. From this interaction came the opportunity to run an immunisation program with the men, which was successful, with the majority of men participating. When asked what the nurse thought were the main issues in men's health, the answer reflected the nature of the men attending this centre – "exposure, liver/alcohol problems and chest infections".

Attendance at the centre was not compulsory and the men were free to come and go as they wished. A record of who attended was kept in a diary of names only, with a line down the centre with visitors and those who were not regular at the centre being placed on the other side. This was an interesting observation as it kept the regular group as a self-entity. They recognised themselves as a separate group within the framework of the centre and the visitors as another group. The majority of men were unemployed, but there were tasks allocated at the centre. Recent renovations had been made at the centre which included showering facilities and bathroom. These were especially utilised for homeless men and available for the new men not familiar with the centre.

My arrival at the centre in a leased company car with racks, desiring to do observation and research, was a cause for concern by the researcher, who was worried about his being accepted by these men. However, this was unfounded, as the men were mostly friendly and approachable. In keeping with the informal relaxed approach, casual clothing was utilised by the researcher. When interviewing the district nurse, she mentioned that nurses to the centre dress formally so they can be recognised, adding, "we don't play those games of dressing as the group does for acceptance". Problems that seemed to arise from the men and from the returned questionnaires appeared to be depression, loneliness and boredom. The fact that they returned to the centre repeatedly and their responses confirmed this by stating that these feelings were the main reasons for attending the centre.

For this group of men, teaching on men's health in the traditional sense would have been ineffective as their needs had to be met from a lower level - shelter, food, warmth, companionship and safety. Once these needs were met, learning would take place with each individual at their own pace and when they were ready. To these men, the important focus was companionship, a sense of identity and the accessibility to information that would positively affect their health, such as housing and immunisation.

Many of these men, through talking to them, acknowledged the fact that they appreciated that there was a venue made available to them which was non-judgmental and allowed them to have access to health care, other male company from similar circumstances and education. Acceptance of each man, despite their different backgrounds, was extremely important for them to come back to the centre and to feel part of the group. The fact that they could come and go from the centre and faced no restrictions, apart from no alcohol and smoking only outside the building, reinforced the relaxed environment created where learning can take place without pressure and unrealistic expectations.

Outsiders were viewed initially with suspicion and the men indicated clearly that they wanted to know what new people were doing there if they were not using the facilities. It was helpful with these men to have the support of the co-ordinator for the researcher to be introduced to the men. One of the main attributes for teaching that the co-ordinator stated was acceptance of the men for who they were and their current circumstances. He suggested that men's health should be addressed in schools. This view is supported by Harrison and Dignan (1999), who say:

> ...this should begin at school, where boys can learn not only about their bodies, but also about the social aspects of taking responsibility for their own care and demanding equal status with women's health (p.12).

For men to come to the centre where learning takes place in an informal setting, the geographic position is important, especially for this group of men. This centre was centrally located and easily visible near a main road in close proximity to an important landmark. A community approach to men's health was important to these men, as health was measured in terms of safety, warmth, shelter and food, thus ensuring basic needs were met before moving to higher needs.

> The therapeutic value and the cost-effectiveness of looking at men's health issues in a group rather than on an individual basis is beginning to be realised: men can be helped to be supportive and open with each other (Davidson & Lloyd. 2001, p.128).

The informality is related closely to the educational approach adopted by the visiting district nurse, by informal conversations and questioning about health and health needs. The District nurse stated that many of the men did not know how to engage health services and this venue was an ideal opportunity to be able to collectively assess at-risk men. The accessibility to these men is greatly enhanced by this drop-in centre where, for homeless men, normally this would present overwhelming problems for health services.

Conclusion

From this project, the researcher has been able to find from the participants just how important a centre like this is. Although there are no signs of traditional teaching programs or resources, the opportunity for counselling, health education, for meeting with other men from similar backgrounds and for education takes place clearly in an informal setting. The recognition that learning and self-esteem can only take place after basic needs have been addressed was paramount to the approach with this drop-in centre.

The participating men were found to be astute, questioning and, above all, to have a healthy respect for the work of the centre and other peers, even though many had individual problems that were at various stages of being addressed. Education within this setting comes from an awareness of the environment in which the individual finds himself and information being accessible to the men in a way that is non-judgmental, appropriate and at their level of understanding.

Teaching for this selected group is very much dependent on the ancient saying, ‘the teacher arrives when the student is ready’. These men initially are suspicious of formal programs, any sign of patronising, and any trust has to be earned by the teacher, health professional or counsellor. Issues of safety and health are an important reason for many of these men attending the centre and are often the starting point for appropriate referrals and health access which otherwise would be denied or neglected.

Notes Project 3

1. Questionnaire

1. How did you find out about this centre?
Advertisement (1); Friend (13); Spouse (0); Other means (Welfare agency, drug volunteer work, community support work, phone book – welfare agency)

2. Why did you decide to attend?
For company; Food / cards; Basically because I have nowhere else to go; To find out what resources are available now for the social aspect; Lack of money for meals after paying rent now from the *Newstart* allowance – free lunch and coffee – meet new people; good fresh food – soup, sandwiches; Get my stockings on my legs because of swelling of leg; Something to do on occasions; Companionship, sandwiches and soup; For company and something to do and somewhere to go; To see what it was about; Companionship and learning to step out in a group; As a social outlet; Community support program; So I could have people around me.

3. How often do you attend?

1 day per week	2 days per week	3 days per week	rarely
5	7	4	1

4. What do you believe are the most important issues in men's health?
Heart – fitness; Not dying; To get the right advice with men's health; The fact that if he gets sick he has someone to talk to; Happiness – learning to talk to others Sharing, making friends with people in the same boat as myself; Getting out and meeting people over a cuppa – something to eat; Security / peace of mind; People need assurance that in the event of illness they have support systems in place; Attending to one's health – know what the symptoms mean; Their own health comes first – for your flu injections; Low morale, loneliness results of unemployment, separation; Substance abuse, poor nutrition; More resources are needed to bring services to a more equal level with women's-only health services; Heart.

4(b) Briefly state the most important information you have received from attending this centre that you were not aware of before.
Enjoy other company of folks; Housing; Housing information; The degree of care and concern expressed by people (men only) at all levels of society for the welfare of 'homeless' men; Cheap rentals, welfare services, jobs in local area, meeting new people, affordable rent through Salvation Army boarding house; My health from district nurse; Help with housing, food vouchers, help with Centrelink; How to access community services; That things like this is about for men to go to; They can help emotionally and financially, counselling, informal counselling; How many men in their middle forties to late fifties out of work; Help stabilise and maintain my health; Assistance for homeless men.

5. How was this information presented to you? For example, brochures, presentation, informal conversation, etc.

Brochures	presentation	informal conversation
5	0	11

6. Was the information presented in the most effective way that enabled you to understand?

Yes	No
14	1

7. From the following, place in box the order of importance the most important aspects of the centre that you find most valuable (area of most importance to the participants).

a) A place with a relaxed atmosphere……5
b) Acceptance from people involved……..4
c) Handout material……0
d) Interaction with other men……..4

e) Health information……..0
f) Community nurse input……...1
g) Food and drink……..2
h) Laundry and bathroom facilities……..0
i) Other (please name)…….0

8. (a) Which areas of health were you given information on?
Flu, heart and stroke; Flu vaccinations; Cold and flu; Where to go for physio and dental, etc. Subsidised medical; Nil; Colds and flu, chiropractic; Diabetes; Everything from something to nothing; Hypertension, podiatry; Staff have advised me on various problems and advised me where to go; Arteries and heart.

(b) List what topics you would like to know more about.
Bronchitis, asthma; Mental health; XXY syndrome; Legals / housing; Women.

9. Indicate one or two areas (if any) that you may consider changing in your lifestyle.
Housing (2); I seem to be permanently unhappy with my life

10. (a) Will you recommend the centre to other men?

Yes	No	Maybe
15	0	1

b) Briefly explain your answer
Friendliness, cooperation; It is a great outlet for men who do not socialize; Yes, I will, and have talked to others to come to the group; It's a good place; Quite often, I meet unemployed people on the street saying how hard it is to pay rent and food out of their dole. Here, they can have a yarn and a feed and keep out of trouble; I believe the centre is of benefit to a wide range of men; Depends on the person; I'd advise anybody who is in need of assistance in obtaining housing, food, etc., to come here; For company.

11. Any other comments regarding the centre?
It's great; Can be a little bit cliquey at times, but overall not bad, an improvement would only be possible with extra funding to a place that is not a shared tenancy, enabling the hours and days to be extended; Many of the attendees have been coming regularly since the centre opened about three and a half years ago; I have recently been released from prison and by coming to the men's group I have been referred to cheaper housing, work, Alcoholics Anonymous, as well as keeping myself out of trouble, it has helped me to stay on the right track for the first time in my life; Yes, it's close to town and public transport; Nice relaxed atmosphere; Great to get together with other guys.

2. Interview with District Nurse

1. What do you see as the main issues in men's health?

Drop-in centre , exposure, liver alcohol problems, chest infections.

2. Why don't Australian men seek health advice earlier?

'They find it difficult in engaging formal health services.'

3. What do you think is the main reason men come to your centre?

'It is somewhere with reasonable access, company, something to eat, can ask health or Centrelink questions. It is not an activity centre – just company, it's about connecting.'

4. What comparisons in health problems do you see between men living in the country and their urban counterparts?

'Let family down in rural areas, especially on farms. Employment prospects limited.'

5. What was it that convinced you to be involved in the centre?

‘Request for district nursing service to sit with target group – didn’t understand how to engage health services. Nurses dress formally so they can be recognised – don’t play those games of dressing as the group does for acceptance. Can boycott admissions in Accident and Emergency. Doctors come here on a regular basis.’

6. Can you isolate the essential factors that make the men’s group successful?

‘That they turn up – they engage. They get responses when needed. The group is more important than we are.’

7. What difficulties have you come across when setting up these programs?

‘Sort of sub-culture. That they perceive they are not surrounded by do-gooders.’

8. From your experience, what are the motivating factors for men to improve their health?

‘To value your life. People who have lived it tough are resilient.’

9. Who do you see as having the prime responsibility for changing men’s views in regard to their health and lifestyle in Australia?

‘Collective responsibilities, not just from one source.’

10. What do you consider to be the best teaching methods that you employ for men’s groups?

‘To know where the person is – no point in being self-righteous. Informal questioning about health. To let them know that a nurse is available.’

3. Interview questions for men’s health co-ordinator

1. What do you see as the main issues in men’s health?

‘Men have no car. Do a lot of walking – biggest health issue? Smoke too much drink and don’t eat correctly. Not enough nourishment – self medicate – self diagnose, and are reluctant to go to the doctor . Doctors who do come to the centre are surprised at how healthy they are. Twice a year – flu injections. Men walk up to three hours, 15-20 kms. Up at 6 a.m., one man with two dogs walks 35km one way. Knew he would get support, food and driven back. Homeless – a lot of men have psychiatric disorders, addictive behaviours, anti-social behaviours – isolation. Reluctance to seek medical attention.’

2. Why don’t Australian men seek health advice earlier?

‘Because they do all the above – self-medicate. Reluctance of doctors to treat these guys. Coordinator often rings doctors on behalf of the men.’

3. What do you think is the main reason men come to your centre?

Sense of belonging – regain some sort of social connectedness. Come here because they can be themselves – no one trying to impose anything on them. Acceptance of their diversity. To get decent food, soup, warmth. No smoking or alcohol in hall, no aggressive behaviour – a safe environment.

4. What comparisons in health problems do you see between men living in the country and their urban counterparts?

‘Urban men have more access, more choice, diversity.’

5. What was it that convinced you to run a men’s health program/drop-in centre?

‘Started men’s program. Men had nowhere to go during day – not welcome at public areas, malls, shops, beach. Nowhere they could call their own place.’

6. Can you isolate the essential factors that make the men’s group successful?

‘Acceptance of diversity - laid back approach. No major impositions – quite a few interventions when needed - high degree of support.’

7. What difficulties have you come across when setting up these programs?

‘Lack of resources. Lack of funds. People’s resistance to men gathering – women – senior citizen’s centre. Other people’s perceptions.’

8. From your experience, what are the motivating factors for men to improve their health?

‘Men want to stay alive longer. Men come to centre after family breakdown, no job, money – reached lowest point. Only way to go is back up. Lost lives, family, health (depression). What motivates them is that they can only go one way. Start to see a bit of glimmer and start to get their self-esteem back. Belong to something – acceptance. They have time and support to attend to problems –accommodation – follows on with health improvement – meet back with family. Dysfunctional family background not always all with husbands. Motivation.’

9. Who do you see as having the prime responsibility for changing men’s views in regard to their health and lifestyle?

‘Government – schools, community health centres, anti-male propaganda. Structural, individual – men have to be responsible for their own health.’

10. What do you consider to be the best teaching methods that you employ for men’s groups?

‘Intensive initial support with what needs to be dealt with, followed up by ever-decreasing level of support quickly – individual and groups. Acceptance.’

References Project 3

Allen, G., Bastiani, J., Martin, I., & Richards, K. (Eds.) (1987). *Community Education. An Agenda For Educational Reform.* Stony Stratford: Open University Press

Ambert, A. (1998). *The web of poverty. Pyschosocial perspectives*. Bingmanton NY: The Haworth Press.

St. Laurence Annual Report (1997). Community Services.

Case, B. (1996). Breathing AIR into adult learning. *Journal of Continuing Education in Nursing,* vol. 27, no. 4, pp.148-158.

Davidson, N. & Lloyd, T. (2001). *Promoting men's health. A guide for practitioners*. London: Harcourt Publishers Limited.

Fincher, R. & Saunders, P. (2001). *Creating unequal futures? Rethinking poverty, inequality and disadvantage.* Crows Nest, N.S.W.: Allen & Unwin.

Harrison, T. & Dignan, K. (1999). *Men’s health. An introduction for nurses and health professionals.* London: Churchill Livingstone.

Hockenbury, D. & Hockenbury, S. (2000). *Psychology* (2nd ed.). New York: Worth Publishers.

Kiger, A. (1995). *Teaching for health*. London: Churchill Livingstone.

Minzey, J. & LeTarte, C. (1973). *Community education: From program to process.* Michigan: Pendell Publishing Company.

Rankin, S. & Stallings, K. (1996). *Patient education. Issues, principles and practice* (3rd ed.). Philadelphia: Lippincott:

Sabo, D. & Gordon, D. (1995). *Men’s health and illness. Gender, power and the body*. Thousand Oaks: Sage Publications.

Scraggs, J. (1985). *Key ideas in personality theory*. St. Paul: West Publishing Company.

Appendix 4
Project 4
Developing successful educational approaches to men's health

Introduction

In the project work to this point, the emphasis has been on men's health education from the perspective of the men who actually take part in the programs. The purpose of this particular project is to research, collect data and reach conclusions about the most appropriate education strategies for these particular target groups of Australian men identified and serviced by the men's health co-ordinators.

This study follows on from three previous projects focusing on health education programs delivered to men from rural, urban and regional backgrounds which incorporated both physical and psychological aspects of men's health. The rich diversity of these separate projects has uncovered a wide range of expectation and delivery formats, together with a common set of needs and an overlap area which will be discussed later. The three main themes inherent within these projects have centred on physical approaches (incorporating health parameters such as blood pressure, cholesterol levels, body mass), mental and emotional wellbeing and meeting the needs of men from a marginalised background. Health cannot be fragmented into merely one area, but an attempt had been made to look at this holistically.

The health needs of men cover many different areas. The fact that one workshop concentrated on the physical boundaries of health needed to be counterbalanced with a men's health workshop which looked at the mental and emotional needs that men experience. All three studies have focused on searching out common factors concerned with attracting and maintaining men from different backgrounds in these programs changing attitudes to health, and reinforcing healthy lifestyles. N.S.W. Health (1999) alluded to this by saying that it was no longer acceptable to define men's health purely through diseases specific to men, such as prostate cancer or testicular cancer, but rather incorporating at least three strands. These included physical conditions such as those just mentioned, but also took in areas of particular morbidity or mortality for men such as injury and HIV/AIDS. The third strand covered the impact on men's health behaviour of such social factors as relationship breakdown, work stress and unemployment.

This final project extends the previous three and is concerned with focusing on the co-ordinators of such programs. It seeks to represent and interpret their experiences and knowledge of health education programs targeting men. The problem is that men, in general, fail to pay attention to their health and this fourth project attempts to unearth principles of marketing courses and teaching strategies that could help to address the situation. Co-ordinators represent an opportunity to sift through the programs' commonalities to identify a strategy that will achieve successful educational policies directed towards improving the health and well-being of men. The main focus of this project will be identifying factors necessary for running a successful educational health program for men, incorporating both (1) ways of attracting men and (2) teaching strategies within a curriculum best suited to Australian men, framed around understandings of Australian masculinity and its relationship to health. The structure

of the research and eventual information gained from this project will test the researcher's speculative findings from previous projects, plus the literature review, against the experiences of community health practitioners.

Literature Review

It is well understood (and literature supports this) that men are negligent with their health and are risk-takers, which means they experience higher morbidity and suffer greater rates of injury and most illnesses (Laws, 1998; Davidson & Lloyd, 2001; Australian Institute of Health and Welfare 1998). Only in relatively recent times has there been an awakening to the discrepancies between men's morbidity and mortality rates compared with those of women and the scant attention generally paid by Australian men to their own health and well-being. The Commonwealth Department of Community Services produced a draft National Men's Health Policy in 1996 based mainly on the recommendations from the first National Men's Health Conference in 1995 (Gibson & Denner, 2000). The fact that such an event was not even held until 1995 is testament to the fact that this awakening is only very recent. This is supported by Gibson and Denner (2000) when they say:

> ...despite the efforts of the health care industry to raise men's awareness and participation in attending to their own needs, men continue to be very poor consumers of health care services. Also, men are still at a higher risk of dying and becoming disabled at an early age than their age-matched female counterparts (p.1).

The implication from this, and from the earlier literature review, is that men appear to be reactive to their health or symptoms rather than proactive (Davidson & Lloyd, 2001, Buckley & Lower, 2002). In other words, men tend to delay a visit to their doctor or health service until the signs or symptoms of their affliction are such that they cannot be ignored or excused. Chest pain, for instance, is often dismissed as merely a case of slight indigestion. The result is that, if men are not proactive with their health, the best medical intervention is of no use when applied too late. If help had been sought earlier, medical intervention could have made a difference and an exacerbation of the condition could have been avoided. When men do visit their medical practitioner, there is the added problem of poor communication skills between two males who are not familiar with each other. Worse still, they are talking about subjects males rarely embark upon and only one of the participants is in an environment that is familiar.

The problem with this superficial type of male communication within the health industry is that once the diagnosis has been made, it can extend to the discharge planning and follow-up care of men in their own home environments. One personal anecdote in the professional life of the author seems to highlight this point and emphasises the lack of attention paid by men when talking about their health and life situations to a male medical practitioner. Assumptions are often made and the intricacies of a person's lifestyle are often not pursued.

> *Barry was admitted to hospital suffering chest pain which he experienced at work. After several days in a cardiac ward undergoing tests and responding to treatment, Barry was discharged to go home with medication for his condition. Three days later, he returned to the ward after coming into Accident and Emergency with a further*

> *myocardial infarction. When asked what he was doing when the chest pain began, he said that he was only doing what the doctor had told him to do – to go walking around the back of his property. Prior to his initial discharge, he had a talk with the cardiologist, who said he could exercise slowly and walk around his yard.*

The communication between the two men was insufficient to explain the dimensions of the situation. The "yard", for Barry, was below a small chalet-style house situated on the side of a large hill with panoramic views. His "yard" was a steep drop down into a gorge which required a considerable amount of energy to traverse. It was on one of these walks to the bottom of his yard and consequent return journey that Barry's chest pains returned and an ambulance had to be called.

This example highlights several factors related to men's communication and their understanding of health issues. During the discharge education talk, the cardiologist failed to clarify from Barry the particular home environment to which Barry was returning. The information the cardiologist offered was standardised and lacking in individual attention. From Barry's side, a common failure of men when involved in talks between specialists and patients is that they often appear mesmerised when the specialist is talking. This can be due to the fact that such discussions often take place in a foreign environment, the way they perceive the elevated status of the specialist and the stressors of the medical condition itself. This often results in communication being in one direction only and stilted. Barry failed to ask appropriate questions in relation to his condition and failed to tell his doctor anything relevant about his home environment.

Both parties were at fault in this example, but the scenario would be (and is) played out many times in the health industry. One of the reasons for less time being spent on patient education is the utilisation of diagnostic-related groups (DRG's). This system provides funding to hospitals dependent on the diagnosis and the number of days the patient is expected to be admitted. This has resulted in shorter hospital stays. Rankin and Stallings (1996) state:

> ...although shortened hospitalisations may save health care costs, certain client populations are at risk for poor outcomes related to patient education … others, such as patients after myocardial infarction, may be too anxious to understand discharge and other educational instructions (p.310).

If the education is going to be meaningful and transparent, this is an area in health that requires specific knowledge of the backgrounds of the men being targeted and their knowledge base on key health issues. Communication amongst men, especially related to health matters, is not as forthcoming as it is with women. Earle (in Laws, 1998) states:

> ...women in general have a social and language competence advantage in talking with male or female health professionals. Many males are not so open with female or male professionals (p.105).

This brings into the argument questions about masculinity and the relationship this gender expression has to men's physical and mental well-being. One aspect of this disparity between the sexes is the separateness that can develop between men's and

women's health and the consequent jostling for funding. The ensuing competition for cash can alienate health workers on both sides. Whitehead (2002) states:

> ...it does this by polarising this debate into one of competition for health resources between women and men, while also inflaming the "moral panic" and ensuing backlash against feminism and women's issues generally (p.53).

The women's movement has been able to successfully raise awareness of women's and children's health and, more importantly, gain funding for clinics and health screenings (Palmer and Short, 1995). Following on from that movement's success in funding and support for women's health, it had been assumed that men's health, once recognised as a field with its own particular needs, would follow in the same direction. Men have not taken to the streets, nor have they voiced their dissatisfaction to the Government through political lobbying. It has therefore been assumed either that there is not a problem or that men do not want to change anyway (Davidson and Lloyd, 2001). From a funding and political point of view, it may have been seen as a more attractive way to gain votes to fund women's health and support centres, whereas the same thing could not be said for men.

Women apparently place more importance on their own health issues than do their male counterparts. In some ways, the rise and success of the women's health movement has helped to feminise the concept of health and further alienate the Australian male from his rightful place within the framework of health care. This has marginalised men, who are reluctant to make use of a health service they see as female-focused. The rise of the feminist movement has not been kind to men's self-esteem. Johnson (1997) dares to enter the fray by saying that:

> ...in the last 20 years, men have been urged to find their souls by exploring their feminine psyche and what a pathetic figure has been thrown up – soft, vulnerable, malleable, indecisive, easily intimidated and lacking in energy and initiative (p.48).

Literature supports the idea that men visit their general practitioners less than their female counterparts (Gray, 2005, Davidson & Lloyd, 2001, Harrison & Dignan, 1999). It points to a number of planks in the platform on which the male Australian psyche is based, including masculinity, male perceptions of visiting the doctor, environment, access times, cost and the style of male communication. Masculinity can be seen to be a potent barrier to men's health and how men service their bodies. Whitehead (2002) says:

> ...deteriorating health can weaken men's association with dominant codes of masculinity, while robust health speaks of men's potency and mastery of situations. Similarly, men's expression of masculinity can have a direct influence on and correspondence with their health, ability to recover from illness and, indeed, incidence of illness (p.202).

It can be concluded from this that masculinity can be a risk factor in itself for male health and men's participation in visiting their health providers and community health programs. Buckley and Lower (2002) support this when they say that:

> ...barriers to accessing services included age, long working hours, the requirements of seasonal work, discomfort in the waiting room environment, privacy issues centring on others not knowing they have visited a service and a fear of knowing their true health status (p.12).

From the literature, it could be assumed that women view health issues more seriously than men, and so place more importance on accessing their general practitioner (G.P.) and women's health programs. In the BEACH report (Bettering the Evaluation and Care of Health, 2003), a joint discussion paper by the University of Sydney and the Australian Institute of Health and Welfare, Bayram, Britt, Kelly and Valenti (2003) state:

> ...data from the Health Insurance Commission demonstrated that a lower proportion of Australian males (76%) attended a GP at least once in 2000-01 compared with Australian females (87%). When males did attend a GP, they did so at lower rates (average 5.1 services per annum) than females (6.2 services). These differences between the sexes were most significant between the ages of 15 and 54 years and over 75 years (p.14).

From these figures, it appears that during childhood and early adolescence, the male is equally represented at health care services, having appointments made for him by his guardian, usually the mother. From the age of 15, these attendance figures for males fall away. The assumption here is that as soon as the male is independent, and cultural and peer pressures start to have an impact on him, the stoicism, denial and masculinity characteristics of the male emerge. This has to be one of the major hurdles for health promoters when planning and recruiting for a men's health workshop. How to overcome this cavalier and denying attitude of many males towards their health and the question of masculinity has to be addressed within the workshop. Lee and Owens (2002) state:

> socio-cultural forces encourage men to engage in stereotypical masculine behaviour in order to differentiate themselves as much as possible from women and the resources which men and boys use to enact gender are largely unhealthy (p.13).

As explored earlier in the literature review - (Barton, 2000; N.S.W. Health, 1999; Buckley & Lower, 2002) - masculinity and the Australian culture are very much involved with this reticence on the part of men to embrace and seek a healthy lifestyle. The result is seen in poor health service utilisation, especially of community resources. There has been a blurring of roles and a questioning of masculinity, with the rise of feminism giving birth to a new type of woman. Petersen (1998) states:

> ...the men who were most threatened by these changes made a concerted effort to resist the "feminisation of culture" that was seen to undermine both the traditional family movement and established identities (p.20).

The way men perceive themselves and their role in society is at times non-congruent and confused and this can manifest itself in the areas of health risk behaviour and retarded health-seeking behaviour. Whitehead (2002) refers to these changes by saying that:

> ...all men, in some form or another, have had to, or will have to, consider their relationship to the questions, criticisms and demands of feminists. But not only of those women who call themselves feminists. For the discourse of women's rights has extended beyond feminist scholarship and is now present, to some degree, in virtually every aspect of the social network (p.64).

This question of masculinity is at the core of the problem of men denying themselves access to health services. The Australian Institute of Health and Welfare (1998) stated that:

> GP consultations are much less common among males than females, with males visiting their GPs 26% less often than females in 1995-96. This difference in GP consultation rates between the two sexes becomes progressively wider with rurality and remoteness. Males in capital cities visit the GP 24% less often than female counterparts and males in "other remote areas" visit the GP 35% less often than females (p.48)

One of the respondents in this project, who is a GP stated that:

> ...men present when there is a dysfunction in their life. They will present to me in my role as general practitioner when they are no longer capable of working or they are in pain, so any particular incident is often related to late presentation, secondary to loss of function. There are always those on the other side of the coin who present earlier, but they are in the minority in relation to women.

Gibson and Denner (2000), from the Centre for Advancement of Men's Health and Centre of Research for the Advancement of Rural Health, said:

> ...men were simply asked whether they were more likely to see a GP after attending the men's health night. On average, 64% of the men indicated that they were more likely to see a GP as a result of the information session, while 31% were not (p.23).

From the perspective of one of the GP's questioned in the project, this is very difficult to prove in practice. This doctor said a male would only rarely admit that it was a health workshop that had prompted him to make the appointment. That may have been the trigger, but the man did not divulge this to the GP Of the male patients he saw, this medico could not be sure of the role the intervention had played. Despite this, earlier feedback from the participants indicated that, following the health workshop, men were more inclined to visit their general practitioner sooner or to have a health check.

This is an important outcome from delivering men's health workshops and one which needs to be recognised when applying for funding for these community projects. It can thus be argued that unless men are made aware of health matters, they will do little to correct damaging health behaviour or seek health assessment. Even in the rural community, away from mainstream health clinics, the concept of men attending community health centres is alien to most Australian males. They see these centres as addressing the needs of women, children and families. They're not for men (Gibson and Denner, 2000). For the mainstream Australian male, men's health education workshops have clearly missed the mark and have attracted only the bare periphery. It could be argued looking at that from the statistics of men attending these workshops

as detailed in the Men's Health report by Gibson and Denner (2000) – that these are the men who do care for their health and prefer to be informed. They stand in contrast to the vast majority of risk-taking younger men who most need the education and are ignorant of their plight. The challenge for health education is targeting men across all financial and age levels to firstly recognise and understand, then to utilise the services that exist in the community which are funded to provide a health service for them. The prime motivating factor should be to develop programs based on adult male learning styles.

The spur for men to seek out health services and be self-motivated to care for their own bodies has to come from health education which is specific and relevant to their personal needs. Only then will men be encouraged to utilise the health services that exist. To encourage this, the health education profession has used various learning theories that take into account the variables that influence behaviour. One of the earliest health-related learning theories used the health belief model (Redman, 2001), based on the belief that health-related behaviour is determined by the individual only if they recognise they have a problem, then consider this problem serious enough to warrant action. Bensley and Brookins-Fisher (2003) state that:

> ...it means health educators should take into consideration individuals' perceptions that they are vulnerable to illness that threatens their health and the actions on the part of individuals that could prevent the threat and eliminate possible illness (p.7).

This may explain the earlier observation in Project 1 that the participants attending men's education sessions were all in the over-40s age bracket. That's where vulnerability to life is becoming more relevant and where men start to understand that they are susceptible to illness and injury and not immune to it.

Another health education theory is the stages of change model, based on the assumption that individuals are at varying levels of readiness in terms of changing their behaviour. This has ramifications when delivering a health education curriculum, as the recipients (men) are all at different levels of readiness and this fact has to be accepted. Co-ordinators may need to be flexible in their delivery and timing.

There are infrastructures in communities which can be platforms for delivering programs that can encourage men, through educational opportunities, to participate. One co-ordinator used a session run by the community health centre on post natal depression in women to involve the partners/husbands in a separate session looking at this subject. From this small beginning, other topics emerged and further sessions were conducted for the men. There needs to be a shift in thinking in men's concepts of health education as merely for women and children, as well as the role played out by health providers – a role which has been soundly feminised. Health services need to take the challenge to men, to be more informed about their health, and education from early school years is the vehicle for this to occur. Burns (2002) states that:

> ...while there is a need for additional funding for Adult Community Education (ACE) providers, it is now appropriate to place more emphasis on the demand side. This means identifying and attending to conditions that alert, encourage and support adults to take up learning and those that enable them to make sound choices about what they learn and how. Generally, the typical ACE customer is

> generally better off, well educated, predominantly female, more likely to be employed, but not in the lower skilled occupations (p106).

This raises the question of equity and why these community programs are not universal across all the social milieu. Why they are predominantly taken up by this middle-upper social class? This may have something to do with costs involved in being a part of these programs (if there is a cost). It can also be observed from the above statement that those who most need these services are not included, as it has been established that those in poorer socio-economic backgrounds have more health problems (Australian Institute of Health and Welfare, 2004). The problem could be related to costs and the financial commitment to undertake such programs, or the perception that these classes will only interest the higher income individual, predominantly female. Bunton and Macdonald (2002) refer to this by saying that:

> ...a further key principle of health promotion, and one that relates directly to participation, is that of equity. It means that educational institutions need to value diversity and widen opportunity and participation, so that all students from all sectors of the community and with all levels of ability can achieve their potential. In an educational context, this often requires a major realignment from the traditional approach of competition and elitism (p.116).

One of the respondents took an alternative view by saying:

> ...there's a whole population of men out there who want a service, other than those forced to come in because of child protection or directed because of the system. I think it's really important for us that services are that broad.

Another one stated in support:

> still a major hurdle, men seem to think of them as places for women or disadvantaged men, (so) it's not accepted.

For workshops or consultations with men to be successful, or have the desired outcome, it is important to look at the role of a teacher or co-ordinator. We need to keep in mind our understanding of how men define themselves in relationships dominated by feminist views. Teachers, on the other hand, must consider how they can influence learning and life-changing behaviour amongst men. Long (2002) says:

> ...the critical role of the teacher is associated with the selection of content, arrangement of the physical environment and the initiation and direction of interaction with the learning community and the individual student. In addition, the teacher represents the organisation in the teaching-learning exchange and is the one who helps to interpret cultural influences from the greater culture (beyond the classroom) (p.14).

Physical health needs to be the basis of such programs, but teachers should not be limited to this one dimension.

Men have other needs that are associated with physical health, such as self-concept, and these can be explored in subsequent groups. In Project 1, it was mentioned by the co-ordinator involved that there was no input regarding the mental health needs of men in his workshops. Davidson and Lloyd (2001) state that:

> ...once in the groups, men readily look at other topics - for example, confidence-building, personal awareness, sexuality – but if the group had been set up specifically to look at confidence building, for example, then hardly anyone would have turned up (p.129).

One co-ordinator stated:

> ...the way I like to base something in a session is I like men to tell me what they know first to fill the gaps and often I can dispel any myths they might have.

Not assuming what men need to know is important when planning health education workshops to allow for flexibility within the structure. Lee and Owens (2002) refer to this by saying:

> ...men's health is better understood as arising from choices made within a complex interacting pattern of beneficial and damaging experiences, opportunities, and expectations that can be understood only in their social, cultural and political context (p.117).

This essentially means that any co-ordinator of men's health workshops requires sensitivity to the needs of the participants and should not be driven by personal interests. He must keep in mind that men have physical, emotional and spiritual needs. One workshop cannot be a plethora of information to satisfy all these areas, but acknowledgment has to be given to the importance of the total health of the individual.

One of the aims of this study is to find out from the co-ordinators just what presentation techniques best serve their clientele - and this will differ according to the target audience. The true measure of a good facilitator is his ability to assess the audience and to be flexible in his delivery, according to the learning needs of the men. These needs may be related to physical health, emotional health or dealing with masculinity issues incorporated in both. Bensley and Brookins-Fisher (2003), state that:

> ...it is important to recognise that there are many ways to address the targeted content and achieve objectives. Sometimes, educators are presented with learners or audiences who are not responding to one or more of the chosen presentation methods. By being flexible and having alternative methods readily available that match the learning objective, the educator will be able to quickly replace the original method with an alternative (p.142).

These methods may include lecture or discussion, small group work, group discussion, video, simulation, demonstration, games, skill practice or problem-solving. Knowledge of adult learning patterns to allow men to know more about themselves and their masculinity should be a key factor for co-ordinators when conducting workshops. The participants in this research all have an investment in this role and, collectively, clear guidelines and recommendations can be formulated.

The fact that the target audience is made up of adult learners has an enormous influence on the style of teaching and is made up of the ability of the facilitator to use the life experiences and expertise the learner has already accrued. It is the

responsibility of the co-ordinator to harness those experiences and, in a group environment, provide new knowledge and support that can have an impact on the health-seeking behaviour and lifestyle of the participants. Taylor, Marienau and Fiddler (2000) refer to this by saying that:

> ...learning from experience can help individuals understand that they construct knowledge. As a result, they are able to respond with increasing awareness to the complexities of adult lives, such as conflicts between their values and their current life choices (p.23).

The source of the learning is not only the co-ordinator, but also the peer group and the individual, where learning can come from airing real problems and working through them in an atmosphere of trust and acceptance. Dilworth and Willis (2003) say:

> ...there is the aspect of mutual collaboration. It is the synergy of the group members, fed by dialogue that promotes learning. There is, too, the self-dialogue through the process of critical reflection that leads to personal growth (p.11).

Fruitful education in the field of men's health is best served by, and needs to come through, a humanistic approach, where the belief is that individuals are free to choose their own direction. Men do not respond well to being lectured. They need to discover things for themselves, through a process of self-determination, before any change in lifestyle can occur. Hinchliff (1999) summarises the main feature of the humanistic approach, or non-directive teaching model, as individuals having a natural inclination to learn, that learning can be maximised by using experience and that self-evaluation encourages independence and creativity. This non-directive teaching model is based on the work of Carl Rogers and other advocates of non-directive counselling. Within this teaching model, the teacher takes on the role of facilitator. He believes that positive human relationships enable people to grow, is non-judgmental and uses reflective comments to raise the participants' consciousness of their own perceptions and feelings (Joyce and Weil, 1986). The non-directive teaching model, as explained by Joyce and Weil, recognises that students do not necessarily need to change, but defines the teacher's goal as helping them understand their own needs and values so that they can effectively have control over their own educational decisions.

This has tremendous ramifications in the area of men's health, as the learning and understanding has to be student-centred if there is going to be a deliberate individual change in health lifestyle, which will not materialise in a didactic environment. These men's health workshops aim to produce an awareness of health issues and, if necessary, seek to bring about a change of behaviour and activity based on informed decisions. Behaviour modification and learning theories such as the non-directive teaching model have been widely applied to physical activity behaviour change. They recognise that when people need to develop a new complex behaviour, that change has to start with small steps and gradually increase. An example of this could be the case of the person who smokes 40 cigarettes a day and who is then expected to stop completely. This is unrealistic and education needs to reflect this. An adult learner who is challenged to change his lifestyle or behaviour usually weighs up the benefits against the negatives. The smoker in the example just quoted may see the benefits of his habit as relieving stress, the body craving the nicotine, something to do with their hands, or they may still see it as a social outlet. These may be barriers for that individual to change his behaviour.

These perceived benefits have to be weighed up against the advantages of not smoking, such as financial savings, better lung function, decreased risk of cancer and lower blood pressure, among others. Some of these advantages may not be known to the participant. That's why the realities of smoking need to be included in the learning package - not as scare tactics, but rather to allow the individual to make an informed choice. Marcus and Forsyth (2003) refer to the decision-making theory by stating that:

> ...a person's weighing of the possible gains versus the difficulties or losses that will be experienced as a result of behaviour change is often referred to as decisional balance (p.30).

For men in today's society, change is inevitable - their only choice is how they will react to that change. As they age, their body changes. However, many men ignore any warning signs and continue to engage in health behaviour that is antagonistic to their health. What health workshops can do is to highlight those changes occurring in the body and therefore make it easier for men to decide to react in a manner that will be conducive to a healthy outcome, whether that be in dietary changes, cessation of smoking or seeking a health check.

Men's health nights were first held in rural towns across central Victoria in 1996. The format was always the same, with presentations by local medical practitioners and well-known sports personalities. They were always held in a male-friendly environment, such as a hotel, football or rugby club (Davidson and Lloyd, 2001). This initial reliance on doctors and high-profile sportspeople to influence the health behaviour of men now needs to be widened to include a more representative view of health from people such as nurses, community health workers and allied health workers. Laws (1998) says:

> ...in some areas, where there are no male health workers to run programs, female leaders have taken on the role and initiated programs in a very competent way, thus continuing the drive for male-specific care (p.78).

With men's health suffering from such a low profile in the public arena and a dearth of literature on this topic compared with that available on women's health, the question arises as to why these co-ordinators have focused on this area. What experiences highlight the position of men's health in Australia? To be involved in this area, one would presume the person would have access to the health industry, either from hospital involvement or a role in community health. Six of the seven respondents were employed in the health industry. One of the participants recognised the importance of this area when working in intensive care units: he realised that the majority of beds were "filled with men suffering major diseases." This man's experience supported the literature - men do not take responsibility for their health.

A study conducted in 1998 by James Cook University titled 'An exploratory study into selective health protective behaviours of rural and urban men in north and north west Queensland' (Jones, J.) sampled 630 men. That study found that few men took precautions against sun damage to their bodies and few took any precautions against noise. It was found that most men had a multi-faceted understanding of health, but this was not reflected in their lifestyle behaviours. Jones (2000) said that:

> ...good health was valued by nearly all, but it was of immediate concern to only a few. Good health behaviours are unlikely to be chosen ahead of other competing behaviours and no significant associations were found between priority of health and behaviour (p.23).

Any men's health program undertaken needs to be evaluated by the participants and recommendations made. Evaluation is an essential component which many educators fail to do (Bensley and Brooker-Fisher, 2003). Participants may enjoy the experience, but that does not mean they have learnt from the workshop or changed their attitude. In the situation detailed in Project 1, the co-ordinator did both a pre-test and post-test of standard health questions regarding simple anatomy and physiology and general knowledge questions regarding some common medical ailments, to check whether learning and greater understanding had taken place. Many programs in this area are government-funded and need to be accountable, with full reporting of the type of course, participant numbers and expected outcomes.

The evaluation stage can take many forms, both formal and informal. These can involve asking students what they thought of the workshop over coffee in a relaxed atmosphere at times when the co-ordinator does mix with the participants. If the preference is for a written evaluation form, this needs to be given out at the completion or near-completion of the workshop. Participants need to be aware that this will be occurring and at what stage of the sessions. The terminology has to be at an appropriate level for the target audience, it needs to be specific and questions designed to avoid being skewed towards either a positive or negative response, but rather objective and non-judgmental. Short-term evaluation of these courses in men's health is fairly standard practice, but long-term impact studies are more difficult. Laws (1998) states that:

> ...evaluation that demonstrates health outcome benefits for the participants is difficult to implement with short-term funding and limited resources. Impact and outcome evaluation which demonstrates positive benefits for participants has the potential to increase funding for men's health initiatives and should be attempted as a priority (1998, p.82).

For the co-ordinator of these workshops, an assessment is essential for continual improvement and to ensure that the program is meeting the needs of participants. Hillier (2002) says, 'we need to evaluate to satisfy ourselves that we are enabling people to learn. We want to identify ways to improve this. We also need to evaluate because our activities are funded and supported by a variety of bodies – public, private and voluntary – all requiring evidence that their objectives are being met' (p.230). Evaluation is often thought of as an end-stage process, something that is reflective of the teaching after the event. Long (2002) refers to this by saying:

> ...in the proper context for teaching, evaluation is continuous. In the best context, both teacher and student are continuously engaged in evaluating the learning; the teacher is also evaluating and teaching (p.24).

These men's health workshops walk a fine line between merely providing a social outlet where men can gather, with health merely as a side serve, and their true function of equipping men with the choices available for their health issues. The hope is that men will get to know the resources available within their communities and

make informed choices for their own benefit and well-being. Part of the evaluation process is to find a balance for these gatherings of men so long-term benefits can be gained. They are never meant to be merely a superficial transient health focus or a passing fad.

Research Design

This research has been designed to target the health promotion co-ordinators who work with men in their communities. It seeks to reveal what they see as the main areas of concern in men's health and to lay down the most appropriate ways to promote changes in health behaviours, in terms of both marketing and teaching strategies. The research will centre on interviews of key personnel working in the area of men's health following a semi-structured questionnaire.

Participants

Seven co-ordinators in the field of men's health, coming from both regional Victoria and Melbourne, were approached to take part in this final project. This number of participants was appropriate for an individual researcher in this type of study as the number of people who choose to specialise in men's health is very small. Seven is also a sufficient number to be able to elicit appropriate data for analysis. The co-ordinators involved also represent a broad spectrum of the health industry. The criteria for inclusion in the men's health field for the purpose of this study specified that the individual be a health care professional employed in the area of health maintenance, diagnosis and counselling. Respondents needed a focus on and current experience with men's health, either on an individual basis or with groups. This process incorporated homogenous sampling, selecting a particular group of leaders so that their common experience could be examined in depth. These people are recognised leaders through research, publications and community involvement in their field and were almost certain to be able to offer information from their experiences that would lead to the formulation of recommendations for delivering health education programs.

The methodology for this project was a descriptive research approach using a structured interview technique developed from the findings of previous studies undertaken by the researcher. It is designed to describe what occurs in practice and to discover new information. The participants were asked whether the interview could be recorded and, when consent was given, information from this source consolidated the researcher's notes. The writing up took the form of thematic analysis, incorporating the need to seek meaning. The available data was interpreted in terms of how accessible the workshops proved for men involved and what teaching strategies were used. This only took place after ethical approval had been granted by the university and after the participants had signed an informed consent to participate. Questions were designed to address the issues involved with educating men about their health. They had to be relevant for the individual and should not state the obvious, hopefully resulting in answers that were not assumed beforehand. The early direction of the questions was meant to encourage the participants to offer a more discursive account of the experiences that had impacted on their work. These questions, it was hoped, would draw out some rich stories and lessons from the respondents' own experiences

and allow them to freely share their opinions and views in a relaxed and accepting environment.

The opening questions were designed to focus on an event or case from their professional experience in men's health that would be personal and would illustrate common characteristics of the men involved. "Could you tell me about an incident(s) from your experience that highlights the position of men's health in Australia. How have you embedded these experiences into the framework of your program?" The aim is to elicit reasons why these co-ordinators entered the field of men's health by the range of their earlier experiences and whether there were any common factors among them. 'We come to know what has happened partly in terms of what others reveal as their experience' (Denzin and Lincoln, 2000, p.442).

The methodology for this project was shaped by the need to seek out specific people involved in the formulation and co-ordination of men's health workshops. This necessitated a semi-structured questionnaire which could be fleshed out in face–to–face interviews with the seven respondents. Personal meetings with every participant were preferred over a mail-out random representative sample, as this allowed the researcher to ensure that the questionnaire would be answered fully and correctly. Another advantage of personal interviews is the opportunity to clarify any questions from the participant and to expand on any particular area the respondent feels to be important. As Minichiello, Sullivan, Greenwood and Axford (1999) state, 'these methods provide the opportunity for the interviewer to follow up the response and to seek either clarification or elaboration' (p.369).

The interview records allow the researcher to analyse the views presented and identify emerging themes and underlying ideas. This is an example of thematic analysis, which comes under the umbrella of qualitative content analysis. To discover which strategies worked and which didn't requires an analysis of the text gathered through the interviews, as well as reflection on the ideas and opinions garnered in the face-to-face meetings. Knight (2002) supports this by stating:

> Face-to-face work offers the chance to change the direction of a whole inquiry to accommodate new insights, comments made by participants, prompts or patter that turn out to work well. They can also jettison things that aren't working (p.50).

The latest trend in interview techniques has been to move away from tight structures that lock the interviewer into a closely controlled set of questions. The interviewer is seen as an important instrument in this revised approach and he can elicit more information than would be produced by a standard questionnaire. Denzin and Lincoln (2000) state that:

> ...interviewers are increasingly seen as active participants in interactions with respondents and interviews are seen as negotiated accomplishments of both interviewers and respondents that are shaped by the contexts and situations in which they take place (p.663).

All the interviews, apart from one, which was conducted by phone, took place at the respondent's workplace or home at a time suitable for the participant and one which minimised distractions. The researcher felt that the familiar environment of the participant's own workplace helped maintain a relaxed atmosphere and demonstrated

the interviewer's interest in the views of the participant. All the interviews were recorded, as well as field notes and this enabled the researcher to review the transcript developed from the tapes prior to analysis.

Findings

After reviewing the transcripts, several common themes emerged. An overall perception was that men across all walks of life displayed a general apathy to, or ignorance of, their health until it became an issue, it threatened their lives or dented their masculinity. This does not mean that men don't want to learn; rather, the opportunities to learn about men's health have not been a priority in the past, nor presented in a way that men have found attractive. A program designed for men in their own environment is appreciated and supported if marketed well and appropriate for them. One participant, who works in intensive care, said he was motivated to move into men's health by the fact that many of the hospitalised patients he came across in a critical health setting were men. One co-ordinator stated:

> ...each time we run large community forums and seminars, the men are overwhelmingly pleased to have us there and are interested in their health.

Another said that:

> ...after being asked to attend the First National Men's Health conference in Canberra, statistics on men's health presented there were woeful. Nothing had been done and men needed to be told. Within three months, 270 men came to a workshop in Castlemaine.

This indicates that targeted workshops, taken to where the men are, in appropriate venues where men normally gather, can reach more participants. This is dependant on the marketing strategy being appropriate. Men do appreciate an effort made on their behalf to address their health issues, provided they trust the credentials and motives of the co-ordinator and they see a benefit in attending. Often, this benefit comes through the marketing of the health workshop that seeks support from wives, partners and girlfriends.

Another theme that has emerged from this study is the importance of the male's spouse/partner in influencing him to attend. Several of the co-ordinators interviewed said they targeted females as a marketing strategy. Statements included:

> ...the best marketing is talking to the spouse.

> ...men's groups are only successful if women are instrumental in getting men to come to the workshop.

One co-ordinator alluded to the premise that women are the prime motivators in getting men to attend and that the marketing of programs is directed to them.

> We target women with promotional material offering a prize at the workshop of a romantic dinner for two or a weekend away. We letterdrop and address it to be read by men only, so wives often open and read it. In Murrayville, a population of 500, 120 men turned up.

This gives credibility to the value of including men's partners in marketing for health education sessions.

Depending on who runs the programs, this form of incentive may not be needed. There are other forms. One particular branch of the Cancer Foundation relies on its reputation and name when attracting men to come to prostate information sessions. As a co-ordinator from the foundation said:

> I think, with our reputation, everybody has heard of the Cancer Foundation …. ringing someone saying that you're from the Cancer Foundation Council really pulls a bit of weight, I've found. I think we have been quite successful in our marketing programs.

Relying on a name, though, is not always a preferred way to attract men to workshops, as there has to be substance behind the name and men have to be given a quality service and a sense of the workshop/session being worthwhile

General practitioner rooms and community health centres are generally not favoured as places where men feel comfortable, according to all the co-ordinators. One of the venues where an interview took place was a community health centre. In the waiting room, the headings of several posters on the wall did nothing to encourage the participation of men. These included "Intervention order court support service", "Family violence after hours crisis service", "Men's separation information group", "Men's behaviour change program", and "She has her father's eyes - she'd rather have his ears – Child Protection Week". While these on their own are important, their concentration in one area of a community health service is almost conceived as anti-male. Men could understandably feel uncomfortable being in this environment. The author certainly did.

Another respondent said:

> I don't think they perceive it as a major role that concerns them. A community centre to them is somewhere you take the kids for their injections. Women might go to know something about family planning background. Men do not access health services unless it's desperate.

Another said men would regard the community centre as having little value for them. It was not a sporting centre, or financial institution, nor did it offer help with motoring, or tips for working their land.

So what are community health centres doing about this obvious reluctance on the part of the men to visit? The major push for targeting men appears to be taking the health centre to them. Educators cannot rely on health information sessions run behind bricks and mortar: men must be reached in their own environment.

Educational strategy was another area in which the co-ordinators expressed definite views. Many recognised the fact that males learn differently to females and therefore need different strategies. One of the co-ordinators stated:

> ...men learn in a more direct fashion, they love being task-orientated, as opposed to women, who are able to circumnavigate questions and explore the nuances of any particular topic.

This view supports the previous findings from project participants - men appreciated a straightforward, honest approach with visual delivery in the form of images and short, effective videos, rather than discussion and an exploration of the topic.

Another respondent stated:

> ...our experiences would be that, generally, men are very black and white in their thinking. They don't think in the grey very often. Men will want to fix it today, though that is changing.

Referring back to the importance of women to men's health, one co-ordinator admitted not being sure of how women learnt. However, he was definite in his belief that men will learn through their wives/partners. Trust was also an important aspect, although only one respondent brought this up. Talking about learning needs, he said:

> ...men are suspicious about services, so I suppose there's a need to build a relationship with a man before working with him.

This respondent said his area had a high incidence of cardiac problems and was in the top five regions for cancer incidence in Australia. This person, a worker in the health industry, was able to see the end result of men's lethargic approach to their health. When he met them, their condition had deteriorated to a point where they were being admitted to intensive care. The majority of beds in intensive care wards were taken up by men in this situation, where poor lifestyle and a refusal to take any preventative action with their health had its inevitable result. In addition to this, the figures from the Australian Bureau of Statistics convinced him of the need to move into this area. Most men see little of these kinds of statistics, if anything - and many do not work in the health industry to see the end stage of years of neglect resulting from our misguided cultural expectations of masculinity. This was brought out in the interviews, when one co-ordinator remarked:

> ...typical farming blokes have no idea. They're great with farming machinery, plumbing machinery, great with everything else, but they don't understand or comprehend what their health is or means.

Several themes have come out of this project. The common denominator is the recognition that, generally, men do not look after their health, nor do they seek access to health support services to help them with preventative manner. A second strong theme is the importance of targeting the females who are in relationships with men, who will encourage their partners or family members to attend these health services and workshops. Another is the environment where these services take place and the importance of having a flexible delivery which can be transferred to men's workplace or to places where men congregate after work, such as hotels or sporting clubs.

Discussion

One major theme to come out of these interviews is the need for a greater effort to inform the public of the health differences between men and women and of the greater mortality suffered by men in all major diseases. Many of the co-ordinators leading these courses – as well as the male participants themselves – were surprised by this fact. The Australian Institute of Health and Welfare (1998) supports this finding by saying:

> ...for as long as mortality data have been collected in Australia, male mortality rates have exceeded the female rates. In 1996, this differential was 38%, having peaked in the early 1970s at approximately 40% (p.7).

This sobering fact is embedded into the framework of a rural co-ordinator's program, as he uses the statistics to reinforce to his participants the state of men's health and how they compare with their urban counterparts.

There needs to be a disclaimer here, and care needs to be taken in not assuming that all men are reticent regarding their health seeking behaviour. Placing all men in this category ignores those men that take pride in their bodies, utilise gyms, watch their weight and take care with their diet. The reporting of negative men's health statistics tend to give rise to a blanket belief that all men do not look after their health. There is little follow up on the statistics of men who change their lifestyle after suffering a heart attack or lose a loved one or simply do care about their health. That all men behave badly is not true and needs to be stated here. To stereotype all Australian men with the same negative image is wrong. Gillon (2007) states:

> ...although the idea of a 'male' gender identity or role has much going for it, one of the clear challenges to understanding men in such terms is that it detracts from the many differences between men. Needless to say, not all men are emotionally inarticulate, ceaselessly competitive or aggressive (p.1).

There are men that are very connected with their feelings and ensure that they have regular physical checkups. It is not the intention of this study to group all men as the same when it comes to the attitudes to their health.

This co-ordinator states:

> ...lower health status, morbidity, mortality, I incorporate that and I actually educate them on it. They don't believe it, that's why I have statistics to back it up. To show that metropolitan men outlive these blokes. They exercise more, they suffer less diseases. It certainly makes them take a bit of notice.

This information needs to be disseminated to the community, whether through specific programs such as these or introduced into school curriculum. Many men are unaware of the high incidence of preventable medical conditions amongst their gender (Bunton and Macdonald (2002) Adams, Amos and Munro (2002) .

Having experienced situations and incidents through his work in the local hospital emergency and intensive care unit, this particular co-ordinator was able to speak from his local knowledge and draw on examples. That gave him credibility and affirmation

in the eyes of the men attending his workshop. In this case, the men see the co-ordinator as a role model with appropriate qualifications in the field and having the credentials to talk on the subject.

This respondent emphasised the autonomy of his programs, how he went about developing the education workshop and the implications of funding coming from the area health services. As the workshops progressed, the clinical assessment expertise of the co-ordinator was utilised as each male who came through the program was physically assessed. This was a factor in encouraging other men to attend.

> I have no problems now recruiting or retaining men for four week programs – up to 450 men have gone through the education program. All have been physically assessed, educated over 4-5 weeks and assessed on their knowledge, so it makes a massive difference. My work is certainly full on now.

This added dimension to the work of men's health workshops is important to the future of the program and provides the opportunity for a health check where otherwise this would not occur, and potential health risks would go undetected with many of the men. As part of his workload at the health service, the co-ordinator is involved in a referral service for men suffering from prostate or bowel cancer, talking with them before their operations, then organising resources for them afterwards. These referrals come from the surgeon and are a demonstration of the respect this facilitator has earned through his work with men's health:

> At last count at the start of this year, I had about 57 bowel cancer clients and roughly 60 prostate clients.

This emphasises the input this person has in the area of men's health: he is directly involved in the intervention phase as well as being part of the preventative process. This direct and relevant approach to men's health is one reason why the workshops were so successful and why the men kept coming for the duration of the course.

In a small rural community, the impact of having a men's health co-ordinator on hand is profound. As this man says: "I'm recognised in this area as a men's health leader". The potential for good of this person's profile in the community cannot be underestimated in regard to health behaviours of the men, their lifestyle choices and in their readiness to approaching their own health practitioner.

The role of a community health centre is not a high priority for men or one which concerns them greatly, this co-ordinator believes:

> Many men see such places as somewhere you take the kids for their injections. Women might go to know something about family planning background, but many men would not recognise this as an area where we do a community service for males.

This stance stems from a position of ignorance on the part of men (Gibson and Denner, 2000). Indeed, it was only after attending the men's health workshop and going back to have a physical assessment from the co-ordinator that these participants realised that the facility even existed. Because of their low impact on men's lives, the way men see them as not useful and the argument raised from the literature review (Davidson & Lloyd, 2001, Buckley & Lower, 2002), there is a strong case for moving

out of community health centres and taking the health programs to where the men normally congregate, that is in the workplace, at sporting venues or in hotels. This was recognised by the respondent, when he said:

> ...my position is to take education to the men as, realistically, men do not access health services unless it's desperate.

This belief was confirmed by another co-ordinator interviewed, when he said:

> I spoke to a fellow - I can't remember his actual problem - but he said to me his doctor used to visit him in the paddock to take his blood pressure and he was diagnosed from the paddock.

The role of the community health centre need not change, but instead of confining its services to the shady side of bricks and mortar, such centres should be more flexible and mobile, taking programs to where men tend to meet. This particular respondent pointed out that while a community health centre serviced the needs of the local community, it often failed to take into consideration those people in outlying districts who had to travel to take advantage of the services offered. Yet this was part of the community health centre's role. In his words:

> ...there's really nothing to service those people 50 miles away, so having it mobile, having a service delivered to people rather than people having to seek services, that's basically what we do.

In Australia, this concept takes on special significance considering the size of the rural areas, our population distribution and the fact that life expectancy of males is approximately six years lower than that of women. Buckley and Lower (2002) quoted the Australian Institute of Health and Welfare (1996) when it said that:

> ...in rural areas, this differential is further amplified, with data indicating large disparities in health status indicators when compared to their urban counterparts … rural men tend to deny symptoms of a chronic nature and only utilise health services when symptoms are regarded as life-threatening (p.11).

Running services such as men's health workshops consistently and reliably is difficult, but the biggest effort needed is setting up the program in the first place. Once under way, sessions were generally found to be easier. In the early days, the co-ordinator would contact significant leaders in the community, major employers and members of the SES or CFA, stating that a general information session was going to be conducted in their area with no cost, no major tests and no programs. Furthermore, he was willing to travel to where they were. After conducting many such workshops, he now says:

> ...nowadays, I don't do anything – I just say to a group or area, whether it be through a local community service or just an ad in the paper, that men's health is coming to their area and it's fully registered within a week….I originally do the footwork, but once it's established they come to you.

This reflects the fact that men appreciate any attempt to reach them in their own environment, where the health coordinator travels to where the men are rather than waiting for the men to visit the health clinic.

When these rural workshops began, the co-ordinator responsible recalled how the men were paid $40 to attend. However, they actually gave it back. These men felt the program had met their needs and payment was not warranted. They wanted the money to go back into more such community programs. People expect that payment is given for services delivered, not received as an incentive to attend a workshop such as this. This approach was in marked contrast to that of another co-ordinator, who has a fee attached to his programs and believes this gives the men a sense of ownership. As with a fitness/lifestyle membership, one has to participate to achieve value for the money invested. The delivery of these programs may also change, depending on the type of audience. A group of businessmen may be given a slightly different approach to a group of farmers.

> It's easily flexible - I may run it for businessmen, might change it a little bit, make it a little bit up-key that they understand. For a rural group, I keep it pretty simple so they understand it.

That these programs have been a success is demonstrated by their participation rates. When the first programs were run, there were nine funded group workshops in the state; now, there was only one being funded in his area.

Flexibility in delivering programs is an important aspect in men's health and tailoring programs to suit the needs and diversity of the participants is vital. It may even take the form of a doctor checking a farmer's blood pressure in his paddock. The course recognises that it is what the consumer needs and not what the health centre values that is paramount. It also needs to include relevant information for participants and must relate to the appropriate and desired needs of the individual. The area covered by the community health centre encompassed a large coastal town with smelter workers and wheat and sheep farming areas. These facts necessitated changing the format to reflect more accurately the information needed for their particular workplace.

The earlier research project involved a comparative study of a men's workshop in Melbourne. Looking now at a country situation, it was confirmed that there are different health issues between men in rural areas and their urban counterparts. These differences are highlighted to the men in the form of statistics in the first week of the workshop. The co-ordinator commented:

> ...rural men don't understand that metropolitan men have far better health status, better access to services….rural men don't get checked up earlier. They don't have a great relationship with medical service providers, so they don't have a regular check-up. They don't have a regular appointment with the doctor and they don't get paid sick leave, so there's a massive difference there.

Another remark related to health in the rural sector was a reference to the lack of emotional and psychological support for men in country areas. It was suggested that, even if this kind of help was offered, it was doubtful whether the men would accept that support. This comment was an acknowledgement that the workshops offered to men steered clear of emotional support and sharing of feelings, focusing instead on the physical parameters of health. Why is this area of health not included, considering the high number of suicides among rural men?

In the delivery of health workshops to men, educational practices have to be assessed in terms of the different way men learn as opposed to women. The co-ordinator also ran a health workshop for women and found the main difference to be women's acceptance of health services and their ability to talk, discuss and share with other women about health matters. Men were more stoic in nature and their masculinity appeared to be a barrier to their seeking out of health services. The co-ordinator stated:

> ...women learn through others. They learn by attending and being interested in their health, whereas men only learn possibly by fear, possibly the visual shock of the slides. Things like that do help with male learning – I think they're more visual and they're more related to financial income. Tell them they are not going to work for six months after a heart attack or bowel cancer and they'll say, who is going to do the work?

This raises the issue of cost and whether money precludes men from seeking health services. For a farmer, the fear of no one else to do the work on the property will be a disincentive to his seeking advice – especially if potential surgery threatens to lead to an enforced rest, with the resultant financial burden.

The teaching strategies utilised centred on the visual and showing men the statistics.

> We showed them slides of cancer, giving them heaps of information. They do get written information, but they're not really blokes who want to read about prostate or heart disease

This co-ordinator had realised how men actually do learn - mainly through the senses, especially sight – and had tailored his program to reflect this.

Conclusion

The participants in this research project offered a range of differing views on the best approach to the marketing and delivery of men's health programs. There were also some common threads – thoughts and experiences that recognised certain similarities with men's responses and the environments in which the workshops took place. This goes a long way in explaining the different approaches currently implemented in the field of men's health. Findings that have come out of this study include the need for men to be educated regarding their health, how this should be undertaken and the teaching environment. Another important factor often overlooked in men's health is the importance of knowing your target audience and their background. Mention of how men learn (compared to women) was an interesting observation, but there is very little in the literature to either support or refute these claims. From the literature and discussion arising from the interviews, the question of masculinity and its effect on men's health behaviours cannot be discounted and needs to be addressed within the health care workshops.

The information offered during the course of this project, when combined with findings from the researcher's earlier studies, provides a better understanding of men's health and the need for community involvement. It is long overdue for men to deal with their health problems proactively rather than reactively. This change can only be achieved through a thorough strategic analysis of what programs are in place

and how the input from both participants and co-ordinators of these programs can be assimilated and put into wider practice.

Notes Project 4

1. Questions for co-ordinators

Research question: What factors are important in developing successful educational approaches to men's health?

1 a) Could you tell me about an incident(s) from your experience that highlights the position of men's health in Australia? How have you embedded these experiences into the framework of your program?
b) Tell me about your job and how it impacts on your work with men's health.

2 a) How do you think Australian men perceive the role of the community health centre?
b) In what ways, if any, do you think community health centres could better meet the needs of Australian men with their health?

3 a) Tell me about the ways you attract men to come to your workshops/seminars or for private consultation?
b) From your experience, could you explain what strategies worked and didn't work with the marketing of your programs?
c) With the many aspects of men's health, do you develop programs that target men in particular areas, incorporating knowledge of local needs? If so, what do they include? What, in your opinion, are the major needs of men in your community?

4. Do you believe there are different health issues, both physical or mental, for men in rural areas compared to their urban counterparts? If so, what are they?

5. From your experiences, do you feel there are differences in the way men learn as compared to women's groups? If so, what are they?

6. What teaching strategies do you employ in your workshops? Which are the most effective? Why?

7a). How do you assess from the participating men that learning has taken place?
b) What indicators do you adopt to provide evidence that there has been a measure of success with the educational health program with men?

8. How do you reinforce the values you work to create?

2. Letter of Introduction

University of Ballarat
P.O. Box 663
Ballarat Vic. 3350
Telephone: 5327 9667

Dear ……
As part of my professional doctorate in education (EdD), I am conducting a study to examine the importance of developing successful educational approaches to men's health. This project is looking at key factors in running a successful educational health program for men, incorporating both ways of attracting men and the best teaching strategies.

The study, targeted at contributors in men's health, will consist of a structured interview comprising eight questions related to your experiences delivering health programs for men. The interview will be taped, but only with your consent, and you are free to withdraw from the project at any time. Information given will be kept separate from any identifying names or places to ensure confidentiality. The raw data collected will be kept in a locked filing cabinet and access to the cabinet is available to the researcher alone.

I would be grateful if you could assist me in this study. It is envisaged that the interview will take approximately 20-30 minutes of your time. All information gathered will be destroyed after five years from the completion of the project. If you are willing to be interviewed, could you please read and sign the attached consent form and return it in the envelope provided. As a contributor in men's health, your experience is valued and, collectively, the information gathered will contribute to the future approaches/delivery of programs designed to support men's health.

Yours sincerely,

Neil Gracie

References Project 4

Adams, L., Amos, M. & Munro, J. (2002). *Promoting health: Politics and practice.* London: Sage Publications.

Australian Institute of Health and Welfare (1998). *Australia's health 1998*. Canberra: Australian Government Publishing Service.

Australian Institute of Health and Welfare (2004). *Australia's health 2004.* Canberra: Australian Government Publishing Service.

Barton, A. (2000). Men's health: A cause for concern. *Nursing Standard,* vol. 15, no. 10, pp. 47-52.

Bayram, C., Britt, H., Kelly, Z. & Valenti, L. (2003). *Male consultations in general practice in Australia 1999-00.* A.I.H.W. General Practice Series No. 11 (February).

Bensley, R. & Brookins-Fisher, J. (2003). *Community health education methods: A practical guide.* Sudbury, MA: Jones and Bartlett Publishers.

Buckley, D. & Lower, T. (2002). Factors influencing the utilisation of health services by rural men. *The Journal of the Australian Healthcare Association.* vol. 25, no. 2, pp. 11-15.

Bunton, R. & Macdonald, G. (2002). *Health promotion. Disciplines, diversity and developments* (2nd ed.). London: Routledge.

Burns, R. (2002). *The adult learner at work. The challenges of lifelong education in the new millennium* (2nd ed.). Warriewood: Business & Publishing.

Davidson, N. & Lloyd, T. (2001). *Promoting men's health. A guide for practitioners.* London: Bailliere Tindall.

Denzin, N. & Lincoln, Y. (2000*). Handbook of qualitative research* (2nd ed.). Thousand Oaks: Sage Publications, Inc.

Dilworth, R. & Willis, V. (2003*). Action learning: Images and pathways*. Florida: Krieger Publishing Company.

Gibson, M. & Denner, B. (2000). *Men's health report, 2000*. Bendigo: La Trobe University.

Giglio, M. & Tobler, H. (2003). Ignorance is bliss for young men drinking to their health. *The Australian*. Feb.19th p.5.

Gillon, E. (2007). Gender differences: in help seeking. *Heathcare Counselling and Psychotherapy Journal* Jul, vol. 7, no. 3, pp. 10-3.

Gray, M. (2005). *Fundamental aspects of men's health*. London: MA Healthcare Limited.

Harrison, T. & Dignan, K. (1999). *Men's health. An introduction for nurses and health professionals*. London: Churchill Livingstone.

Hillier, Y. (2002*). Reflective teaching in further and adult education*. London: Continuum.

Hinchcliff, S. (ed.) (1999) *The practitioner as a teacher*, (2nd ed.) London: Bailliere Tindall.

Johnson, T. (1997). *No man's land*. Rushcutters Bay: Halstead Press Publishers.

Jones, J. (2000) *An exploratory study into selective health protective behaviours of rural and urban men in north and north-west Queensland*. James Cook University. (Thesis/dissertation)

Joyce, B. & Weil, M. (1986*). Models of teaching* (3rd ed.). New Jersey: Prentice-Hall International, Inc.

Knight, P. (2002*). Small-scale research*. London: Sage Publications.

Laws, T. (1998). *Promoting men's health – an essential book for nurses*. Melbourne: Ausmed Publications.

Lee, C. & Owens, G. (2002). *The psychology of men's health*. Buckingham: Open University Press.

Long, H. (2002). *Teaching for learning*. Florida: Krieger Publishing Company.

Marcus, B. & Forsyth, L. (2003). *Motivating people to be physically active*. Illinois: Human Kinetics.

Minichiello, V., Sullivan, G., Greenwood, K. & Axford, R. (1999*). Handbook for research methods in health sciences.* Sydney: Addison Wesley Longman Australia.

Monash University Centre for Rural Health (2000*). Promoting rural health: A bibliography with international coverage*. Traralgon, Victoria: Monash University Centre for Rural Health.

N.S.W. Health. *Moving forward in men's health* (1999) [online]. Retrieved July 22, 2002., from http;//www.health.nsw.gov.au/health-public-affairs/men'shealth/

Palmer, G. & Short, S. (1995). *Health care and public policy. An Australian perspective* (2nd ed.). South Melbourne: MacMillan Education Australia Pty. Ltd.

Petersen, A. (1998). *Unmasking the masculine*. London: SAGE Publications Ltd.

Rankin, S. & Stallings, K. (1996). *Patient education. Issues, Principles, Practices* (3rd ed.). Philadelphia: Lippincott.

Redman, B. (2001). *The practice of patient education* (9th ed.). St. Louis: Mosby.

Taylor, K., Marienau, C. & Fiddler, M. (2000). *Developing adult learners*. San Francisco: Jossey-Bass.

Whitehead, S. (2002). *Men and masculinities: Key themes and new directions*. Cornwall: MPG Books Ltd.