



**Report on the first phase of the study on men's usage
of the
Bradford Health of Men services**

**Professor Alan White
Professor Keith Cash**

Leeds Metropolitan University

February 2005

Table of Contents

	A summary of the lessons learnt from the first phase	4
1.0	Introduction	8
1.1	Context	8
2.0	Research	9
2.1	Research Design	9
2.2	Research Management	9
2.3	Data Collection	9
2.3.1	Observations	9
2.3.2	Interviews	9
2.3.3	Ethical & Research Governances issues	11
2.4	Description of the sites	11
2.4.1	The Lads Room	11
2.4.2	The Council Depot MOT drop in	11
2.4.3	The Barbers Shop	11
2.4.4	The Youth Centre	12
2.5	Analysis of the data	12
3.0	The Interviews with the Health of Men Key Workers	13
3.1	The attributes of the key workers	13
3.2	Background of the HOM group	13
3.3	Personal qualities	13
3.4	Men and their health	14
3.5	Men and their emotions	14
3.6	Men's usage of the health service	15
3.7	Gaining access	16
3.8	Men will go to health centres for health checks	17
3.9	Ethnicity	18
3.10	Lessons to be learnt	19
3.10.1	What works?	19
3.10.2	What doesn't work	20
3.11	Lessons that can be learned from different settings	20
3.11.1	Work in schools	21
3.11.2	Anti-bullying work in schools	23
3.11.3	Working in bars	23
3.11.4	Drop-ins	24
3.11.5	Health Fairs	25
3.11.6	Residential Events	25
3.11.7	Other work	25
4.0	Field work and interviews from the four clinical settings	26
4.1	The Lads Room	26
4.1.1	Getting to know about the service	26
4.1.2	Benefits of the service	26
4.1.3	Teaching about condom use	27
4.1.4	Asking for condoms	27
4.1.5	Managing the lads process	28
4.1.6	Aspirations of the lads	29
4.1.7	Other sexual health issues	29
4.1.8	Non-sexual health issues	29
4.1.9	Using the doctors	30
4.1.10	Girls using the service	31
4.1.11	Issues with the Lads Room	32
4.2	The Youth Club Initiative	32
4.2.1	Issues with the Youth Club Health Sessions	34
4.3	The Council Refuse Collection Depot	35
4.3.1	Having a health check	35
4.3.2	General Practitioners and health checks	36

4.3.4	Family & the influence of the female partner	37
4.3.5	Health problems	37
4.3.6	Issues with MOT's	38
4.4	The Barbers Shop	38
4.4.2	The approach	39
4.4.3	The clinical interview	39
4.4.4	Two case studies	39
4.4.5	Issues relating to the barbers shop	40
5.0	Organisational Issues	41
5.1	Lack of available evaluation	41
5.2	Relationships with other health professions and agencies	41
5.3	The role of Key Workers and ways of working across city	42
5.4	Direction of the project	42
6.0	Conceptual Model	44
6.1	The approach	44
6.2	The Lads Room	46
6.2.1	Threatened futures – the Lads Room	46
6.2.2	Managing the frame	46
6.2.3	Limitations to the frame – the Lads Room	46
6.2.4	Benefits to the frame – the Lads Room	46
6.3	The Youth Centre	47
6.3.1	Threatened futures – the youth centre	47
6.3.2	Managing the frame	47
6.3.3	Limitations to the frame – Youth work	47
6.3.4	Benefits to the frame – Youth work	47
6.4	The MOT's	48
6.4.1	Threatened Futures: The MOT's	48
6.4.2	Managing the frame – The MOT's	48
6.4.3	Limitations to the frame – The MOT's	48
6.4.4	Benefits to the frame – The MOT's	48
6.5	The Barbers Shop	49
6.5.1	Threatened Futures – The Barbers Shop	49
6.5.2	Managing the frame – The Barbers Shop	49
6.5.3	Limitations to the frame – The Barbers Shop	49
6.5.4	Benefits to the frame – The Barbers Shop	49
6.6	The lessons learnt from the four settings	49
	A Common Reference Frame	51

A summary of the lessons learnt from the first phase

Introduction

This is a summary of the full report on the first year of the HOM project in Bradford, published in March 2005 and available at www.healthofmen.com. In this summary there is a concentration on three things, the background to the project, the experiences of the HOM team in setting up and managing projects and the views of the men involved in the projects.

The summary is mostly a list of the things that the team found to be important in setting up projects and, equally important, some of the things not to do.

There is, of course, a much fuller discussion of the details of projects, supporting data and the theoretical model of how men and health workers interact to manage health.

Background

In 2002 Bradford was awarded a £1m grant from the New Opportunities Fund to set up a Healthy Living Centre based on men's health. The foundation of the grant application was the work being undertaken by the Bradford Health of Men (HOM) team, a group of practitioners who had developed innovative men's health services for some of the hardest to reach groups in society.

Bradford is recognised as an area of widely different health challenges, from the deprivation of the inner city, to the prosperous suburbs in Airedale and Keighley. Bradford has a higher than National average level of deprivation, but there is considerable variation between the four Primary care trusts (PCT's). Of the 9 wards occurring within the bottom 8% of deprived areas of England, 7 are in the Bradford City PCT. In contrast, some wards within the Airedale PCT are within the top 10%.

Bradford men's life expectancies, range from around 72 years for a man in Bradford PCT to around 76 in the Airedale PCT (national average 75.7 years). Bradford also has higher than national levels of coronary heart disease, cancers and deaths due to accidents. There are also higher levels of smoking and alcohol intake (Manson-Siddle 2001).

The Project

The study was qualitative in approach with a series of case studies. In the first instance four different settings have been chosen to represent the broad constituent of men who are being catered for within the current provision by the HOM group, with each setting comprising a different 'case'

At each location a series of interviews, both structured and unstructured were undertaken and field notes were made relating to the interactions between the men and the health worker.

The Lad's Room: a facility set up by one of the members of the HoM team in the 'Information Shop' located in the centre of Bradford.

The Barber's shop: an initiative that runs weekly from a Barber's shop in Bradford where a bi-lingual Health Support Worker works alongside a qualified member of the HoM team offering health advice and screening to men.

The Youth Centre: a series of evening sessions on health are undertaken by one of the Health of Men team in partnership with the Youth Team with a group of lads at a youth centre on an inner city estate in Bradford

The Council Refuse Collection Depot: jointly organised with Bradford Metropolitan Borough Council, an initiative where the HOM team visits the depot of the Council Refuse department in order to carry out health checks, known as 'MOTs'.

Key findings

The key findings presented here are from the interviews with the Team and the findings from the four projects that were evaluated. The full details of each project can be found in the full report.

Men and their health

1. A variety of health issues were identified in the interviews as being particularly problematic for men, the issue of prostate and testicular cancer, hypertension, diabetes etc, were noted, but mostly these were from an educational or screening context rather than from a treatment perspective.
2. What emerged very strongly from the interviews with the team was that men do care about their health, whether it be their physical health, sexual health, or emotional health.
3. Men are more than willing to discuss issues such as fatherhood, relationship problems and other broader issues as well as their physical health. However, men lack the opportunities to discuss these concerns with health professionals because they perceive the health service as a place you went to when you were 'poorly', or because of the social constraints on them through being a man.
4. The team tended not to discuss men's health in terms of disease processes or life expectancy, more in terms of lifestyle and public health issues such as smoking, alcohol and drugs.
5. The team did recognise that there was a difference between how younger men and older men saw their health and that there is a tendency for men to take the body for granted until age became a factor.

Men's usage of the health service

1. The men did not see the GP as a place they felt comfortable taking the kinds of issues that they were talking to the HoM team about.
2. There was a perception that the G.P's were an 'illness service' where you went when 'poorly'.
3. There was anxiety in some of the younger men that the GP's were too close to their families, so that there was a strong possibility that parents or others may get to know that they been to the surgery.
4. The men were reluctant to 'bother the doctor' with what they perceived to be trivial or potentially embarrassing problems. Some men seemed to have a lack of confidence in the doctor's ability, with a 'what do they know?' mentality being present.
5. A common response was that they would 'go if it was needed' but the tendency was to 'see what it's like tomorrow'.
6. Health centres don't fit in the way that men like to work: men make more snap

decisions. They worry about this ache or pain and the time that they decide to do something about it they want to do it there and then, a spontaneity that is rare or difficult to manage at a Health Centre.

7. Health Centres tend to close early and not open at the weekend so there appear to be barriers to the working man accessing clinics. This is a specific problem with men as they are more likely to be working full time, more likely to be working over 48 hours a week and are less likely to have a job that involves flexi-time (DoH 2004).

Issues of ethnicity

- For South Asian men it was found that by linking in with the Mosques and getting the agreement of the religious leaders was a good way of gaining access to the men.
- Older men from the African Caribbean community were noted as being particularly reluctant to talk about issues that were related to the 'sexual organs', which made work around prostate cancer difficult.

Lessons to be learned

- The most important aspect of working with men was the gaining of trust in the service being offered and getting known by the boys / men.
- Being able to negotiate a way in, for instance by selling the idea of men's health to the religious leaders enabled the team to access areas.
- The team felt it was important that they knew the people and were talking their language, but that this did not mean trying to be one of them.
- There was benefit in being seen as a professional, with expert knowledge but that they were seeing the problems from the man's perspective and listening to what they say.
- An important element of the work with men was the need to go to them rather than waiting for them to come to you. But it was also necessary to have a male friendly approach, which included being able to instil trust through being non-threatening i.e. wearing casual clothes and being positive without being confrontational.
- When setting up the services planning had to be done to ensure that the men would have the time to talk about their issues rather than feeling rushed. It also helped when sessions involved male specific resources with a strong practical element rather than just talking.
- Tapping into the group effect by getting the men to see it as a shared experience was also seen as a positive aspect of work. This links into the competitive nature of men in that many saw the achievement of weight loss, for instance, as being a challenge against each other as much as the personal benefit.

What doesn't work

- Just talking had a limited value, and usually required some aspect of intervention or incentive to engage.
- Being judgemental was also seen to be a very negative approach, with men quickly disengaging if they felt that they were being patronised, or their circumstances were not being taken seriously.
- Men appear to have a dislike of 'experts' telling them what to do.
- The assumption that it is fine to provide the same provision for all men and expecting it to work

The attributes of the team

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

The team all have wide experience of working in varied settings that have usually involved a high degree of autonomous working. They did not seem tied to the medical model but had more of a public health perspective in their dealings with other health professionals and the men and boys they came in contact with. Many of the Key Workers recounted personal or professional experiences of where a man's health had been problematic and how this had a big impact on their decision to start working with men.

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

Conclusion

There are several conclusions from the first year of the project

- Personal qualities such as sensitivity to men's specific needs and an ability to negotiate outside of traditional health settings are crucial to the setting up of projects.
- Many of the ways that men approach health services show that they do contact them but they delay in seeking help or advice.
- The projects that have been established provide a means of increasing the speed of contact that men have with orthodox health services.
- A model of how men make decisions about accessing services has been developed and reported in detail in the full report.
- The model needs to be discussed and developed over the coming year.
- New projects might benefit from using this model as an explicit template for developing the project.

1.0 Introduction

In 2002 Bradford was awarded a £1m grant from the New Opportunities Fund to set up a Healthy Living Centre based on men's health. The foundation of the grant application was the work being undertaken by the Bradford Health of Men (HOM) Key Worker's, a group of practitioners who had developed innovative men's health services for some of the hardest to reach groups in society.

This grant, with matched funding from the local Trusts, has enabled a cross city programme of activities and within each PCT there is 1 full-time "key worker" who is part-funded by the Big Lottery. The Lottery also funds a full-time 'half post' based in the Bradford District Public Health Partnership. Each PCT also provides additional support to the project as their "in-kind" contribution. In one PCT this includes two additional dedicated "key workers". This is a cross city initiative; with Health of Men Key Worker's being employed within one of the four PCT's covering the Bradford and Airedale district but having the ability to work across the city sharing expertise and also allowing for support for events being set up.

We now see in Bradford services that have been developed for men across a wide range of different ages and socio-economic and ethnic backgrounds. Work is being undertaken in schools, young person settings, in the workplace, in community settings used by different ethnic minority groups (such as the Barber shop work) and now also in more main stream health care settings – such as a health centre.

Over a six month period data collection has been undertaken in 4 of the projects covered by the HOM Key Worker's: the Lads Room; an MOT session at a council depot; the Barber Shop on Leeds Road and in Keighley; and the evening youth work sessions at the Estate Youth Centre.

This interim report is divided into four main sections:

- Introduction and context – to men's health as an issue and the work of the Bradford HOM Key Worker's.
- The research design and a description of the projects undertaken
- A thematic analysis of the interviews with the Health of Men Key Worker's and the interviews and fieldnotes from the field
- The presentation of a conceptual model to explain the men's usage of the services.

1.1 Context

Bradford is recognised as an area of widely different health challenges, from the deprivation of the inner city to the prosperous suburbs of Airedale and Keighley. A recent analysis (using the Index of Multiple Deprivation and Townsend Score) confirms that Bradford has a higher than National average level of deprivation, but there is considerable variation between the four PCT's. Of the 9 wards occurring within the bottom 8% of deprived areas of England 7 are in the Bradford City PCT. In contrast some wards within the Airedale PCT are within the top 10%.

This is reflected in Bradford men's life expectancies, which ranges from around 72 years for a man in Bradford PCT to around 76 in the Airedale PCT (national average 75.7 years). Bradford also has higher than national levels of coronary heart disease, cancers and deaths due to accidents. There are also higher levels of smoking and alcohol intake (Manson-Siddle 2001).

2.0 Research

The work being undertaken by the HOM Key Worker's has offered a unique opportunity to explore how services that have been tailored to meet the needs of men influence their decisions relating to accessing health care.

Within the constraints of the limited research budget a decision was made with the Key Worker's to utilise the research money to create in this first year an over-view of the services and a model of the issues influencing why the men were accessing the services on offer. The rationale for this approach being that if it was possible to identify why the men were using these services as opposed to conventional health care provision then we can start to determine how future services should be configured.

2.1 Research Design

The study is qualitative in approach. The study comprises a series of case studies, with each project comprising a different 'case'. In the first instance four different settings have been chosen to represent the broad constituent of men who are being catered for within the current provision by the HOM group.

2.2 Research management

The development of the research and the overseeing of the research process were undertaken by a research group consisting of:

Professor Alan White

Professor Keith Cash (Professor Cash retired in the July during this study)

Representatives of the HOM group

Service users

2.3 Data collection

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

2.3.1 Observations

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

2.3.2 Interviews

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

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

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

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

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

More specifically the questions posed included:

- Biographical details – age, marital status, ethnicity, employment
- Why are you here today?
- Do you have any health problems?
- Have you got your own GP?
- Have you gone to your own GP recently?
- Does this service offer something the health centre doesn't?
- What do you like/dislike about going to your own GP?
- What do you like/dislike about this service?
- Can you describe why you decided to come to this service today?

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

The questions for the HOM practitioners were based on the following key areas:

- The practitioners perceptions of men as patients
- The practitioners experience of working with men – what works and what doesn't

Questions took the form of the following examples:

- How long have you been working in this area?
- What difference have you found in men's responsiveness to health messages etc through using these new services?
- What differences do you see in the way men and women access health care?
- What do you find works in relation to services aimed at men (of different ages, different ethnic backgrounds, different socio-economic status)?
- What do you find does not work in relation to services aimed at men (of different ages, different ethnic backgrounds, different socio-economic status)?

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

The secretarial staff within the School of Health and Community Care at Leeds Metropolitan University undertook the transcription of the tapes. The respondents' names were removed from the transcripts.

2.3.3 Ethical & Research Governance issues

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

2.4 Description of the sites

Four sites were specifically targeted for this initial phase of the study. They were chosen as they represented the breadth of the work undertaken by the Key Worker's: the Lad's Room; The Council Depot MOT drop-in; the Barber shop drop-in; and the evening health classes run for the lads at the Youth Centre.

2.4.1 The Lad's Room

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

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

2.4.2 The Council Refuse Collection Depot

Organised with the Bradford Metropolitan Borough Council the HOM Key Worker's visit the depot of the Council Refuse department in order to carry out health checks [known as 'MOTs'].

One session was attended, with 12 interviews carried out with the men who attended for a consultation.

2.4.3 The Barbers Shop

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

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

2.4.4 The Youth Centre

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

There were six lads participating in the group and a total of five sessions were attended with Field Notes made and one short group interview undertaken

2.5 Analysis of the data

Standard qualitative thematic analysis was undertaken on the interviews and fieldnotes with the main categories being identified through clustering of the emerging themes.

3.0 The Interviews with the Health of Men Key Worker's

Ten one-to-one interviews were undertaken with the Health of Men Key Worker's. These were conducted at their place of work and lasted between 45 and 65 minutes each.

3.1 The attributes of the Key Worker's

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

3.2 Background of the HOM group

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

3.3 Personal qualities

A strength of the Key Worker's was that they seemed to be able to gain the confidence of the men and to be accepted as individuals that could be trusted – this seemed to be based on their ability to make themselves non-threatening to the men and was summarised by one Key Worker as 'deference' - the use of smiling and the use of appropriate humour to break the ice, whilst maintaining a professional affect. This adoption of a certain negotiation style enables them to enter environments that others using a more traditional approach would find difficult.

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

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

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

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

There were, however, no illusions present and they realised that the work they were involved in was not easy and was not always welcomed by the men themselves or the organisations that needed to give permission for the Key Worker's to gain access to the men. A further emerging characteristic therefore was persistence. The way the Key Worker's talked about how they would have to sometimes wait long times for them to become either invited into a setting or to be accepted by the local boys or

men displayed a great tenacity and an unwillingness to 'give in'. This though was tempered by a realism that if they were not making progress then they would stop.

3.4 Men and their health

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

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

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

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

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

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

3.5 Men and their emotions

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

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

3.6 Men's usage of the health service

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

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

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

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

The Key Worker's recognise that though the men are concerned about their health they lack the understanding of how the service works such that there is a fear that their condition may not be sufficiently bad enough that it warrants attention from the doctor. Many of the Key Worker's talked of how men would worry that they would be 'wasting the doctors time', especially as they knew that the service was over stretched and their attendance may be taking the place of someone in greater need.

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

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

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

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

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

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

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

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

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

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

3.7 Gaining access

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

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

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

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

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

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

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

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

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

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

3.8 Men will go to health centres for health checks

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

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

3.9 Ethnicity

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

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

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

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

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

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

3.10 Lessons to be learnt

There are clear lessons emerging as to what works and what doesn't when setting up services for men:

3.10.1 What works?:

From the interviews the general consensus was that the most important aspect of working with men was the gaining of trust in the service being offered and getting known by the boys / men. Until the men had gained confidence that the service was useful and safe, a process that usually involved word of mouth validation then it was unlikely to succeed. Being able to negotiate a way in, for instance by selling the idea of men's health to the religious leaders enabled the Key Worker's to access men with the benefit of having approval from respected members of the community. This legitimised their work and their presence, making it easier for the men to justify to themselves and others their use of the service. Working with the young also meant having to negotiate the help and respect of the community workers, who were also seen as gate keepers to the youth centres.

“what really works is where you link up with other organisations, whether it's a school, whether it's a smoking cessation service, whether it's a health visitor, whether it's a pub, whether it's a workplace, whatever it is, do that because that's a context in which the men not only feel comfortable but where they go, and then you have to come in strategically and passing health messages or health promotion into their settings”

The Key Worker's felt it was important that they knew the people they were trying to help and were talking their language, but that this did not mean trying to be one of them. One of the Key Worker's recounted work with young lads early in his career:

“I played football [with them] and I think it was probably the second week there and there was somebody new in the group ... John said, “Does everyone know [HOM Key Worker] here?” – as much as he knew I was a footballer because he had just been playing football with me so that was it I was accepted to that degree I also was separate because I wasn't part of that group and then one of the things that I had learnt really is that when I was in the group I would try too much to be part of it by swearing and more profane than the rest of them cos I had just started doing this work and tried to be part of the gang and the youth worker who had more experience afterwards said, “What are you doing all this ‘bloody and fuck and everything’ you're not one of the lads you know.” – and I realised that's what I was trying to do I was trying to be one of the lads and I couldn't be because I wasn't.”

There was benefit in being seen as a professional, with expert knowledge but that they were seeing the problems from the man's perspective and listening to what they say. This includes the offering of services that the men want – i.e. smoking cessation, sexual health advice and condoms, weight management classes. For many of the services with the ethnic minorities and the asylum seekers being seen as people who know and can explain the health system and enabling referral service to the GP's was identified as a major advantage in delivering services.

Another key feature of the work with men was the need to go to them rather than waiting for them to come to you. But it was also necessary to have a male friendly approach, which included being able to instil trust through being non-threatening i.e. wearing casual clothes and being positive without being confrontational. Having

respect for the men was also seen as being very important, but also ensuring that there was an element of fun.

When setting up the services planning had to be done to ensure that the men would have the time to talk about their issues rather than feeling rushed. It also helped when sessions involved having things to do, with a strong practical element rather than just talking and having male specific resources. Tapping into the group effect by getting the men to see it as a shared experience was also seen as a positive aspect of work. This links into the competitive nature of men in that many saw the achievement of weight loss, for instance, as being a challenge against each other as much as the personal benefit.

It was also recognised that to get the men to the services there needed to be an incentive with branding being important in the first instance and events such as karting or having time out of work being welcomed. For work with young men this was seen as a key aspect of getting their attendance with the realisation that no one was accessing the services until they offered something in return.

Signs of success can be difficult to find however, for one Key Worker the reduction in the number of times he was told to 'f off' was an indication of success and that the lads were calling into the health centre to see him to get condoms also showed how they were beginning to appreciate his role.

Publicity is important and a high visibility helps to attract men, and women's, attention to the service. The Key Worker's report using different forms of promotion to broadcast the arrival of a new service or to highlight a health issue.

3.10.2 What doesn't work?:

When asked what didn't work the Key Workers seemed unanimous in their opinions of what didn't work when considering how to target men effectively. It seemed that just talking had a limited value, and there usually required some aspect of intervention or incentive to engage. Being judgemental was also seen to be a very negative approach, with men quickly disengaging if they felt that they were being patronised, or their circumstances were not being taken seriously. This was linked in to a dislike of 'experts' giving them health messages. One of the Key Worker's recounted a very good talk by a fitness coach to a group of men who rated it very badly, when they were asked why they said they did not appreciate an ultra fit slim man preaching to them who were over weight and unfit. The talk needed to be by someone that they could relate to and on their level.

Another problem was the assumption that providing the same provision for all men and expecting it to work - i.e. the a drop-in event at the local university, which was organised along the same lines that had been successful at a college and elsewhere, was deemed a 'failure' - the free condoms offered as an incentive seemed to have less impact on university students.

3.11 Lessons that can be learned from the different settings

The Key Worker's have experience of working in many different settings and within the interviews their views on the various services that have been developed were explored.

3.11.1 Work in schools

There needed to be good coordination with the teaching staff and the school nurses to meet the real needs of boys. What became very apparent from the interviews with those that undertook this work was that the boys were extremely receptive of the sessions and really did want to know about their health and normal development.

What was evident was that teachers are often reticent about tackling certain subjects with boys around their sexual health which were therefore left un-discussed. The Health of Men Key Worker's were able to take a more direct approach covering issues that the boys want and need to know. Issues around puberty, personal hygiene, drugs, sexual health and the use of condoms were seen as very important, but also issues relating to bullying needed to be tackled. It was often reported by those engaged with this work that it was easier when the teacher left them with the class rather than staying. However, others felt that the teacher staying in helped with class discipline and also it helped broaden the teachers understanding of the issues. In part the decision as to whether the teacher stayed or not was dependent on class size, subject area, year group and also the skills and confidence of the Key Worker's.

There were many other beneficial factors other than just the content of the sessions such as the introduction of health professionals into school, which allowed the boys a different version of the health service than having illness managed by the family practitioner. There was a recognition that there was a real benefit in getting to the lads in primary school and being able to follow them through into secondary school, not only allowing for the development of a health theme but the lads got to know the Key Worker's better. This led to one of the Key Worker's being known as the 'condom man'; though not the most flattering of titles it did denote that the boys knew about condoms and where they could get them!

"We were out walking down the street and a couple of lads shouted across 'hey [names of two of the Key Worker's], check your balls out' and we started laughing, but at least they knew us and also knew the message"

There were skills required to undertake this work: the ability to speak to large assemblies; the ability to take a class; and the use of boy friendly activities and resources – such as the acknowledgment that boys like to be doing things and not just talking, using resources such as the prosthetic testicles, the spectacles that distort the vision to simulate being drunk.

There was also the skill in managing groups of lads and their questions:

"We always say that we will answer questions that are appropriate for them to know at that time, you always get boys who are trying to push you but we tell them that it is not necessary for you to know that at this time and then we carry on the lesson"

One way that was described of dealing with this issue was to get the lad's to write out their questions, which were put into boxes and then read them and answered if they were felt to be ones that were relevant for their age.

The Key Worker's do more than large group sessions, there is also work that they undertake with students with behavioural difficulties, where their skills in working with young men have specific advantages. Apart from having male appropriate resources it was in relation to how they approached the lads and how they discussed their problems.

“I put myself in the situation of doing it and also the other thing I do is I tell stories about yourself – I am thinking about some boys which I was working with at the referral unit in [local town] and the bad boys School who have 7 in the class and ended up with 2 because they were all pulled out and had something like 4 teachers for 7 boys or 3 teachers to 7 and they kept coming in and out of the classroom and the boy would say something and then they would say, “right you out” and they had obviously identified something they though was going to kick off and with the boys who were left talking about erections and what happens when you get them on the bus – bend over double in order to walk out without anybody noticing. “It’s alright for you lads today with the baggy trousers but when I was a lad they had fasteners which were really tight” you could see a lot of them grinning away because they know what you are talking about. I think it’s getting rhythms going and rhythms in the sense of how you use humour in a way that the lad or men connect. Ultimately in this classroom the 2 lads sat side by side on chairs and were rocking like that and were rocking in complete harmony – that reflects a perfect physical example of the rhythm that they were completely engaged – to do with getting an atmosphere which allows them to express something is – thoughts of their common experiences and find the commonalities really and think that is important and are of very basic things that every lad experience”

A feeling that is evident within some of the Key Worker’s, however, is that their role should begin to change to one of being a support for teachers rather than the providers of the class room sessions. This is based on the increasing demand for their input across broader and broader age ranges potentially leading to such a stretching of the service that they will not be able to meet the need. It is also based on a desire to make the teachers and school nurses more aware of the issues themselves such that the boys receive a generally more male aware education.

‘You’ve just got to watch your boundaries, because you could be there all the time ... they are pushed for resources and when they see something for free they really latch onto it’

There is resistance felt by the Key Worker’s to handing over the role back to the teachers, one of which is the feeling that being male makes the talk more real to the boys, especially in schools with an all female workforce. One of the Key Worker’s, who had been a school nurse discussed how the fact he was male had a definite impact on his work and the reception he got from the male pupils, with a significant proportion using him for issues that his female colleagues would not have faced. This was also picked up by another Key Worker who had a different slant on the implications:

“you go into the class room and talk about puberty and it changes the way the class works you can see that they are interested and so it’s hard to disentangle that from whether its because I’m a man or because it something unusual and if all primary school teachers were men that it wouldn’t make any difference”.

However one of the young men using Lad’s Room when he was discussing his experiences of the Key Worker’s working in his school noted that that the difference may be more than just gender:

“He [HOM Key Worker] was just right chilled out about it, so different to the teacher - more depth, teachers just do superficial stuff” – 15 year old - Lads Room 25th May

The report by Ofsted (2005) on the delivery of PSHE provision does tend to reflect the view that the lessons are best when done by outsiders¹

This is an area that needs to be explored further.

3.11.2 Anti - bullying work in schools

Another aspect of the work that is being done in schools is in relation to anti-bullying sessions. There is recognition in the Key Workers that the lives of many young boys and girls are badly affected by bullying and as a result have been undertaking key work in schools on this area. A significant expertise is being developed in this area; with resources being developed that should be evaluated.

3.11.3 Working in Bars

The recognition that men need to be targeted in their own settings has led to an increase in work in public bars. The Health of Men Key Worker's have used this approach extensively and have gained a lot of experience in this area.

There are two main forms of approach, the first is where work with individual men is undertaken to offer either advice or to do a health screening check and the other is through pub quizzes, which are common forms of entertainment.

In both situations the cooperation of the owner is essential, but the Key Worker's recognised that this required a lot of persistence for some locations. The owners often required reassurance that the issue of alcohol intake was not included.

The sessions required a lot of planning such that the right evening and the right time slot is chosen. By using posters the men can be given a warning that the event is happening. For the screening sessions an early evening time was felt to be the most beneficial, where the men were returning from work and had some 'brain space' to enable them to engage with the screening. Later on in the evening it became more difficult due to the effect of increased alcohol consumption and competition from other events

To undertake the screening sessions it is also important to have a quiet area where personal conversations can be held. Getting the first 'punter' was always the most challenging, because after one has had a go then others usually followed. The most effective way was to go in alone, buy a drink [because that put you in the same situation as others in the bar], being known to be a professional health care worker and having the tenacity to not be put off by the first refusal.

However once the sessions were underway there were often men and women coming up for health advice and screening

“When we tell them who we are we always have men and women coming up and asking about this or that’

Often it seems that the female partner use the opportunity of the Key Worker's being there to get men to face up to problems they may be experiencing:

“You get women saying “Go on Ed, go on Ed, you suffer from that, you get up at night ...”

A strategy the Key Worker's notice some men use is to ask questions about their 'friends' rather than asking directly about their own health problems.

¹ <http://www.ofsted.gov.uk/news/index.cfm?fuseaction=news.details&id=1658> accessed 20th Feb 2005

3.11.4 Drop-in's

Another way that has been adopted for targeting men are Drop-in events, which come in two sorts, those that were one off events, such as held at a rugby match and those that were being set up as a longer term commitment to providing health care to either a workplace or other social setting. Again this is going to where the men are, rather than waiting for them to go to the health centre. The Drop-in's that the Key Worker's offer include the Lad's Room, MOT sessions within the workplace and the Barber shop work, all of which have been included in this study.

"Don't do drop-ins where men don't go".

The drop-ins that have been set up in the men's own environment, especially when it is evident that it has been put on for their convenience rather than the health professional was appreciated by the men. The initial MOT sessions held at the council depot were run to coincide with the men's shift pattern:

'If you are trying to walk in someone else's shoes they are more likely to listen to you... It was freezing cold; it was the middle of winter. Turning up and doing that sort of work, you know, when it is dark and stuff, it shows there is a commitment.'

However a key feature that emerged from the interviews with the Key Worker's was that these required a willingness to persist with the venture even if for quite a long time there seemed to be little interest in the service. From their experience it seems that the 6 months is about the time it takes to become known and trusted.

There was a worry for some businesses that the Key Worker's would go in and tell all their staff that they were unwell and have to have time off, but once they had been persuaded that a fit workforce would be more productive and happy with less sick time they were invited in and then invited back once they had had their sessions with the men.

There are many examples given by the Key Worker's of health issues that have emerged through these that may not have been discovered otherwise:

"This man came in and said he had a dull ache in his chest, which he had for months, I said, "why didn't you do something" and he just shrugged his shoulders and said, "Well..."

"Surprising what the men discuss, relationship issues, being a father, and even those who do not have a health issue come again, obviously thought that was a service that was worthwhile, I'll go again"

I questioned the Key Worker's that commented on the work related drop-in as to why they thought the men were not using the firm's occupational health service. It appeared that there was a lack of confidence in the confidentiality of the service and that if they present with a health problem then it might affect their ability to work or prospects of promotion:

"They are told many times it is a confidential service, but how long will it be before it is around the workplace?"

3.11.5 Health Fairs

There were two opinions on the effectiveness of health fairs, one group had found that they were not effective and did not attract enough attention from the men in the area. An alternative view was that if the event was specifically targeted at men and was well publicised that events such as Dad's and Lad's events then they could be very effective. One piece of advice was to avoid using the term 'health' in the advertisement as that was sure to turn the men off!

3.11.6 Residential events

Residential events have also been organised, which have also seem to have had a very positive effect. One run with Dad's and Lad's created an opportunity for fathers and sons to interact in a way that had not been able to before, creating much stronger bonds between them.

'This lad was really impressed [he said] "I never knew my dad could kick a football'

The other advantage identified is that taking the men away from their home environment can help them to relax and open up about health worries.

This bloke got chatting and said, "I feel safe here, I can open up"

3.11.7 Other work

There were other areas of work that were identified by the Key Worker's, but with insufficient information to be able to discuss them further such as:

- Work with mental health and disabled groups
- Friends of Airedale Hospital, screening for all the volunteers,
- Work at the Bangladeshi centre, including a day trip to Malham for an outing, went for a walk, and talking about health and health and safety.
- Men's work in prisons,
- Speaking to men in hospital

4.0 Field work and interviews from the four clinical settings

Four aspects of the teams work were focused on this year: the Lad's Room; the Drop-in sessions at the Council depot; the Barbershop; and the health sessions held at the Youth Centre.

4.1 The Lads Room

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

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

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

4.1.1 Getting to know about the service

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

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

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

4.1.2 Benefits of the service

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

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

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

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

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

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

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

“He makes you feel comfortable”

“It is the way he listens to you”

“You feel like you have got a friend”

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

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

4.1.3 Teaching about condom use

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

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

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

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

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

4.1.4 Asking for condoms

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

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

² FN – Field Note

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

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

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

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

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

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

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

4.1.5 Managing the lads process

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

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

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

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

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

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

AW - Do you try and separate them?

³ Teenage Information Centre, Teenage Advice Centre

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

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

...Dragging stuff out of him"

4.1.6 Aspirations of the Lads

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

4.1.7 Other sexual health issues

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

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

4.1.8 Non sexual health issues

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

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

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

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

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

"I ended up telling him about a past girlfriend and he actually listened, instead of being someone who kind of dozes off instead of listening to you, he asked me if I used contraception and I said I do apart from this one time and I got a girl pregnant and she's now got a kid, of mine, and has an injunction out on me as an unfit father. He asked if I was coping alright, and I said it's a case

of having to. ...But if you can get classified as an unfit father by providing for the person you're caring for and your kid, all I can say is that rule is crap.

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

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

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

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

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

4.1.9 Using the doctors

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

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

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

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

Interestingly the girls interviewed had similar fears:

'Can't trust the doctors'. 18 year old Afro Caribbean Female
'You have a file at the doctors'. 14 year old Caucasian Female
'They will tell your mum'. 14 year old Caucasian Female

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

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

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

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

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

“I wouldn’t talk to him about sex” 17 year old Caucasian male

4.1.10 Girls using the service

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

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

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

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

‘They [the family planning service] will tell your mum’
‘You hide your face when you go in so no one sees you’
‘They preach at you’
No ‘back biting’ that goes on at Family Planning

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

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

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

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

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

4.1.11 Issues with the Lads Room

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

4.2 The Youth Club Initiative

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

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

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

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

Youth Club Health Sessions

- Testicular self examination

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

During the sessions usually one of the members of the Youth Centre attended. It was a shame that the same member could not have been there for continuity. The first session had a worker who stopped the boys from swearing and maintained an element of control, whereas in the other sessions the workers did not intervene. In the session on male hygiene a female worker came in to listen, which I felt was inappropriate, but the session went ahead and the boys engaged with the discussion, seemingly not minding her presence.

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

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

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

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

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

During the session on healthy eating a large selection of fruits were brought in, which the lads ate during the session and the rest was taken out for the rest of the youth

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

centre to finish off. This was followed by an evening where the entire centre had a talk on healthy eating and there only fresh fruit and healthy drinks on sale instead of the usual soft drinks and sweets. This proved more popular than had been anticipated with more money being taken on the evening than a usual evening where pop and sweets were sold.

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

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

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

"Yeah, he's like laid back a lot more and he talks to you like a normal person"
"He doesn't talk to you like shit"
"He treats us with respect"
"He's different" [from teachers]
"He's not a teacher, he's sorted"

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

4.2.1 Issues with the Youth Club Health Sessions

The key points that have emerged from this work are:

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

4.3 The Council Refuse Collection Depot

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

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

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

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

4.3.1 Having a health check

The men were very impressed that the HOM Key Worker had come out to them and were generally happy with the service. There were generally very favourable comments about the consultation, with a feeling that they were able to relax and speak freely of any concerns they may have and that generally they were pleased with the service.

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

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

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

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

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

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

4.3.2 General Practitioners and health checks

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

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

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

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

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

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

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

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

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

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

4.3.4 Family & the influence of the female partner

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

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

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

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

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

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

4.3.5 Health problems

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

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

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

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

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

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

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

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

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

4.3.6 Issues with the MOT's

1. The MOT's seem to be well received by the men and the interviews suggest that they would not have accessed the conventional services for the health checks given by the HOM team. Effort must be made to ensure that men are aware that they can obtain health checks at health centres – it is not just an 'ill health' service.
2. Some of the men interviewed wished that they could have had cholesterol check done. These are part of MOT's undertaken elsewhere in the city, as are blood glucose levels. It would be useful to consider parity across the city.
3. There was an issue for one man about how sound-proof the rooms were that were being used with a wish that the MOT's were done off premises. This would have resource implications and may limit the number of Key Workers able to function at any one time – however a mobile clinic that can work across city may be a way forward.
4. There were incentives for the men to access this session, both monetary and through the involvement of the manager, it would be useful to compare this event with one in a different setting where no incentive had been offered.

4.4 The Barber's Shop

The setting

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

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

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

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

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

The HOM worker would go to the shop, say hello to the barber and then started unpacking his equipment such as the BMI scales.

4.4.2 The approach

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

There were four sorts of response to the man:

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

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

4.4.3 The clinical interview

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

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

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

4.4.4 Two case studies

The man from abroad

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

8. His blood sugar was high enough to cause acute problems (it was in the high twenties) when the first measurement was taken.
9. It was difficult to interview him in depth because there was a (natural) suspicion that because he was a visitor, there might be certain repercussions if he went to more orthodox health facilities.
10. The need for monitoring was the result of his being unable to afford the

medication that he needed and to access orthodox health services.

11. There is a political and moral dimension to this case. The man was accessing health services in a situation where it would have been difficult to refuse health care (ignoring for the moment a possible moral imperative to deliver that care no matter what the status of the man) because to do so would have compromised the work in the barbers shop. If questions were asked about the legal status of a man then the Key Worker's could reasonably expect that the uptake of the service would be seriously jeopardised.

My GP is not interested

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

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

Some Issues

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

4.4.5 Issues relating to the Barber Shop.

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

1. The barber was a part of the community in a way that many barbers are no longer. It is a traditional barber's shop that is now probably specific to certain communities. It implies stability a regular clientele and little influence of fashion. There was a noticeable lack of fashion conscious young in the shop. The arrangement to use the BS was the result of a personal relationship and initiative of the HOM worker who made it.
2. It was a place to meet sociably, not just for an instrumental purpose of having a haircut. This was a result of both cultural factors and the personality of the barber.
3. Without a comparative study it is difficult to judge how specific to this shop was the freedom to have a conversation about health without apparent embarrassment.

The effectiveness of the project in getting men engaged with orthodox health services is difficult to estimate because there had been very little feedback from local GPs about the referrals to them. The HOM had structured the referral form to encourage feedback but less than 5 GPs had responded.

5.0 Organisational issues

From the analysis of the interviews, the fieldwork and from attending the Key Worker's meetings there are various organisational issues that have emerged that need consideration by the team; these include the lack of outcome measures for their work; the relationship of the Health of Men Key Workers with other health professions and agencies; The role of the Key Workers and ways of working across the city; and a seeming lack of direction.

5.1 Lack of available evaluation

The biggest problem facing the team appears to be in relation to getting feedback as to the success of their work. The team undertaking screening events and identifying health problems but there is almost no contact back from health clinics as to whether the men have been to the doctors and had treatment. Having no outcome measures apart from numbers seen gives little opportunity to fully evaluate the effectiveness of the service.

This lack of formal evaluation extended to the schools where although the sessions were individually very well evaluated it was difficult to determine the long term benefits of having the team going in as opposed to the teachers. This was tied to the general problem of deciding how you evaluate health promotion:

“How do you evaluate a talk with youngsters about puberty?”

There was also an issue in relation to the confidential nature of the team extending in many cases to the anonymity of those who used the services. Many of those who use the service do not want to give their names and are reluctant to even share their post code, resulting in difficulty in tracking cases.

At the very least all this work needs to be monitored more effectively; there needs to be a stronger commitment from the health centres to feed back to the team on the success of the referral system. There needs to be a formal evaluation process created with the agreement of the management of the health centres under the direction of the PCT's to ensure an audit trail exists.

In part, this could be achieved through the wider adoption of the electronic recording that is being trialled, whereby data is entered onto a laptop at the site of the screening event and downloaded directly onto the NHS website for inclusion into the patient's files. If screening information is downloaded to the health centre to become integrated into the patient's records there could be a reciprocal recording of action taken as a result of this information. However, according to the team, a problem with this approach seems to be that some men are suspicious of the technology and are unwilling for their details to be recorded.

5.2 Relationships with other health professions and agencies

An issue that seems to be a problem for some of the team is in relation to how they are perceived by other health professionals. In part this is because their work cuts across many other groups' activities:

“... there is still a suspicion from health professionals ... of what we are about, even when we were trying to get the ok to do finger prick test for diabetes or cholesterol ... 'who are you to be doing this?'”

Though the team are all health professionals themselves many either do not know of their work or have worries over encroachment onto their activities. The team are addressing these with information being sent to the practices but there are still a limited number of referrals coming through to the HOM team from the mainstream health services.

5.3 The role of the Key Workers and ways of working across city

There are differences that exist in the way the services for men have been set up in the individual PCT's that have an impact on this being a cross city initiative. These involve the ability of the Key Workers to undertake certain screening tests such as Cholesterol and Blood Glucose in one PCT, such that what constitutes as 'MOT' in one setting can differ in another.

There would appear to be a need to have clear protocols and guidelines produced to enable greater clarity in what was on offer and to enable the Key Workers to work within a clear and recognisable brief.

These would also enable the support workers within the team to have city wide agreement as to the extent of their role and responsibilities, as some uncertainty exists at present.

5.4 Direction of the project

An impression gained from speaking to the Key Workers is that their services have been built around the perceived need of men, invitations to access groups of men or boys, or around specific talents of the team rather than through a strategic planning process. To this point this has been a very important and necessary stage in developing services, knowledge and expertise. The freedom and flexibility to work in a dynamic and responsive manner has allowed for innovative practice to be nurtured and possibilities explored that would not have been envisaged just a few years ago.

However, caveats are emerging, as the national awareness of men's health grows so does the responsibility of the team to consider how what constitutes men's health and how the lessons learnt can be rolled out across the broader health community. There is a realisation that health services need to change, with the Wanless report highlighting the importance of moving to a more public health focused health services, however there is a reality that the health centre is going to remain at the centre of the health provision and it is unlikely that the extent of focused outreach work that is being undertaken in Bradford could be rolled out across the country. Therefore, what is needed is for the lessons being identified by the HOM team on how men use health services and how services can be configured to make them more appealing to men can be transferred back into more mainstream services.

As part of this process the work of the HOM team has to continue to develop its expertise and to use the opportunity given by the lottery funding to build on the successes and to consider how these valuable lessons can be built into strategic health development within the area and how planning of future developments can become proactive rather than reactive.

A definition of what constitutes men's health has emerged from the Men's Health Forum, which has taken a very broad scope:

“A male health issue is one arising from physiological, psychological, social or environmental factors which have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either the individual or the population level”. (MHF 2004)⁷

This is helpful in determining the breadth of factors that can impact on the health of men and boys, however in terms of setting up services it requires a broader view of health than could be catered for within the health service alone.

“At some time you have to draw the line between social factors and health. They are definitely linked but somehow you have got to demarcate, particularly in our jobs, that your focus isn't too broad”

This also requires the team to continue developing the links with the other agencies, such as education, social services, housing, employment, and the judiciary to enable the creation of models of care.

⁷ MHF (2004) Getting it sorted: a policy document for men's health. London, Men's Health Forum. www.menshealthforum.org.uk

6.0 Conceptual Model

What has emerged from the study is a clearer indication of the decision making processes that are present when men access the services of the Health of Men team.

Health care can occur in many settings, but traditionally settings are health clinics where the health care professionals have configured services for their own convenience. The expectation is that the patient will learn to use the service and will conform to its structures and ways of working. Within the majority of the work of the HOM team there is reversal of this expectation, with the team generally going into the men's environment, usually as a visitor, and engaging with the men on their terms. This alters significantly the nature of the negotiation.

It has been possible to identify how these novel approaches have influenced the willingness of men to engage with the health service.

What is emerging?

- There is a complex series of negotiations between the lads and the HOM team, focusing on:
 - Place
 - The way the service has been set up
 - Aspirations; and
 - Incentives
- A model of how the decisions to access services are made.

6.1 The approach

Utilising an approach to data analysis initially based upon games theory, a theoretical framework was developed.

Negotiation theory works on the premise that to resolve differences a common reference frame and an understanding of the problem needing resolution is required

Each individual character will adopt a position towards the problem and will have a preferred outcome, in addition to a fall back position or threatened future if their preferred option is unsuccessful. These will pose a number of dilemmas, which may preclude a successful resolution to the problem.

In summary:

- Characters (who is involved)
- Options (what each character can or cannot do to alter what is at stake)
- Scenarios (e.g. positions, default futures, threatened futures)
- Preferences (what each character would like to happen)
- Occurring within a Common Reference Frame

Characters – for youth work and lad's room

- Young lads
- HOM team member
- Youth Workers / Information Shop staff
- Researcher

In these settings the young lads are influenced by both who they are with and also their different backgrounds:

- Whether they access the service as:
 - Individuals
 - In pairs
 - In groups
- Different ethnic origin
- Different socio-economic background
- Different ages
- Different personal situations
 - Fathers
 - With girlfriends
 - Without girlfriends

Characters for MOT at council depot

- The managers
- The men on the vans
- The men on the streets
- The Health of Men team

Characters for the Barber shop

- The Barber
- The HOM Key Worker (bi-lingual)
- The HOM Key Worker (nurse)
- The customers

The Practitioners

The practitioners have to be able to work with the men in the different settings and seem to have adopted certain styles of working:

- Public health model
- Non judgemental
- Able to see beyond the behaviour of the lads
- Non – threatening
- Creative
- Male focused
- Willing to wait for success
- Willing to go to the boys / men
- Able to use humour appropriately
- Realistic

In each of the settings it is possible to see how the men have different threatened futures that have influenced their decision to use these services:

6.2 The Lads Room

6.2.1 Threatened futures – the Lads Room

In this case we have focused on why the men would prefer to use the Lad's room in preference to the doctors, the chemists or the family planning services for sexual health advice and getting condoms:

- Doctors
 - too close to the family
 - they have notes and records
 - wasting the doctors time – 'you need to be poorly to go there'
 - risk of 'upsetting the doctor'
- Chemists
 - being seen
 - cost
 - reaction from staff
- Family planning (for those who knew about it)
 - limited choice
 - being 'preached at'

6.2.2 Managing the Frame

In order to facilitate the Lads use of the service the HOM team member uses strategies to manage the frame:

- Seeing the boys in pairs or by themselves – not in groups.
- Offering advice and guidance on the first visit and always seeing the lads privately rather than it being a public event.
- No appointments
- No recording of names – anonymity

6.2.3 Limitations to the Frame – the Lads Room

There would appear to be limitations to the use of this service that need to be considered before it could be more widely used in different settings.

- HOM Team see this as a 'Health' service – the majority of Lads see it as a source of free condoms
- The service is run by one person and it is difficult for another to take over – too personal.

A further issue that needs to be recognised and considered within health planning is the girls' use of the service and their views on their personal threatened futures by the use of the Family Planning Services.

6.2.4 Benefits to the Frame – the Lads Room

The boys find the service extremely useful and talk very highly of the Key Worker who runs the service.

They feel that the service is aimed at them and offers them what they want. There are lads who use the service for more than sexual health concerns and those that do use the service for sexual health get tuition in how to use contraceptives appropriately.

The reputation of the service is very good and has stood the test of time with high numbers of boys and girls using the service each year.

6.3 The Youth Centre

6.3.1 Threatened Futures – Youth Centre

In comparison to the Lad's Room the lads were not accessing the sessions for a specific service, their goal had to be different and in part it could be seen that this was the promise of the weekend away. There were no other options for the lads as to where they might go for this service and therefore their decisions were either to take part or not. In this respect the lads did not seem to have many threatened futures in their decision to undertake the sessions:

- Losing out on the adventure weekend;
- Not being part of the group;
- Disclosure of personal information to friends during the sessions.

When the lads were asked what they thought of the health sessions they tended to focus on the way that they had been treated, but they also were pleased with the sessions and felt that they had benefited from them:

“Yeah, he's like laid back a lot more and he talks to you like a normal person”
“He doesn't talk to you like shit”
“He treats us with respect”
“He's different” [from teachers]
“He's not a teacher, he's sorted”

6.3.2 Managing the Frame

The HOM team member leading the sessions had to have strategies to enable each evening to go well:

- Lot of preparation to find male specific activities and information
- Showing respect i.e. Listening to the lads
- Willingness to be patient and to expend time – organising sponsored walk etc
- Ignoring the behaviour
- Taking a broader picture of success.

6.3.3 Limitations to the Frame – Youth Work

- Difficult to validate how common the frame is – do the lad's share the 'health' message?
- There appears to be a limited transferability from these sessions to the boys using the health service more effectively.

6.3.4 Benefits to the Frame – Youth Work

- The lads enjoyed the sessions and stated that they gained a lot of benefit from the content.

- The sessions were well attended and there were useful discussions on health issues with the lads.
- The sessions that had practical elements saw the lads engaged in learning skills as well as acquiring knowledge.
- The lads engaged with the preparatory work for both the sponsored walk and the weekend away.

6.4 The MOT's

6.4.1 Threatened Futures: the MOT's

The men using the service had different threatened futures to the young men in the other settings. They tended to be older men who were realising that their health was changing and that they needed to be more aware of what was happening to their bodies. They had also been advised to attend by a colleague who had had cancer and in addition were receiving an incentive of overtime salary for their time spent.

- Concern over what may be found
- Unwillingness to 'bother' the doctor
- Family pressure to get health checked.

6.4.2 Managing the Frame – the MOT's

- Independent practitioners reducing the perceived risk of management having access to the content of the consultation.
- Removal of the need for an appointment off site
- Giving the men time to talk

6.4.3 Limitations to the Frame – The MOT's

- Unable to offer cholesterol and glucose testing
- Lack of feedback to the HOM team from the Health Centres
- May be dependent on incentives

6.4.4 Benefits to the Frame – the MOT's

- Men were having health screening that wouldn't have done so.
- Previously undiagnosed problems were being identified with referrals made to their GP's.
- The men found the sessions very helpful and they appreciated being seen at work.
- Men were receiving advice on their weight and activity levels.

6.5 The Barbers Shop

6.5.1 Threatened Futures: the Barbers shop

The customers using the service had a threatened future as did the Barber shop owner:

The Customers

- Rejection from the GP
- Embarrassment from taking a trivial problem to the GP
- Potential but ill-defined health problems

The Barber

- Loss of business
- Delicate matters being discussed in the shop
- After the sessions were successful, the possibility of losing them and therefore potential business.

6.5.2 Managing the Frame

- The HOM Key Worker had to be able to manage sensitive health checks within an environment where there was little opportunity for privacy.
- There needed to be a bi-lingual Key Worker present to enable the sessions to occur

6.5.3 Limitations to the Frame – The Barbers shop

- There needs to be a high degree of cooperation with the owner of the shop.
- There is the possibility of the service being used inappropriately by visitors who do not wish to use the conventional services.
- The lack of private space limits the work that can be undertaken in this setting.

6.5.4 Benefits to the Frame – the Barbers shop

- The service is welcomed and well used by men living in the location
- Health screening was being undertaken and previously undiagnosed problems were being discovered.
- The Team were enabling men who were out of the Health Service to become part of mainstream provision.
- A model of care is being trialled with a disadvantaged group.

6.6 The lessons learnt from the four settings:

- There is a need to create a common reference frame – not just a common setting – which can be achieved by moving into the men's own environment such that:
 - All are engaged on the same task
 - All share the same aspirations
 - All are aware of the threatened futures
- The skills the HOM team use appear to enable men that were not using conventional services to become engaged with their health.

- The majority of the men seen as part of this study appear to be concerned about their health, but do not see the Health Centre as a place to go to unless you are 'poorly'.

A Common Reference Frame

Customer	BARBER SHOP	No involvement, Incentive—free health check / care
Member	YOUTH CLUB WORK	On their estate, In their centre, Incentives— Health information, entertainment & weekend away
Volunteer	MOT's	On own territory, Voluntary, Incentives - paid over- time & free health check
Visitor	THE LAD'S ROOM	Their service, Anonymous, Incentives— free condoms
Appointment	HEALTH CENTRE	Official service, Files kept, Unknown territory, Incentives— diagnosis, treatment and sick note