

Engaging vulnerable men in community based health promotion

by

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Declaration

I declare that the writing of this thesis and research contained within is my own work. Any assistance received has been acknowledged where appropriate

Signed: _____

Lisa Kirwan

Date: _____

“If you do just a little research, it is going to be evident that anyone that ever accomplished anything did not know how they were going to do it. They only knew that they were going to do it”

(Bob Proctor, The Secret)

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Abstract

It is well established that men suffer poorer health and die younger than their female counterparts. The health status of men is closely linked to economic opportunity in society and those in the lowest socio-economic group carry the disproportionate burden of ill health and have traditionally been difficult to engage. The impetus for this study was underpinned by recommendations made by the Irish National Men's Health Policy and is particularly relevant in the current economic downturn. The Carlow Men's Health Project (CMHP), a community based partnership, also recognised the need to support vulnerable men and thus developed a strategy to improve their health and wellbeing.

Using mixed methods (surveys, interviews, focus groups etc), this thesis investigated the specific components of the strategy; the delivery of short programmes (men's health programme and physical activity programme) and awareness raising activities conducted by the CMHP over an 18 month period. Specifically, it will examine the individual components of the short programmes that were associated with effective engagement of men, the factors necessary to deliver an effective print media campaign, and the factors that contributed to successful partnerships working.

The researcher concludes that the CMHP successfully adopted a community development approach to address the needs of men in Carlow. The short programmes highlighted the need to find an effective "hook" or "incentive" to engage men and also men's need for structure and tangible outcomes. The print media campaign found that localisation of stories is necessary to ensure issues alluded to are meaningful to men. It also demonstrated the importance of literacy demand and design in enabling men to interpret health messages. Although the CMHP experienced a number of challenges to partnership working, findings suggest that the REAIM planning tool was seen as a very beneficial to effective planning of interventions. Finally, the dedicated and enthusiastic partners involved with the CMHP was fundamental to their success.

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List of Abbreviations

CDC –	Centre for Disease Control and Prevention
CMHP –	Carlow Men’s Health Project
CSO –	Central Statistics Office
DOHC –	Department of Health and Children
EMHF –	European Men’s Health Forum
GP –	General Practitioner
HNA –	Health Needs Assessment
HP –	Health Promotion
HSE –	Health Service Executive
IPAQ –	International Physical Activity Questionnaire
MHFI –	Men’s Health Forum of Ireland
NMHP –	National Men’s Health Policy
PA –	Physical Activity
PR –	Public Relations
QoL –	Quality of Life
SEG –	Socio Economic Group
UK –	United Kingdom
WHO –	World Health Organisation
WIT –	Waterford Institute of Technology

Introduction

1.0. Introduction

The focus of this research is to identify the most effective ways to engage vulnerable men in community based health promotion. Specifically, the purpose of this chapter is to outline the justification for and background to this research and to provide the reader with an overview of the structure of the thesis.

1.1 Justification for this research

Gender specific health inequalities are economically, socially or culturally determined systematic differences in health between men and women, in contrast to biological differences between the sexes (Dahlgren and Whitehead, 2007). Banks (2004) suggests that there seems to be no biological reason why men should not live as long as females, as men are not doomed to an early grave by genetics. Yet, in the 21st Century, the highest male life expectancy in many European countries does not reach its shortest female equivalent (European Men's Health Forum (EMHF), 2005). It is unacceptable that this gap between male and female life expectancy still exists, with females living on average five years more than their male counterparts. Figures from the Central Statistic Office (CSO, 2009) show that Irish women live to an average age of 81.6 years compared with Irish males whose average life expectancy is 76.8 years. Furthermore, males are approximately 60% more likely to be born prematurely, to have conditions related to prematurity and to suffer birth injuries (Harvey and Simon, 2010). Men are also more vulnerable to injury, disease and death at every stage of their lifespan from conception to old age (Stillon, 1995; Kraemer, 2000). White and Cash (2004) carried out a European wide needs assessment of men's health and their findings were as follows; 17% of all male deaths were due to cardiovascular disease, 8.5% to cerebrovascular disease, 8% to lung cancer and 3.1% due to male specific diseases. The Inequalities in Mortality Report suggests that, in Ireland, excess mortality amongst males represents a fundamental inequality in health with the total mortality rate for men being 54% higher than for women (Balanda and Wilde, 2001).

Although still in its infancy, over the past number of years, there has been increased emphasis placed on men's health research and related programmes nationally and

internationally. Men's health is particularly important considering that the health of a man can also have an impact on the health status of women and children in turn damaging family health, economics and the strength of relationships (Bonhomme, 2004). Richardson (2004) believes that gender impacts men's health whereby a man perceives himself as masculine and his degree of adherence to masculine norms impacts the value he places on his health. The Irish National Men's Health Policy (NMHP) takes into account the impact of gender when defining men's health and state that it is;

“any issue that can be seen to impact on men's quality of life and for which there is a need for gender competent responses to enable men to achieve optimal health and wellbeing at both an individual and population level”.

(Department of Health and Children, 2008, pg 17).

The existence of gender inequalities in health status is unequivocal and will be discussed in more detail in subsequent chapters. However, encouraging men to care for their health is the major challenge that health professionals now face (Leishman and Dalziel, 2006).

The rationale for this piece research came from the Irish NMHP which calls for targeted support for socially disadvantaged men (R10.1) and research into the social determinants of men's health (DOHC, 2008). The NMHP states that “many communities of men are vulnerable to health inequalities” and therefore it is very important to work with those most vulnerable as this is the group most in need and least likely to avail of health promotion activities (DOHC, 2008, pg 98). There is also a growing body of evidence to support this highlighting the link between socio economic status and health as those in lower socio economic groups have shorter lives and poorer health than their counterparts in the higher socio economic groups (Townsend, Davison and Whitehead, 1988; Davey Smith, Bartley & Blane, 1990; Marmot and Wilkinson, 1999). Morbidity rates and rates of premature mortality are also higher among those with lower levels of education and those on low incomes (Wilkins and Savoye, 2009). Furthermore, men who are married, well educated, in the higher social class and have a healthy lifestyle are generally easiest to reach but the least in need of health promotion interventions (McMahon, Hodgins and Kelleher, 2002). Additionally, men are more likely than women to have unhealthy lifestyles, consume alcohol in excess, smoke, eat unhealthily and engage in other risk

taking behaviours (Griffiths, 1996; Courtenay, 2004; George and Fleming, 2004; Galdas Cheater and Marshall, 2005). Therefore, those most in need of health promotion are those least likely to have access to or want to avail of these services and this presents a challenge to the health services.

Finally, research highlights that men are also particularly vulnerable in times of transition, for example, when they experiences loss, in terms of divorce, separation from children, redundancy, retirement, death of a spouse etc (Conrad and White, 2008). This research is specifically pertinent given the current economic climate in which many men are experiencing the negative effects of unemployment on their health. In addition, it is crucial that already limited resources are spent where they are most needed.

1.2. Background to research

Carlow is an inland county in the South East of Ireland and it is estimated that the male population in Carlow is just over 25,000 (CSO, 2006). There are two areas of Carlow town (Tullow Road and Graiguecullen) which are designated RAPID (Revitalising Areas by Planning, Investment and Development) areas. The aim of RAPID is to reduce the deprivation faced by residents of these communities by prioritising state and local resources at the needs of the areas targeted. The CMHP was formed to support vulnerable men in these areas. The CMHP, which began in June 2007, is currently represented by Carlow County Council – RAPID, the Health Promotion Department of the Health Service Executive (HSE) South Area, Carlow County Development Partnership, St Catherine’s Community Service Centre, the Men’s Development Network, County Carlow Sports Partnership and Open Door Community Development Project.

No member of the CMHP has a remit solely for men’s health and all partners came together with varying degrees of experience and expertise in this area. Partners had been struggling to engage with men and the partnership approach supported them with this task. Additionally, the Irish National Men’s Health Policy calls for pooling of resources. The research aspect materialised as the CMHP recognised the opportunity to document their experiences and outcomes with a view to supporting

the CMHP to strive for best practice and to support others to engage in community development work with men. From the outset, the CMHP experienced several challenges to partnership working such as; lack of experience of men's work, limited fiscal resources (no dedicated funding) for men's health available and human resources (time).

This dissertation represents an independent investigation of a strategy which was developed and implemented by the CMHP to improve the health and wellbeing of vulnerable men in Carlow. The research was commissioned and funded by the HSE. The methodology is designed to answer the following research questions.

1. What are the individual components of programme design associated with effective engagement of vulnerable men in community based health promotion? (Chapter Three)
2. How effective is a print media campaign as a tool to communicate health messages to vulnerable men? (Chapter Four)
3. What are the factors that contribute to successful partnership work in community based health promotion with vulnerable men? (Chapter Five)

1.3. Steps taken by the CMHP to target vulnerable men

Figure 1 outlines the steps taken by the CMHP to target men and improve their health and wellbeing. A health needs assessment (HNA) was conducted initially to inform the development of the CMHP men's health strategy. Following a HNA (See section 1.3.1.) the CMHP developed a strategy to target the needs of their target group. The implementation of the strategy evolved as the CMHP learned from their ongoing experiences. This influenced the methodological approach to this research (See section 1.4.). This was done carefully without jeopardising the integrity of the research. Reid, van Teijlingen, Douglas, Robertson and Ludbrook (2008) state that this type of research needs to be flexible and responsive to the needs of partnership.

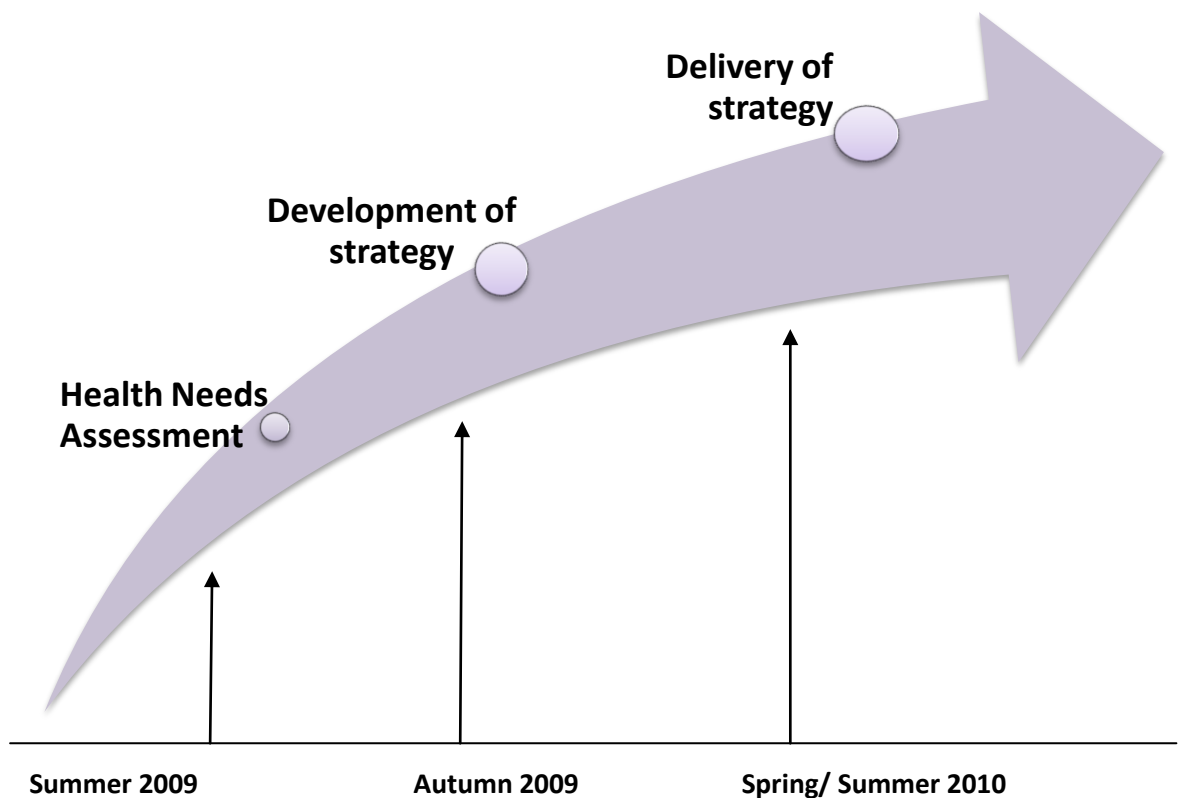


Figure 1: Steps taken by the CMHP

1.3.1. Health needs assessment (HNA)

National and international research states that Irish men do not access health services as frequently as women citing reasons such as; the appointment system, opening hours and the long wait at their GP surgery (Grayland and Wilson, 2009; Richardson, 2004). Therefore, the NMHP recommends moving health services into informal settings (DOHC, 2008). The initial stage in the development of the strategy was conducting a HNA with men. Research has suggested that assessment of need is the necessary starting point for any planned health promotion intervention with a group or within a community (Perkins, Simnett and Wright, 2002). The CMHP decided to use a free health check as a “hook” to engage the men to complete the HNA. Research has found that health checks are successful at targeting men, because they are fast and convenient. However, the successfulness of health screening rely on attracting, identifying and treating those at high risk of a disease

(Bankhead et al, 2003; Brosnan, Collins, Moneley, Kelly and Leahy, 2009). Health screenings are also useful in directing men to make informed decisions about reducing their risk of disease (National Screening Committee, NSC, 2000). So ultimately, the CMHP brought health checks to strategically chosen locations where vulnerable men convened and conducted a cardiovascular health check and HNA which included; demographics, general health status, health behaviours and priority health needs (See Appendix 1.1. for copy of HNA questionnaire). The consultation with each man took approximately 20 minutes. The locations included; farmer's marts/shows, a community event held in a RAPID areas and the Department of Social and Family Affairs office in Carlow town.

Results of HNA and health checks

Table 1: Summary of Health Needs Assessment

Measure	Result	N = 164
Education		
• Primary	18%	30
• Some/completed secondary	54%	89
• Some/completed third	27%	44
• Other	1%	1
Employment status		
• Employed F/T	15%	25
• Employed P/T	7%	11
• Self employed	32%	52
• Unemployed	35%	58
• Retired	10%	16
• Unable to work	1%	1
• Other	1%	1
Cholesterol > 5mmol/l	28%	46
Body Mass Index	38% - overweight	62
	45% - obese	74
High Blood Pressure	61%	100
Do not meet recommended PA guidelines	68%	112

Almost a fifth of the men only had primary school education with men at rural venues more likely to only have had a primary school education. Although over half of men had some or completed second level education, anecdotal feedback suggests that rates of partial completion were high. Furthermore, only 15% of men screened were employed full time. The majority of men (65%) perceived their health to be good or very good, yet 28% had high cholesterol and BMI measures highlighted that 38% were overweight and 45% were obese. Further measures showed that 61% of the men had high blood pressure and 68% of the men did not meet the recommended physical activity guidelines. Half of the men (50%) had consulted with their GP in the previous six months which is lower than that reported in “Getting inside men’s health” which found that 77% of men consulted with their GP in the previous 6 months (Richardson, 2004). During the interview process, 40% reported feeling down depressed or hopeless or worrying a lot during the past month. The main reasons cited for this were unemployment and financial worries. Sixteen percent drank alcohol four or more times a week and men who drink were more likely to have high blood pressure and high cholesterol. Men cited lack of something else to do as a barrier to cutting down on drink.

Based on these demographics and results it is evident that these strategically located health checks were successful in attracting high risk men. Also, from interviewing those partners who facilitated the health checks and HNA it is evident that they were emotionally impacted by some of the stories relayed by men. To conclude, by actively engaging the men in this phase, the basis for community participation in the development of the strategy was established. It also introduced men to the CMHP and furthermore supplied the CMHP with a database from which to recruit men or engage men in the future.

1.3.2. Strategy development

Following the compilation of results, garnered during the HNA, the CMHP set about prioritising achievable strategic action areas which could be implemented to improve the health and wellbeing of vulnerable men in Carlow. The strategy was developed by the CMHP and adhered to and built on best practice with respect to engaging men in community and health promotion work as outlined in the literature. The final

strategy consisted of two main components to proactively engage men around their health and these are outlined in Table 2 below.

Table 2: Components of the CMHP strategy

Strategic Area	Components
Delivery of Short Programmes (Chapter Three)	<ul style="list-style-type: none"> • A “men’s health” programme • A “physical activity” programme
Communications and PR (Chapter Four)	<ul style="list-style-type: none"> • A six week “men’s health” series in local newspaper

1.4. Methodological Approach

A methodological challenge with this study was trying to capture the impact of evolving studies; the delivery of short programmes (Chapter Three), the six weeks series in newspapers (Chapter Four) and the process of partnership working for men’s health (Chapter Five). Therefore, action research was chosen as the guiding methodology. Action research can be defined as the study of a social situation in order to improve both practice and quality (Winter and Munn-Giddings, 2001). The World Health Organisation (WHO, 2001a) outline in their recommendations to policy makers regarding evaluation that action research is invaluable for evaluating health promotion programmes and this claim is supported by other researchers (Hart and Bond, 1995; Bowling, 2002). It has been suggested that action research differs from other research designs because it intends to uncover and resolve problems rather than just investigate them. Therefore, it is the improvement of practice rather than merely the generation of theory (Whitehead, Taket and Smith, 2003). This method was chosen because of its flexibility and the design can be informed by the interim findings, which is suitable when working with a community group. Waterman, Tillen, Dickson and de Koning (2001) state that action research is useful in developing innovation, improving health care, developing knowledgeable practitioners, and in the participatory involvement of users and staff in research. It is therefore a suitable method for bringing about actual changes in practice, particularly in the area of men’s health.

Action research uses many different research methods (Bowling, 2002). Quantitative data can be objective but often lacks depth which is needed to understand how the programme works while qualitative data can enhance this understanding but is considered less objective (Besculides, Zaveri, Farris and Will, 2006). By combining the two, you adopt a mixed methodology approach which strengthens research as no method is without weakness or bias (Webb, Campbell, Schwartz, Sechrest and Belew-Grove, 1981). Using a mixed method research design is a central feature of the overall guiding methodology of action research (Bowling, 2002). The impact of this strategy was investigated on a number of levels using mixed methodologies and the concept of the REAIM framework (where applicable), which provides a useful framework for determining the programmes strengths and weaknesses. REAIM is a systematic way to evaluate health behaviour interventions. It is used to estimate the potential impact of interventions on public health (Glasgow, Vogt and Bowles, 1999). REAIM consists of the following five dimensions; Reach, Effectiveness, Adoption, Implementation and Maintenance (Glasgow et al, 1999). The CMHP used the REAIM planning tool in the planning stage of each strategy component and where possible, relevant dimensions were incorporated into the research framework. The specific methodology used in each study will be detailed in the relevant chapters.

1.5. Ethical Clearance

Before data collection took place, ethical approval was granted by Waterford Institute of Technology's Research Ethics Committee. In doing this, the researcher was required to adhere to a number of considerations; anonymity of participants was upheld, data was securely stored, all information was treated as confidential and no information was provided to any other party without written consent from the participant.

1.6. Structure of this dissertation.

Chapter Two reviews the current literature in the area of men's health. The investigation of specific components of the strategy are outlined in Chapter Three (short programmes) and Chapter Four (media campaign). Finally, the experiences of the CMHP partnership are outlined in Chapter Six.

***Literature
Review***

2.0. Introduction

The Vienna Declaration on the health of men and boys in Europe states that it must be acknowledged that men and women differ regarding their biology, their roles and responsibilities that are assigned to them, and their position in their family and community (European Men's Health Forum (EMHF), 2005). It must also be highlighted that men are not a homogenous group either and that characteristics and behaviours also vary from one man to the next. It is these factors that influence the causes, consequences and management of disease and ill health and also the effectiveness of health promotion policies and programmes targeting men (Ostlin, Eckermann, Mishra, Nkowane and Wallstam, 2007). The importance of targeting these policies and programmes at the most vulnerable men has also emerged in the literature. A lot of men experience disadvantage as part of their daily lives and these are the men with the poorest health outcomes. Vulnerable men are those men who experience disadvantage such as poverty, unemployment, educational disadvantage, social isolation and poor living conditions in their everyday lives (Balanda and Wilde, 2001). There are many different communities of vulnerable men in Ireland which include; traveller men, gay men, unemployed men and isolated men. An examination of mortality statistics in Ireland noted substantial differences within certain groups of men, particularly in relation to social economic status (O'Shea, 1997). The Irish National Men's Health Policy (NMHP) highlights some of the specific issues affecting marginalised groups of men and suggests that these need to be considered when addressing the health inequalities that exist (DOHC, 2008). Some of the issues affecting marginalised groups of men include; social exclusion, poverty, unemployment, illiteracy, lack of understanding of rights, lack of equity to health and social services, and the link between imprisonment, homelessness and drug use (DOHC, 2008).

As mentioned in Chapter One, the area of men's health has evolved over the last decade. In 2001, the World Health Organisation's, Madrid Statement, encouraged the integration of gender mainstreaming into public policies that determine health to ensure that males and females have equal opportunity to enjoy good health and not just the achievement of equal mortality and morbidity rates (WHO, 2001b). Since the first International Conference on Men's Health (The World Congress on Men's

Health), was held in Vienna that same year there has been an increase in the number of conferences held nationally and internationally specifically dedicated to men's health. Worldwide, organisations such as the European Men's Health Forum (EMHF), which is an independent, non-governmental, non-profit organization, have been established to raise awareness of men's health. The Men's Health Forum in Ireland (MHFI) was formed in 2002. The MHFI seek to promote, influence and enhance all aspects of the health and wellbeing of men and boys in Ireland (MHFI, 2010). Men's Health Forums also exist in a number of other European countries with similar missions. Further international developments include the Gender Equality Duty (The Scottish Government, 2007) which places a responsibility on all public agencies to take gender into account when planning and delivering services that facilitate equal access and subsequent health outcomes between men and women (Equal Opportunities Commission, 2007). It also emphasises targeted support to improve men's access to General Practitioners (GPs) and other essential health services. The introduction of three academic journals (The International Journal of Men's Health, The Journal of Men's Health and Gender and the American Journal of Men's Health) dedicated to men's health was also a welcome development for men's health researchers.

In Ireland, the Health Service Executive (HSE) has developed a number of regional men's health strategies in the Western Health Board (2003), North Eastern Health Board (2004) and the Mid-Western Health Board (2005). The HSE also commissioned a qualitative research report (Men Talking) and funded a range of community development initiatives in men's health (McEvoy and Richardson, 2004). They currently fund the Men's Development Network, which assists those men affected by marginalisation through community development initiatives (DOHC, 2008). In addition, there has been an increase in men's health research in Ireland. For example, the Department of Public Health and Primary Care in Trinity College Dublin also carried out research on men's health through a primary care initiative (O'Dowd and O'Keefe, 2004). In Ireland, one of the first politically led activities intended to improve men's health was the development of the National Men's Health Policy (DOHC, 2008). The aim of this policy was to promote positive health and wellbeing for men in Ireland through an integrated health promotion and preventative approach to service delivery. It also outlines recommendations relating

to areas such as; strengthening public policy on men's health, promoting and marketing men's health, creating strategies to promote gender competency in the delivery of health and social services, building services with a focus on preventative health, developing supportive environments for men's health and strengthening community action to support men's health (DOHC, 2008). Furthermore, it was anticipated that this policy would act as a blueprint for other countries (Richardson and Carroll, 2009) and in early 2010, Australia followed in the footsteps of Ireland and became the second country in the world to have a national policy dedicated to men's health. The Australian policy encourages men of all ages to take action to improve their health and recognises that this requires information, assistance and support (Department of Health and Aging, 2010). These developments have further been supported by an increase in activities by practitioners and activists at the grass roots level (White and Robertson, 2010). However, despite the emergence of increased activity in men's health promotion, a great deal more research is needed on the wider determinants of men's health. The challenge also remains of how to effectively translate this research into best practice initiatives that can address the issues affecting the health of men.

It is evident that there has been an increase in the literature on the topic of men's health, yet much of this literature focuses on reducing sexually transmitted infections (Choi and Coates, 1994; Exner, Gardos, Seal, Ehrhardt, 1999; McKay, 2000; Elwy, Hart, Hawkes, Petticrew, 2002; Johnson, Hedges, Diaz, 2003; Rees et al., 2004) and erectile dysfunction (Solstad and Hertoft, 1993; Feldman, Goldstein, Hatzchristou, Krane and McKinlay, 1994; Jonler et al., 1995; Benet and Melman, 1995; ; Melman and Gingell, 1999; Laumann, Paik and Rosen, 1999; Kurahashi, Sasazuki, Iwasaki, Inoue and Tsugane, 2008). There appears to be a shortage of research that focuses on vulnerable men, living on low incomes and the community as a setting to engage men. It is likely that this is due to the fact that researchers largely recruit men in employment as they are easier to target (Office for National Statistics, 2008; Men's Health Forum 2008; White, Conrad and Braney, 2008; Malcher, 2009; Cook, Simmons, Swinburn and Stewart, 2001; Marsden and Moriconi, 2008). Another limitation of the existing literature on men's health is a tendency to overlook the best ways of reaching and successfully engaging men around their health. It is therefore crucially important to increase health professional's understanding of how to engage

men who are not present in the workplace or primary care settings. Specifically, this literature review will discuss the factors that influence men's health, in particular those who are most vulnerable. It will also discuss best practice for promoting men's health using a community development approach, communicating health messages to men and engaging men with their health.

2.1. Men and their health practices

Across the western world, men have higher levels of illness and die younger than their female counterparts (White and Cash 2004; Dahlgren and Whitehead, 2007; CSO, 2009). Courtney (2000a) suggests that addressing the poor health practices of men could lead to improvements in the health status of men. It is beyond the scope of this review to discuss all the factors that influence the health status of men. However, the author will give an overview of the four most relevant to this study; health promoting behaviours, risk taking behaviours, coping with stress and use of health services.

2.1.1. Health promoting behaviours

This section will discuss men's health behaviours namely their use of drugs. It will also convey men's physical activity and dietary practices.

Use of drugs

According to the SLAN survey, over the last decade, there has been an increase in alcohol consumption with a concurrent increase in cancers relating to alcohol, alcohol poisoning and alcohol dependency (Morgan et al., 2008). There are clear gender differences in both the consumption of alcohol and in the consequences of excessive use. Ramstedt and Hope (2005) highlight that males drink three times more alcohol than females, are more likely to binge drink and experience alcohol related problems. Another study found that 84% of men surveyed took a drink, with 35% drinking above the normal recommended limits (O'Dowd and O'Keeffe, 2004).

Cavelaars, Kunst and Mackenbach (1997) found that excessive drinking was significantly higher among less educated men in Greece, Ireland and Portugal. Furthermore, the College Lifestyle Attitudinal National (CLAN) study found that Irish 3rd level male students drank nearly twice as much as female students which is consistent with research from other countries (Carpraro, 2000; Pritchard, Milligan, Elgin, Rush and Shea, 2007). The chief reason for male admission to psychiatric hospitals is related to alcohol disorders and the rate of admission was more than 60% higher than the female rates in 2008 (CSO, 2009).

Additionally, a higher percentage of men (25%) reported being smokers than women (22%) in 2010, while more females (23%) than males (17%) had not used any drugs (legal or illegal) during the last month (Office of Tobacco Control, 2010; National Advisory Committee on Drugs, 2007). Finally, according to the National Advisory Committee on Drugs (2007) males are 3 times more likely to use a combination of alcohol, tobacco and drugs than females (3% and 0.9% respectively).

Physical activity and dietary practices

In Ireland, Morgan et al. (2008) reported that decreases in physical activity and increases in obesity are most pronounced in men. Men represent the largest demographic group whose health is most affected by physical inactivity but whose health behaviours are least understood (Seeback, 2005). Currently, the Irish guidelines recommend that adults (18-64yrs) take 30 minutes a day of moderate activity 5 days a week or 150 minutes a week (DOHC and HSE, 2009). Devine (2010) found that 18% of men in the Republic of Ireland take part in physical activity daily, with slightly higher proportions doing so several times a week. However, 23% of men said that they never take part in physical activity (Devine, 2010). It has also been highlighted that a lot of men are unaware of the current physical activity guidelines (O'Dowd and O'Keeffe, 2004). Richardson (2004) found that the proportion of men who reported having a sedentary lifestyle almost doubled between the age categories of 18-29 and 30-39 years (9.9% to 18.3% respectively).

In addition to physical activity, diet is another factor that determines a man's body weight. Men are less likely than women to read food labels, be aware of nutritional information for specific foods, limit salt intake or eat healthy foods (Satia, Galanko, and Neuhausen, 2005; Levi, Chan and Pence, 2006). Despite the known effects of poor diet on health, it is no surprise that men report eating more high calorie foods, less fruit and vegetables and consume higher amounts of sugar than their female counterparts (Baker and Wardle, 2003; Guthrie and Morton, 2000). There has also been an increase in the amount of fat consumed in the typical Irish man's diet, with 15% of Irish men consuming fried foods on a regular basis (Morgan et al., 2008) and 19% of men hardly ever making a conscious decision to eat healthily (Irish Universities Nutrition Alliance, 2001).

Obesity

As a result of lack of physical activity and poor dietary practices, levels of obesity in Ireland have been rising and it is proposed that by 2015 one third of all Irish adults will be classified as clinically obese (Mokdad et al., 2001; WHO, 1998a). Men deposit weight around their stomach and this tends to be more problematic than the hip and thigh areas where women deposit much of their fat (Conrad and White, 2008). O'Dowd and O'Keeffe (2004) found that 27% of men in their study in a primary care setting in Dublin were obese and nearly half were overweight (49%). This is supported by Morgan et al., (2008) who found that 44% of men are overweight and 22% are obese. Also Gregory, Blanck, Gillespie, Maynard and Serdula (2008) found that men were more likely than women to underestimate their weight and were more likely to disagree that their excess weight was a health risk. McCarthy, Gibney, Flynn and Livingstone (2002) examined overweight, obesity and physical activity levels among Irish adults and found that more attention needs to be given to certain groups of the population, such as men.

2.1.2. Risk taking behaviours

Men engage in a variety of risk taking behaviours which contribute to their higher levels of morbidity and mortality. One statistic which highlights this is that men in

their 20s are five times more likely to die than females of the same age (Richardson, 2004). This could be due to men's involvement in risk taking behaviours such as polydrug use, poor sexual practices, violence, accidental injury and engagement in crime. The Report on Vital Statistics for 2008, compiled by the CSO (2008), highlights that twice as many men died from external causes of injury and poisoning during 2008 (1,215 men and 506 women). Accidents contributed to 62% of all external causes of injury and twice as many males died due to accidents compared with females in 2008. Furthermore, 58% of accidental deaths in males under 25 were due to road traffic accidents (CSO, 2008). Richardson (2004) reports that men aged 18-29, those in SEG 1 and 2, and those with 3rd level education are more likely to drive under the influence of alcohol and to speed. Research highlights how young men are more likely to engage in wreckless driving and less likely to consider speeding, drink driving etc as dangerous driving behaviour (CSO, 2004; Finn and Bragg, 1986). Alcohol is also estimated to be linked with at least 30% of all road accidents (DOHC, 2002).

Furthermore, 92% of violent crimes were committed by men in 2005 (An Garda Siochana, 2005). The CSO (2009) found that the prison population in Ireland is overwhelmingly male with just 7.4% of the 6,455 people committed to prison being female. Research suggests that unhealthy and risky behaviours are more prevalent among prisoners and the average life expectancy for male prisoners is also significantly lower than the general population (Hall, 1999; Smith, 2000). Imprisonment is particularly harmful to the wellbeing of already vulnerable men as they are exposed to a range of physiological and psychological risks that increase the likelihood of poor health outcomes (Collins Centre for Public Policy, 2009). The two most common risk taking behaviours by men are poor methods of coping with stress and limited help seeking behaviour.

2.1.3. Coping with stress

Stress has consistently been shown to have negative effects on a person's health, both directly and indirectly. These effects include; poorer mental health, vulnerability to infection and risk of conditions such as hypertension and diabetes (Adler and Newman, 2002; Rice, 2000). For men stress is often caused by economic

strain, unemployment, family and relationship problems. Chronic stress is also associated with lower socio economic groups and this in turn leads to increased morbidity and mortality amongst this cohort (Adler and Newman, 2002). O'Dowd and O'Keeffe (2004) researched poorer men and concur with this as they highlight that 85% of men in their study were stressed, with 35% of these men citing work pressures and 31% family problems. Research has also shown that unemployment is associated with increased stress and adoption of unhealthy lifestyles, such as increased alcohol consumption which contributes further to health problems (Conrad and White, 2008; Brownhill, Wilhelm, Barclay, Schmied, 2005). It has been suggested that this is due to the increased psychological burden and stress unemployed men experience (Stern, 1983). This will be discussed in greater detail later in the review. O'Dowd and O'Keeffe (2004) found that 31% of men increased their cigarette intake when stressed. Men in this study also experienced further negative consequences such as depression and aggressive feelings associated with stress (O'Dowd and O'Keeffe, 2004). Male students were also less likely to seek help for mental health problems and more likely to try to sort it out alone, to take drugs, get drunk or do nothing (Hope, Dring and Dring, 2005).

In Ireland, depression is an under-recognised but widespread problem amongst men (Baker, 2001). As previously mentioned, research has found that young males are extremely over represented in Irish suicide statistics and there has been a 154% increase in suicide rates amongst young males between 1980 and 1990 (Lester, 2003; Burke and McKeon, 2007). There were 506 deaths due to intentional self harm in 2008, 386 males and 120 females with the highest numbers (26%) recorded for males in the 25-34 age group (CSO, 2008). Figures for suicide in 2010 are as yet unavailable but the number of deaths by suicide reached 527 in 2009 (CSO, 2009). For many men and young men in particular suicide may be a mechanism they draw on when they fail to cope with stress or mental health problems. It is also known that the majority of males who take their own lives have alcohol in their system. Therefore, alcohol consumption can have a significant influence on suicide among men (Bedford, O'Farrell and Howell, 2006; Madden, 2009).

2.1.4. Use of Health Services

Despite being an important determinant of a person's health it is widely recognised that men do not use health services as frequently as women, even after reproductive and gender specific conditions are accounted for (Springer and Mouzon, 2008). The Pfizer Health Index which was conducted in 2008, used a nationally representative sample to measure the perceptions of health and wellbeing of people in Ireland. They found that men are less likely to have attended their GP or gone for a health screening than women. Worryingly, White and Banks (2004) found that the incidence of melanoma in 17 European countries is higher in females yet the death rate from melanoma is higher in men in all these countries. This may be due to men delaying attendance at health services, thereby reducing treatment options and increasing risk of mortality and morbidity. Furthermore, Sharpe (2002) found that men often wait until they are in considerable pain or are convinced they have a serious health problem before they visit their GP. In contrast, Smith and Robertson (2008) believe that there has been an increase in the number of men engaging with their GP. It does however appear that consultations focus on physical assessment and fail to address the wider social determinants of men's health which are known to be important (Williams and Robertson, 2006).

Meyer (2003) suggests that there are many barriers that prevent men engaging with health services which include; perceived hostility, discrimination in the health service delivery system and a shortage of primary care facilities. Banks (2001) supports this as he found that men felt disconnected from health services and that their fears were not considered. A number of men in Bradford were interviewed to investigate the reasons why men did not attend the GP and responses included that they were reluctant to "bother the doctor" and they would go if they needed to but tended to "see what it is like tomorrow". Men also tended to believe that they should only visit the GP when they are poorly (White and Cash, 2005). A recent study explored this in more detail and reported that men felt health professionals did not consider men's level of fear and anxiety, unnecessarily prolonged waiting times and gave inadequate information which further contributed to their anxiety (Buckley and O'Tuama, 2010). Therefore, lack of male specific health services as well as men's resistance to seek help puts men at an evident health disadvantage when compared to women (Sadovsky and Levine, 2005).

2.2. Factors that influence men's health

Throughout the literature there is widespread agreement that disparities exist between male and female longevity however there is little consensus on the best ways to address this issue (CSO, 2009; Griffiths, 1996; Courtenay, 2004; George and Fleming, 2004; Galdas et al., 2005). A variety of factors contribute to this health inequality, such as gender (Courtenay, 2000a; Courtenay, 2003; O'Brien, Hunt and Hart, 2005), marital status (Kaplan, 2006), unemployment (Mathers and Schofield, 1998; Voss, Floderus, Diderichsen and Terry, 2004) and the fact that health consultation rates and help seeking behaviours are lower in men than in women (Moller-Leimkuhler, 2002). It is now widely recognised and accepted that these social determinants of health are often the root cause of poor health outcomes. The WHO (2004, pg 1) state that;

“The social conditions in which people live powerfully influence their chances to be healthy. Indeed factors such as poverty, food insecurity, social exclusion and discrimination, poor housing, unhealthy early childhood conditions and low occupational status are important determinants of most diseases, deaths and health inequalities between and within countries”.

Of note is the fact that the WHO definition does not name gender as a determinant of health which appears to be a blatant omission as no account of social life is complete if it ignores gender (Schrock and Schwalbe, 2009). Therefore, it is important that the social conditions in which a man find himself are considered when trying to address their health needs. However, when the social determinants of men's health are factored in, the scope and depth of the health crisis is even more evident and poignant (Treadwell and Ro, 2008). Many factors, both individually and combined, affect the health status of men and consequently where men live and how men act affects their health. It is beyond the scope of this review to address all the determinants of men's health but the following sections will examine the influence of gender, socio economic status, employment, education, income, and relationships.

2.2.1. Gender and Men's construction of masculinity

Men suffer poorer health than their female counterparts across their lifetime. One suggestion put forward for this disparity is that males engage in risky behaviours,

which can be harmful to their health, as a means of creating, displaying and maintaining their male hegemonic identity or to actively negotiate social status and power (Baker, 2005; Courtenay, 2000a; Courtenay, 2000b; White and Cash, 2004). According to Courtenay (2000a), men are active participants in creating their degree of masculinity through their adherence to social norms. However, children are born into a world in which young boys must learn to identify themselves as males and signify their masculine selves (Schrock and Schwalbe, 2009). For young men, physical risk is promoted, naturalised and celebrated often through males participation in sport (Young and White, 2000; Kimmel and Messner, 1998). This can also be learned through childhood interaction and media representation. Hamilton, Anderson, Broaddus and Young (2006) analysed 200 of the most popular children's books and found that male characters were typically portrayed as aggressive and assertive, more likely to work outside the home and less likely to nurture than female characters. Often a man's work defines their status in the masculine hierarchy and often requires them to demonstrate stoicism and the denial of bodily pain for example soldiers, fire men, police etc (Lee and Owens 2002). Therefore, one's beliefs about masculinity and manhood are deeply rooted in their culture and strongly supported by institutions which they participate in (Williams, 2003). Men in the same country will tend to share certain experiences which shape their constructs of what is considered to be masculine (Mahalik and Morrison, 2006). The social constructionist theory suggests that males act in certain ways because of the concept of masculinity they adopt from their culture. For example, in most cultures men are portrayed to be emotionally and physically strong, independent and more prone to risk taking behaviours and these attributes are subsequently associated with unhealthy eating practices (Kiefer, Rathmanner and Kunze, 2005; Seidler, 1989).

It is apparent that the emotional development of a man impacts on their ability to cope in certain situations. Research suggests that men tend to use problem focused coping strategies whereas women use emotion focused coping strategies (Endler and Parker, 1990; Zuckerman, 1989). Other authors suggest that men suffer from a condition known as "alexithymia" which refers to their inability to express emotions (Carpenter and Addis, 2004). As previously mentioned, men are less likely to seek help and have become socialised to learn to ignore pain in the hope that it will

disappear (Bonhomme, 2004). Davidson and Arber (2003) discuss the two categories of men who do not attend health services; skeptics and stoics. Skeptics are those who don't like doctors and see them as a waste of time while stoics are those men who refuse to give in to pain and just get on with things even when they feel awful. Buckley (1999) found that men also feared being seen as hypochondriacs if they raised health concerns outside of obvious illness. This again may be due to the social constraints placed on them through being a man (White and Cash, 2005). Furthermore, it has been suggested that men's risk taking behaviours are often influenced by incorrect perceptions of their peers behaviours (Robinson and Robertson, 2010). Courtenay (2004) suggests that men may sometimes overestimate their peer's involvement in unhealthy behaviours, which can result in him engaging in unhealthy behaviours. Courtenay (2003) identified thirty key determinants of men's health and found that men's health behaviours are a major determinant of their premature mortality and reduced life expectancy. The impact of masculinities gone wrong can be found in ambulances, emergency departments and cemeteries worldwide (Malcher, 2009).

Nutrition is one such behaviour that is influenced by gender as activities related to food such as shopping and cooking are typically presented as female activities (Caplan, Keane, Willetts and Williams, 1998; Roos, Prattala, and Koski, 2001; Wardle et al., 2004). Women also tend to be more interested and have a greater knowledge of nutrition than men (Kiefer et al., 2005). Similarly, it could be argued that men in Ireland consume excessive alcohol as a means of displaying and reinforcing their masculinity. O'Brien, Hunt and Hart (2009) suggest that the consumption of alcohol appears to be more about the enactment of a particular type of masculinity. Men in this study viewed binge drinking as a masculinity competition that allowed them to adhere to an informal hierarchy of masculinity. One of the study participants stated that his masculinity was challenged when he chose to avoid drinking heavily (O'Brien et al., 2009). This hegemonic masculinity is the idealised form of masculinity which represents power and authority (Connell, 1995). It is the socially dominant gender construct that reflects and shapes a man's social relationship with women and men, therefore representing power and authority (Courtney, 2000a)

Traditionally, the stereotype of the ideal male is risk taking, protective of women, strong and not particularly interested in health. Therefore, if men adopt the traditional masculine norms they are more likely to have poorer health than those who have less traditional norms (Sabo and Gordon, 1995). O'Brien et al. (2009) found that older men in their study reflect on how their views on masculinity and health changed over their life course. Nowadays, not all men aspire to hegemonic masculine ideals as previously discussed. New age men have begun to emerge alongside the older men, creating tension between the ambitious bread winner and compassionate father (Kimmel, 1987). It appears that new age men favour gender equity and these men look after children, are sensitive and support females to develop careers outside the home (Peacock and Levack, 2004). It is those men who engage in health damaging behaviours as a means of displaying their masculinity that pose the greatest challenge for health professionals with a remit for improving the health of men and boys (O'Brien et al., 2009). Health professionals need to help men appreciate the fact that stereotypical male roles can pose a serious risk to men's health outcomes and also act as a barrier to the promotion of men's health (Galdas et al., 2005). Pollack (1999) illustrates this well when he states that;

“If we don't allow our boys to cry tears, not just at five or at six, but at ten and at fifteen and twenty, then some boys are going to cry out with their fists and some boys are going to cry bullets and then it's going to be too late and we can't just point the finger at them”.

2.2.2. Socio economic status

In 1996, the population of Ireland was classified into ten specific socio economic groups based on their level of skill or educational attainment (CSO, 2002). This classification of socio economic status has generated a plethora of studies examining their relationship to health. Mackenbach et al. (2007) carried out an extensive review of literature and reported a close association between lower socio economic status and poor health habits. A large body of research supports this suggestion that there is a strong association between poor health and low socio economic status amongst men (Courtenay, 2003; Adler and Newman, 2002; DOHC, 2008; Baker, 2005; Grayland and Wilson, 2009). In fact, some authors suggest that socio economic status is one of the strongest predictors of the gender differences that exist in health status (Williams and Collins, 1995). The WHO refers to the disparities in

health status by socio economic group as the social gradient in health (Wilkinson and Marmot, 2003). As mentioned earlier, research has highlighted that men in the lowest socio economic group experience disproportionate ill health and premature death from all causes of death compared to those in the highest socio economic group (Townsend et al., 1988; Davey Smith et al., 1990; Marmot and Wilkinson, 1999).

Data available from the Office for National Statistics in the United Kingdom (2006) highlights that the gap in life expectancy between those in the lowest and highest socio economic group is as high as 7.4 years. It is now recognised that men from the lower socio economic groups, with low income and low educational attainment generally have poorer health related behaviours than the general population (DOHC, 2008). Alarming, following diagnosis of prostate cancer, men from lower socio economic groups were less likely to be treated with radical surgery or radiotherapy (Lyratzopoulos, Barbiere, Greenberg, Wright and Neal, 2010). Furthermore, Grayland and Wilson (2009) found that men living in the most deprived areas of Birmingham die younger from heart disease, than those in more affluent areas. Therefore, it is evident that men living in disadvantaged circumstances experience higher rates of mortality than their wealthier counterparts (Kunst and Mackenbach, 1994). It has been suggested that each station east from central London (on the cities underground railway), male life expectancy falls by nearly a year. A man born in Westminster, the affluent part of the city, can expect to reach the age of 79, whereas a man born a few miles away from Canning Town, East London, will not live to see 73 years of age (Kunst and Mackenbach, 1994). A recent Irish study also reported that younger and middle class men are becoming a little more interested in their health whereas older men and those from lower socio economic backgrounds have been cast even further adrift than before (Pfizer, 2008). Furthermore, the burden of ill health and premature mortality affects men in lower socio economic groups more than women in the same group (DOHC, 2008).

Socio economic status is generally made up of three components; employment, education and income. These three components combined are associated with approximately 80% of premature mortality (Adler and Newman, 2002) and will now be discussed in more detail.

2.2.3. Employment

Employment status is a very important social determinant of health as it determines one's income, affects self-esteem and also the type of employment a person is likely to obtain (Naidoo and Wills, 2000). Gradman (1994) suggests that employment allows a man to meet the social norms for masculine attitudes and behaviours. This was borne out in Vigorito and Curry's (1998) study of magazines aimed at male audiences. In this study men were most often portrayed at work, thus affirming productivity and bread winning as a sign of masculinity. According to Balanda and Wilde (2001), those in the lowest occupational class experience 100-200% higher rates of mortality than those in the highest occupational class. A more recent study from the UK found that men (20-64 years) in semi skilled and unskilled manual occupations are three times more likely to die from coronary heart disease and stroke than men of the same age in professional and managerial occupations (British Department of Health, 1999). Research has also found that men from the lowest occupational group are at least 5 times more likely to die from suicide and 16 times more likely to die from alcohol abuse, compared to males from the highest occupational group (Balanda and Wilde, 2001). A more recent men's health study in Ireland examined male occupational class and found that men in lower occupational classes have worse health, in all years, and for all health conditions (McEvoy and Richardson, 2004).

Although employment is often associated with good health there is convincing evidence to suggest that unemployment is linked to higher morbidity and mortality rates (Bartley, Sacker and Clarke, 2004; Mathers and Scholfield, 1998; Morris, Cook and Sharper, 1994). Even more worrying is the fact that males are more likely to be unemployed long term than females (Central Statistics Office, 2005). Mathers and Scholfield (1998) identified a causal relationship between unemployment and ill health and found that this relationship is particularly prominent in men. Morris and his colleagues (1994) carried out a prospective cohort study among 6,000 British men who had been continuously employed for five years before the initial screening. They found that men who experienced some unemployment or retired in the subsequent five years were twice as likely to die as those who remained in continuous employment (Morris et al, 1994). Voss et al. (2004) supports this and found that unemployment was linked to premature death even after factors such as

socio economic status, lifestyle factors, genetics and early childhood factors had been addressed. Williams (2003) reports that unemployment and job insecurity were linked to increased levels of stress, illness, disability and mortality. Furthermore, Bezruchka (2009) reports that losing one's job was associated with a 54% chance of reporting fair or poor health, and for those with no history of existing health conditions the likelihood of reporting new ones increased by 83% with job loss. Also, unemployment has been linked to an increase in daytime drinking, which as previously discussed has long term impacts on a man's health.

Men's health is significantly affected by social deprivation associated with unemployment and the current recession is likely to have a major impact on the physical and mental health of men (Office for National Statistics, 2006; Mind, 2009). According to Foras Aiseanna Saothair (FAS), Ireland's National Training and Employment Authority (2009) males have been worst affected by the rise in unemployment in this current recession. This is primarily due to their high representation in the construction sector. FAS suggest that there are twice as many men as women on the Live Register, with the 'gender gap' increasing by over 100,000 over the last two years (FAS, 2009). Loss of jobs and lack of job security is putting many people at risk of poverty and social exclusion which have consistently been shown to place a significant burden on men's physical and mental health. Unemployment rates for men in Ireland were about 5% in recent years but increased significantly to 15% in 2009 (CSO, 2009). Despite the evident relationship between unemployment and poor health, Madden (2009) found that the fall in unemployment over the period 1994-2000 contributed to a reduction in the levels of mental stress. However, some fear that what is now being experienced is on an entirely different scale to previous economic downturns (Stuckler, Basu, Suhrcke and McKee, 2009).

Many journalists have suggested that debt, marriage breakdown and depression caused by the recession are to blame for the alarming 25% rise in the number of recorded suicides (Rogers, 2010). An article in the Daily Telegraph (January 26, 2009) suggested that living in uncertain economic times can have damaging effects on the health and wellbeing of society. The current recession is having detrimental effects on men's mental health according to Mind (2009), the leading mental health charity for England and Wales. Their study on men and mental health found that nearly 40% of men felt low and worried about money and job security (Mind, 2009).

The Irish Medical Times also published an article which suggested that in 2009, 422 men took their own lives compared to 105 females. Therefore, the annual suicide rate increased by 24 per cent to 527 people, compared to 2008 (Irish Medical Times, 2010). Corcoran and Arensman (2010) concur with this trend suggesting that unemployment was associated with a 2/3 fold increase in male suicide, particularly those aged 35-54. Males accounted for 70% of suicides and 40% of those were under the age of 35. This represents the same group that make up the largest proportion of those on the live register (Kenny, 2010). It could be argued that the impact of unemployment is magnified for those men who find it difficult to communicate emotionally and seek help.

2.2.4. Education

Education is the foundation of a person's future as it influences a person's employment opportunities and potential earnings in later life (Adler and Newman, 2002). Research suggests that a lower educational level poses an additional risk of poor health and differences in mortality by educational level persist into old age (Huisman et al., 2005; Volkers, Westeret and Schellevis, 2007; Augustus, Kwan, Fink, Connor, Maliski and Litwin, 2009; Penson, Stoddard, Pasta, Lubeck and Flanders, 2001). Cutler and Lleras-Muney (2008) analysed data from the National Health Interview Survey and found that those with better education were less likely to self report a past diagnosis of disease, anxiety or depression. Richardson (2004) also found that less well off men and those with a less formal education are more likely to report having neglected or paid little attention to their health. Huisman et al. (2005) analysed data from longitudinal mortality studies by cause of death between low and high educational groups. They found that the difference for cardiovascular diseases accounted for 39%, cancer for 24%, other diseases for 32%, and external causes for 5% in men. Furthermore, an American study found that the least well educated workers are at greatest risk of ill health when jobs are lost during a recession (Edwards, 2008).

According to the Department of Education and Science (2008), females (85.7%) are more likely to complete their leaving certificate than males (75.5%). The early school leaver rate among females (18-24) in 2007 was 8.7% compared to 14.2%

amongst males. Fifty one percent of females (25-34) had a third level qualification in 2008 compared to 38.7% of men in the same age group (Department of Education and Science, 2008). These statistics highlight that men are also at a disadvantage educationally compared with women. This may be influenced by the fact that males are more likely to experience developmental disorders, such as reading delay, hyperactivity and autism. The combined effect of these disorders with other factors can influence a male's educational ability (Kraemer, 2000). Men are also underrepresented in community based adult education programmes despite the fact that there is a growing awareness internationally that men benefit from community based educational approaches (Golding, 2009; McGivney 1999a, 1999b, 2004). In Ireland in 2007, there were 25,860 participants in Back to Education funded initiatives, however only 23% of participants were men (AONTAS, 2009). O'Connor (2007) also found that men's participation in education and further training diminishes with age. Evoy and Hanlon (2010) recommend that community organisations identify and address the educational needs of men affected by poverty, exclusion and marginalisation.

2.2.5. *Income*

Income can also affect the standard of living and housing that men can afford and it is well documented that where people live and their surrounding physical environment impacts on their health (Naidoo and Willis, 2000). Therefore income is linked to life chances in a number of ways (Marmot, 2010). Having insufficient money to lead a healthy life is also a significant cause of health inequalities (Wilkinson and Pickett, 2009). It has been suggested that the link between income and health is stronger at lower incomes, however the effect still exists above the poverty level (Pamuk et al., 1998). Adler and Newman (2002) highlight that those in the lower socio economic groups are increasingly likely to live in poorer communities and in poorer quality housing. Additionally, Gould and Jones (1996) found that owner occupiers have better health than those who rent. Income influences people's choices of healthier lifestyles. For example, low income families are more likely to buy high calorie, filling foods than nutritious foods (Naidoo and Wills, 2000). Furthermore, men in lower socio economic groups are much more

likely to be physically inactive (The Scottish Government, 2009). This in turn leads to problems such as obesity, diabetes, heart disease and other health conditions amongst those people with lower incomes. Meyer (2003) also found that men with a low income in the United States are less likely to have health insurance than low income women. In Australia, single men with an income under \$12,000 per annum are more likely to live in insecure accommodation such as; lodging houses, homeless shelters or on the streets (Council for Homeless Persons, 1999). Gould and Jones (1996) also highlighted that owner occupiers had lower levels of morbidity and mortality. Baker (2001) states that poverty is disempowering and can create a range of problems for men such as emotional stress and low self esteem. This can result in men's high involvement in risk taking behaviour as a means to compensate for their feelings of emasculation (Baker, 2001). Finally, men who have lower incomes or who are unemployed may also be more excluded from social networks in the workplace (Baker, 2001).

2.2.6. Relationships

Many authors have suggested that a man's social relationships and the way they arrange their social life (for example, social cohesion, social capital, public participation etc) impacts on their health outcomes (Berkman and Glass, 2000; Thurston, 2005; Ballinger and Verrinder, 2008; Adler and Newman, 2002). Men who lack contact with their relatives, friends and neighbours, those divorced, never married and older men are extremely vulnerable to social isolation (Arber, Price, Davidson and Perren, 2003). Strong social networks and interpersonal relationships are associated with reduced risk of many health problems such as; common cold, depression, heart attacks and strokes (Harvey and Simon, 2010). The Australian Medical Association (AMA, 2008) believes that isolation is a particularly important factor in controlling preventable illnesses in men living in rural areas. This highlights how positive relationships can have a positive impact on one's health. In general, men have fewer supportive social networks and this further augments poorer health among men (Baker, 2001). Many men suffer isolation due to social and economic changes, as well as other factors, discussed previously, such as unemployment, poor education, poverty and poor living conditions (DOHC, 2008).

Research has consistently shown that unmarried men have an increased likelihood of premature morbidity than those who are married (Gove, 1973; White and Cash, 2004; Richardson, 2004). Baker (2001) supports this as he found that males in relationships with females normally have better health than single men. Those in relationships also now tend to cohabit and Kaplan (2006) believes that a sense of social connectedness and support increases life expectancy as men who live alone have poorer health (White and Cash, 2004). Richardson (2004) also supports this as he found that marriage has a positive influence on a man's health, especially with regard to adopting positive health behaviours. A recent study examined the difference between those who are separated or divorced and those who never married and found that those who never married have a greater risk of premature death than those separated or divorced (Kaplan, 2006). The number of divorced and separated older men who live alone has greatly increased over the past 20 years and these men have poorer health than those who live with a partner (Eurostat, 2002). Furthermore, Bartlett (2004) suggests that marriage is associated with fatherhood and becoming a father increases and strengthens a man's social networks. This is supported by other studies who found that men who portrayed themselves as reluctant to receive health promotion guidance believe that fatherhood was the event in their lives which encouraged them to adapt their lifestyles (O'Brien et al., 2009; Verdonk, Seesing and de Rijk, 2010; Nixon, Whyte, Buggy and Greene, 2010). Moreover, Mansdotter (2006) suggests that men who take longer periods of parental leave, are family oriented and on an equal footing with their partner demonstrate better health than other men. Bartlett (2004) suggests that separation from children significantly increases the risk of chronic health conditions, psychological impairment and death. Despite this, "unmarried" or "natural" fathers are not recognised in the Irish Constitution (McKeon, 2001).

2.3. Strategies to promote the health of men.

Now more than ever, during the current social and economic crisis, services providers need to fully engage with men to support them to improve their health and wellbeing. There is also increasing evidence to suggest that the community settings is most effective for targeting the most vulnerable men (low education, income and

unemployed). The following sub sections will review the current literature available on the community development approach to men's health, communicating health messages to men and engaging men in the community.

2.3.1. Community Development Approach.

The UK Men's Health Forum suggests that services are not being delivered in ways that take into account men's attitudes and behaviours (Williams, 2003; Men's Health Forum, 2009). Traditionally, health care has focused on the medical model with services being delivered in clinics which have been convenient to the professional worker. Men have been expected to conform to its structures and it is evident that this approach is not working (Conrad and White, 2008; Athi and Debney, 2001). DeVille-Almond (2000) suggests that this approach generally attracts the worried well and health conscious. It is now acknowledged that health professionals need to find ways to break down the barriers that prevent males from attending traditional health settings as men are more likely to use services that are quick, convenient and accessible. Richardson (2004) identifies the need to locate and conduct men's health initiatives in the community and other settings where men feel at ease, and also where those men who are most vulnerable can be targeted. Therefore, community based health promotion has arisen from a recognition that settings such as primary care are not successful in attracting and engaging with those men most at risk (McKinlay, Plumridge, McBain, McLeod, Pullon and Brown, 2005). Furthermore, important documents such as the Vienna Declaration on the health of men and boys in Europe (EMHF, 2005) and the NMHP (DOHC, 2008) support the need to harness community potential in order to improve men's health.

A community can be defined as a group of individuals united by social connections, common identity and common goals who often live in a common locality (Raeburn, Akerman, Chuengsatiansup, Mejia and Oladepo, 2007). The popular approach used when working with a community to improve their health is community development. Ireland NMHP identified community development as a strategic area – strengthening community action to support men's health (DOHC, 2008). In brief, community development involves empowering communities to identify their own health needs, decide on how these needs can be met and formulate an effective plan of action

(DOHC, 2008). The impetus can be generated from within the community i.e. bottom up, from local agencies i.e. top down (McDonald, 1995) or a partnership between the two (Conyers 1986). Panda (2007) believes that grassroots initiatives which promote participatory decision making and local self reliance are most successful. The challenge of working with men using this approach is that men, unlike women, have not traditionally mobilised themselves locally to improve their health and wellbeing. Consequently, the top-down approach where work is structured around professional leadership, provided by external resources that plan, implement and evaluate development programmes is more common (McDonald, 1995; Nikkhah and Redzuan, 2009).

2.3.1.1. Empowering men to identify their needs

Empowerment is the process in which an individual, groups and communities take control of their circumstances and achieve their goals (Nikkhah and Redzuan, 2009). Since the community development approach is based on empowerment and strength building, it can enhance the health, wellbeing and quality of life of a target population, specifically men (Raeburn and Corbett, 2001). Heenan (2004) believes that local communities can be empowered by community based health promotion projects and that community based interventions can reach people on a large enough scale to have an impact on public health problems (Merzel and D’Afflitti, 2003). However, the success of any community development initiative demands that people emotionally identify themselves with the programme and are involved in the decisions that are affecting their lives (Nikkhah and Redzuan, 2009). Consequently, it is important that the community are involved in programme planning from the very beginning.

It is recommended that conducting a health needs assessment be the starting point for any planned health promotion intervention with a group or within a community (Perkins, Simnett and Wright, 2002). Barry, Doherty, Hope, Sixsmith, and Kelleher (2000) adopted a community based approach when assessing a rural community’s health beliefs. They carried out an in-depth cross-sectional survey to assess the needs of four rural communities and found that actively engaging the community from the beginning helped to ensure that the intervention strategies were both

meaningful and acceptable to the target community. If men's health needs are considered, unanticipated practical ideas will emerge that will prove very useful in working to achieve optimum health for men (Wilkins, 2005). This process will also facilitate and empower men to become active agents for their own health needs. However, an issue with health needs is that it can often be difficult for community workers to deliver sustainable initiatives as government commitment may be ill defined and ambiguous (Kierans, Robertson and Mair, 2007). This can be of particular concern especially during economic downturns such as the one presently occurring in Ireland. Another issue is the difficulty associated with demonstrating the effectiveness of empowering communities through HNA.

Many of the evaluations of HNAs, carried out to date indicate that well designed, large scale, community based interventions have only produced modest effects. For example, The Kaiser Community Health Promotion Grants Programme permitted communities to identify their health needs and allowed them flexibility in developing and adopting the intervention to meet their needs. This approach produced no measureable improvements in the communities health related norms or behaviours (Wagner et al., 2000). This can provide a challenge for health professionals when trying to access funding for such initiatives. Thus, qualitative investigations of these initiatives might be more effective in assessing the impact that such initiatives can have on the wider determinants of men's health.

2.3.1.2. Partnerships for men's health

The Irish NMHP recommends building and strengthening alliances and partnerships within the community and voluntary sectors when working to improve men's health (DOHC, 2008). Richardson and Carroll (2009) believe that those tasked with implementing the NMHP have the opportunity to work with a range of partners (environment, education, employment etc) when developing men's health initiatives, and with whom to promote men's health within existing systems and structures. A good working partnership, with a variety of agencies, is vital to the success of any strategy aimed at improving the health of men (Conrad and White, 2007). Research has found that partnerships are an essential element of any type of community based health promotion activity as they pool resources, expertise and energies (Wagner et

al., 2000; Schulz, Israel and Lantz, 2003). They also foster local cooperation and conduct strategic planning exercises based on the local situation and its priorities (Organisation for Economic Cooperation and Development, 2001). This type of collaboration and sharing of resources, both human and fiscal, can help agencies to become more cost effective particularly during the current economic climate when agencies need to be accountable, cost effective and sustainable (Booth, 1981; Department of Human Services, 2008).

The Organisation for Economic Co-operation and Development (OECD) defined social partnerships as

“a system of formalised cooperation, grounded in legally binding arrangements or informal understandings, co-operative working relationships and mutually adopted plans among a number of institutions. They involve agreements on policy and programme objectives and the sharing of responsibility, resources, risks and benefits over a specific period of time”.

(OECD, 1990)

Thus, the partnership approach involves agencies with a common target group and goals, coming together to develop and implement an intervention to improve health, ensuring different perspectives are brought to the table when tackling a problem (Green and Kreuter, 2005). All partnerships have two generic functions; to complete group projects and fulfil its member's needs (Arrow, McGrath and Berdahl, 2000). Ball (2010) conducted research into collaboration and reports that partners felt their achievements were possible because of the good will on the part of the members to get on with the job and deliver good quality services to local residents. Lasker, Weiss and Miller (2001) have the same opinion advocating that the synergy which is created from working in partnership results in greater achievements than each group working on its own could ever achieve. Presently, there is a paucity of literature available on the effectiveness of men's health partnerships. What's more, research has failed to prove that partnership work is effective. The following subsections will discuss the characteristics of successful partnerships and the challenges associated with partnership working.

Characteristics of successful partnerships

Throughout the literature there appears to be agreement on the successful factors needed for a good working partnership. Authors suggest factors such as shared vision, organisational arrangements, ownership and trust are very important factors (Audit Commission, 1998, Ling, 2000; Powell et al., 2001). The partners involved with the Well Men's Services in Scotland found that factors associated with successful service implementation were; clear realistic objectives, motivated well informed staff, access to support services and a supportive, wider organisation context (The Scottish Government, 2008). Heenan (2004) also recommends that aims and objectives be clearly articulated by all partners involved, as unrealistic expectations of what can be achieved can lead to demoralisation and disillusionment. Hardy et al. (2003) argue that having clear working arrangements, with time limited and task oriented structures, to focus and give clarity to individual partners. Johnson and Johnson (1997) suggest the use of operational plans when working in partnership and outlines the following advantages; enhanced communication between partners, guidance for the group in planning and carrying out tasks, assists the group when evaluating both the group process and group outcome and finally conflict regarding the course of group action is more likely to be decided by a rational, analytic process. On the contrary, Pettigrew, Ferlie and McKee (1992) have argued that as a starting point, a broad vision may be more likely to generate movement than a blueprint. Nevertheless, it is important that there is clarity around partnership working arrangements in which roles and responsibilities are clearly articulated (Hardy, Hudson and Waddington, 2003).

As previously mentioned, trust is highlighted throughout the literature as a key element of partnership working (Jones, Parrott and Lemieux, 2001; Ball, 2010; Armistead and Pettigrew, 2004). Jones, Thomas and Rudd (2004) believe that personal skills of members are an essential ingredient in building trust. Some of these skills include; networking, flexibility, understanding of roles, effective communication skills and individual personality factors. This is supported by Miller (2008) who suggests that a working group can only be as good as the attitude of its members. Therefore, it is also important to identify partners who complement each other and strengthen partnership goals (Deslauriers and Orologia, no date). Salto Youth (2007) suggest that it is necessary to build a partnership where all partners

feel they can trust each other, learn from each other, work together and trade ideas. A successful partnership is one where a “learning culture” is fostered and those involved grow, learn from and appreciate this co-operation (Deslauriers and Orologa, no date). Participants in one study recognised that partnerships are a rich learning environment. It emerged that this in itself motivated other participants to learn so that they could reciprocate. It is however noted that this requires participants to open up, become vulnerable and be challenged and influenced by others (Armistead and Pettigrew, 2004). It has also been proposed that change in personnel can affect the building of trust between partners. Therefore, partnerships need to be protected from the departure of socially skilled individuals as the ultimate aim of partnerships should be collaborative sustainability (Hardy, Turrell and Wistow, 1992; Jones et al., 2004; Cropper, 1996).

Effective lines of communication are necessary to allow information flow easily between organisations, partners and the larger community (Deslauriers and Orologa, no date). Partners can often be based in locations physically remote from each other and therefore meeting to make quick decisions is not always possible. Thus, everything needs to be planned and coordinated (Huxham, 1996). As a result Arrow et al. (2000) argue that large groups can be more difficult to manage because of problems associated with coordinating tasks and maintaining motivation. Another issue with respect to group size, highlighted by Arrow et al. (2000) is that partners may end up leaving the group if they see their role as unnecessary in a large group. Miller (2008) recommends that some mechanism is put in place for positive feedback, praise and encouragement to maintain partner’s motivation. It is essential that those involved feel valued and that their input is acknowledged (Heenan, 2004).

A healthy partnership should not prevent partners from having discussions, disagreements or misunderstandings, but instead provide a space in which it can take place in a safe and empowering environment (Salto Youth, 2007). Reid et al. (2008) discusses the reality of partnership working when undertaking evaluations of men’s health services. They found that there are times when different opinions need to be resolved. It was reported that for the most part this occurred rapidly and progress was very smooth (Reid et al., 2008). What’s more, Ball (2010) found that respondents in his study disagreed with the statement that “lines of responsibility and communication were clear”. They stated that this was due to the fact that those at a

strategic level were not proactive in finding out what happened at a local level (Ball, 2010). Reid and his colleagues (2008) also agree with this stating that professional boundaries, lack of collective goals and different accountability structures have all been linked to ineffective partnership working. Therefore, effective communication between all partners and stakeholders is necessary to ensure the partnership is successful.

Challenges associated with partnership working.

Despite the known advantages of partnership working a number of challenges to this approach did emerge from the literature. As suggested previously, it is important that all partners having a shared understanding of the aims and vision of the partnership as conflicting interests may prevent the partnership from having its desired effect on a community. One study found that staff involved in their partnership evaluating men's health services had varying levels of experience and perceptions of evaluation ranging from very positive to very negative (Reid et al., 2008). Therefore, all partners need to feel that they are working on something in their line of thinking because if partners are unable to identify with the goals and objectives pursued, they will not support the partnership fully (Deslauriers and Orologa, no date). Reid et al. (2008) found that reaching consensus in a partnership where a range of different values and beliefs are evident can be difficult. Also, it emerged that many partners can be at odds with committing to the partnership and its goals, on one hand, and to their respective employers and organisations on the other (Huxham, 1996; Zuckerman, Kaluzny and Ricketts, 1995). Armistead and Pettigrew (2004) discuss this further in their study which found that individual partners need to be committed to the goals of the partnership but also supported by the organisations they represent. Ball (2010) supports the previous findings, identifying a hindrance to partnership working as lack of devolved budgets and remits of certain partners taking precedence over working together to achieve a common goal and also how representatives fulfil their roles and functions. This is a particular concern during the current economic climate when budgetary constraints are particularly evident in the community sector.

The issue of involving members of the general public in health partnerships is frequently cited in the literature (Dennis, 2003; Rhodes, Foley, Zometa and Bloom, 2007; Nemcek and Sabatier, 2003). People in Public Health, a national study (United Kingdom), which investigated the opportunities and challenges of involving lay workers in improving health in their community. They suggested that the top down nature of health services and the attitudes of health professionals was the biggest barrier to lay people trying to do public health work (South et al., 2010). Additionally, a cross sectional study surveyed staff who sat on committees with community representation in Australia and they reported the role of the representatives as follows; representing the community, improving communication between health services and the committee and providing constructive feedback (Nathan and Braithwaite, 2010). Worryingly, less than half the staff thought the community and health service agreed on the role of community representatives (Nathan and Braithwaite, 2010). This can cause huge problems when trying to build and maintain trust within the partnership. Reid et al. (2008) also discusses the challenges of engaging the target group of hard to reach men in partnership working. In their study men were represented by a national men's health lobby group and none of the men took part directly. Nonetheless, involving members of the general public is a cost effective way to reach the right people and tackle health problems but only if the correct training and supports are put in place (South et al., 2010). It can also be important in ensuring that more effective services are developed thus facilitating men's overall utilisation of health services (Banks, 2001; Office for National Statistics, 2006; Wadsworth, 1997). This process is central to the community development approach and is known as empowerment (Raeburn and Corbett, 2001). Empowerment occurs when men are encouraged to take control of their circumstance and thus improve their health (Nikkhah and Redzuan, 2009). If this cannot be facilitated there should be an ongoing, two way communication with the target group to engage them and create a feeling of ownership (Deslauriers and Orologa, no date).

Alexander et al. (2010) looked at the potential challenges of working in partnership in four community health alliances in the United States. They suggested that although involving staff to achieve some of the goals of the partnership can be effective it can also deprive partners of "ownership" of activities and may result in

them reducing their participation superficially at some level (Alexander et al., 2010). It may also cause conflict or the withdrawal of support of a key member which can strain the partnership unless supports are put in place to reduce this (Butterfoss, 2007; Ball, 2010). Unsuccessful partnerships are those characterised by frequent turnover of members, or even resignation from the group (Alexander and Macdonald, 2005). Although in theory the concept of partnership sounds achievable, a men's health initiative which designed an intervention to engage men with their health at a rugby stadium found that the intervention was under resourced in terms of delivery staff and administration staff. They found that interventions required a central coordinator to be the primary contact, take ownership of the programme and ensure all intervention components are delivered (Witty and White, 2010). However, this partnership did decide to use student volunteers to take on some of the workload and this approach appeared to be mutually beneficial.

Another factor which can affect member's ability to commit or have a sense of ownership is around leadership issues. Research studies have looked at the different types of leadership that can take place in a community health partnership and have documented the advantages and disadvantages of same (Alexander, Comfort, Weiner and Bogue, 2001; Bracht and Gleason, 1990; Fawcett, Francisco, Paine-Andrews and Schultz, 2000; Hageman, Zuckerman, Weiner, Alexander and Bogue, 1998; Philips and Springer, 1997; Weiner and Alexander, 1998). Armistead and Pettigrew (2004) describe the characteristics of a good leader as follows; being a positive role model, demonstrating vision, inspiring, motivating and facilitative. Some research suggests that partnership work requires everyone to take on the leadership role as partnerships may not be successful if only one or a small number of partners are perceived as dominant (The Scottish Government, 2010; Deslauriers and Orolaga, no date). Neutral leadership is that which fosters equal voice representation of partners, regardless of resources, power and size and this reduces the threat that no one partner dominates (Alexander et al., 2001). Other research concurs with this finding as partnership members interviewed felt that all active members should possess leadership qualities (Armistead and Pettigrew, 2004; Alexander et al., 2001; Shortell et al., 2002). In many partnerships, there will be "followers" and "leaders" and these roles can be assigned by or presumed by other partners. One study which looked at the effectiveness of 25 partnerships referred to "subsidiary" leaders. They state that

this occurs when partners recognise the need for different partners to take on different leadership roles at different times (Shortell et al., 2002). Although there are many benefits to having a leader in place, it can also hinder other partners, consciously or not, from making their full input (Deslauriers and Orologa, no date; Pobal, 2006). Another challenge with having an allocated leader is the challenges that can be created if this individual leaves the partnership. It can paralyse the partnership for significant periods of time, resulting in loss of momentum, gaps in task coordination and negatively affect partnership cohesion (Alexander et al., 2010).

Another challenge which emerged with regard to working in partnership was the time it can take to successfully build a partnership. Armistead and Pettigrew (2004) suggest that because partnership skills have to be learned and because time was needed to build trust, members felt that planning may have been compromised. However, successful events then appeared to foster trust and confidence (Armistead and Pettigrew, 2004). Therefore, it must be acknowledged that the process involved in the building of partnerships can be time-consuming, demands massive commitment and trust. Reid et al. (2008) correspond with this finding and identified that working in partnership can be a slow process following their evaluation of a National Well Men's Service. This is true for the lifecycle of any group and not just working partnerships.

Finally, Hardy et al. (2003) refers to the importance of monitoring, measuring and learning as an essential element of measuring performance which in turn may strengthen communication and trust. Furthermore, a commitment to regular monitoring and reviewing ensures that lessons are learned from mistakes made in the partnership process (Pobal, 2006). Funding agencies, partners and evaluators have also shown an increased interest in assessing the effectiveness of partnership in addressing public health problems in recent years (Butterfoss, Goodman and Wandersman, 1996; Lasker et al., 2001; Sofaer, 2000). However, a challenge for partnerships when working with funding agencies can be the pressure of accountability which can be imposed to measure short term outcomes (Brown, Butler and Hamilton, 2001). Research suggests that this monitoring and evaluation should take place from the very beginning of the partnership process (Deslauriers and Orologa, no date). Such an exercise can stimulate discussion about the process of partnership working in the group that would not be possible otherwise (Ball, 2010).

Butterfoss et al. (1996) have stated that evaluation of partnerships can be complex because of the evolutionary nature of the partnership process. Moreover, care should be taken to ensure that the monitoring demands are kept to a minimum and do not dominate partners efforts. If this occurs it can result in a loss of focus of longer term goals (Alexander et al., 2010).

2.3.2. *Communicating health messages to men*

Men's health has received intermittent media attention through television and radio but never to the same extent as women's health (McKinlay et al., 2005). Mass media is often used to communicate to, persuade and influence a group to consider, adopt or change to a more health enhancing behaviour, for example, to quit smoking (Atkin and Wallack, 1990). Mass media is also used to raise awareness of men's health issues, sometimes through events such as National Men's Health Week (NMHW). In Ireland, the MHFI and its partners ran an extensive media campaign during NMHW, 2010 to raise awareness amongst men of physical activity (Kirwan, Murphy, Lambe and Carroll, 2010). Cock and Holden (2008) suggest that the increased community interest in men's health has been enhanced by greater media attention to gender specific health issues such as prostate cancer, erectile dysfunction etc. This increase in community and media awareness of men's health means that there is a greater demand for organisations to participate in men's health promotion (Cock and Holden, 2008). The subsequent sections will look at how men are represented in the media, the effectiveness of using mass media to promote men's health and finally developing effective messages.

2.3.2.1. Representation of men in the media

It has been suggested that the representation of men in the media falls within a range of stereotypes reinforcing notions about masculinity and manliness (Children Now, 1999). Lyons and Willott (1999) investigated the representations of men's health in the British media. This was based on the analysis of an article titled "A women's guide to men's health" which was published in The Mail on Sunday (Lyons and Willott, 1999). They found that women were constructed as knowledgeable and

responsible for men's health, while men were presented as passive and in need of women's protection. Additionally, the "Boys to Men" report stated that almost $\frac{3}{4}$ of children aged 10-17 describe men on television as violent while $\frac{2}{3}$ describe them as angry. These perceptions were validated by an independent analysis of how males act and how masculinity is portrayed in the most popular programmes boys watch. The results of this analysis were that the majority (74%) of males performed anti-social behaviours such as ridiculing, lying, aggressive or defiant acts (Children Now, 1999). Gough (2006) also carried out an in depth analysis of British newspaper articles (n=44) and concurs with the above findings. He found that despite the warnings about the detrimental consequences of men's diets, the area of nutrition is trivialised and mocked in many media texts. Therefore, men's relative ignorance can be discounted and in some cases their risky dietary practices celebrated (Gough, 2006).

Coyle and Sykes (1998) reviewed articles on male mental health which appeared in the Independent newspaper in 1996. They found that these articles portrayed men as victims of social change and pressured men to adopt a "new man" approach which has the capacity to discuss and display emotions. They concluded that these articles posed a threat to traditional masculinity which is health damaging. O'Brien et al (2009) state that the media should use contemporary images of men and masculinity that encourage a new breed of men who embrace different ways of displaying masculinity through their engagement in health promoting behaviours. In 2010, a focus group was conducted with middle aged men (n=82) from a socially deprived area of Britain, to obtain men's perspectives in relation to health promotion (Coles et al., 2010). These men disliked the idealised images of the masculine body as fit, young and having muscles stating that they would ignore such images as they were not realistic or achievable for men of their age (Coles et al., 2010). Richardson and Carroll (2009, pg 6) suggests that one of the key promotional and marketing challenges for men's health is;

“to reverse the paradigm that help seeking is synonymous with weakness in men and, rather, to portray good health maintenance and prompt help seeking as part and parcel of being a man – achieving optimum vitality, vigor and productivity, and enabling men not just to be productive in their work, but productive also in many other roles that they play”.

Robinson and Robertson (2010) support this notion and believe that social marketing becomes problematic when homogenised images of hegemonic masculinity are used for promotional activity instead of social marketing planning procedures informed by current men's health research. Therefore, research which examines articles published on health behaviours concludes that journalists and editors of local newspapers need greater access to research findings in order to disseminate health information at a local level (Caburnay et al., 2003).

2.3.2.2. The effectiveness of mass media to promote men's health

Breckon (2005) suggests that public relations and marketing rely heavily on four communication related tasks. The first step is identifying and assessing the target group. This involves differentiating populations into sub categories of people who share needs, wants, lifestyles, behaviours and values that make them likely to respond similarly to public health interventions (Grier and Bryant, 2005). Wellings and Macdowall (2000) suggest that the effects of a mass media campaign will be smaller where the target group is large and heterogeneous. As previously discussed, with any type of health promotion activities, a health needs assessment (HNA) is required as a starting point for planned interventions as it enables individuals to increase control over and improve their health (Raeburn et al., 2007; WHO, 1986). It will provide comprehensive and impartial information about the health needs of men as well as a structured foundation for media planning (Health Canada, 2000). Also, by completing this task health professionals will have increased awareness of issues such as the literacy levels of the target audiences. This is important because providing written information does not necessarily mean it can be easily read and understood (Griffin, McKenna and Tooth, 2003). Worryingly, Weiss, Hart, McGee and D'Estelle (1992) have found a relationship between people with poor literacy skills and an increased risk of poor health. Fitzsimmons, Michael, Hulley and Scott (2010) assessed the readability of online consumer orientated Parkinson's disease information using two validated measures and stated that SMOG test should be carried out when evaluating consumer-orientated healthcare material. They suggested that the Flesch-Kincaid formula significantly underestimated reading

difficulty compared with the “gold standard SMOG formula” (Fitzsimmons et al., 2010).

The second step is to identify the most effective message senders and communication channels for each target group and therefore careful consideration of the target groups needs is required. This involves finding out what essential information needs to be communicated and what channels or mechanisms would best allow men to give their attention to a message (Rochlen and Hoyer, 2005). This activity is often referred to as formative evaluation. Broad spectrum approaches to health promotion make use of communication channels such as radio, television, newspapers, leaflets and billboards (Wellings and Macdowall, 2000). In 1988, Connell and Crawford surveyed individuals from an urban and rural Pennsylvania town to assess their source of health information. At this time the majority of respondents reported print materials to be the most frequently used source of health information (Connell and Crawford, 1988). This is supported by Caburnay et al. (2003) who suggest that local newspapers are particularly influential in smaller communities as people are more likely to actively and thoughtfully process this information. However, a more recent report by the UK Men’s Health Forum has recognised that men are enthusiastic users of a wide range of new technologies and want to harness this to develop health services, information and products to engage men around their health (Men’s Health Forum, 2011). Also, 70% of respondents to the malehealth.co.uk survey said the internet was their first stop for health information mainly because it was quick, private and free, although it is acknowledged that this source may be biased (Men’s Health Forum, 2011). The Health Research Board concur with these findings suggesting that males in the 18-29 year age group are more likely to use the internet than females, highlighting the benefits of the internet as a health promotion tool to reach young men (Gallagher, Tedstone, Moran and O’Doherty, 2008). However, figures from the Office for National Statistics (2010) contradict this showing that women are more likely to look up health information on the internet than men (44% versus 34%). Furthermore, often those most vulnerable to poor health will have poor access to communication technologies and information related to health care services (Population Council, 2010).

Additionally, formative evaluation is necessary to ensure that messages can be pre tested with the target audience (Neiger, Thackeray, Barnes and McKenzie., 2003). This is necessary to test messages, develop characters or storylines and decide on the most effective and relevant media following consultation with the target group. In turn, this ensures that messages are less likely to be misunderstood and misinterpreted (Wellings and Macdowall, 2000). As outlined in this section, the needs of each group will vary and therefore formative evaluation is crucial to assist health professionals in identifying both the appropriate channels and messages to reach their target group. Messages, appearance, visuals and readability are important in attracting the attention of the target group and therefore must be appropriate.

2.3.2.3. Developing effective messages

The effect of health campaigns on behaviour change depends in part on the framing of the campaign message and the way it relayed by journalists (Goffman, 1974). A key challenge appears to be enabling men to critically interpret mass media messages in order to make informed decisions and to adopt greater control over the factors that influence their health (National Social Marketing Centre (NSMC), 2007). It is important that those communicating health messages are aware that the proposed norms do not conflict with men's normative norms. Negative demand refers to the challenge social marketer's face in marketing health services or products to men as they are asking men to go against long standing societal norms (Kotler and Armstrong, 2003). These societal norms include; encouraging men to solve problems themselves, not admit vulnerability, and avoid seeking help (Addis and Mahalik, 2003). If men can be convinced that health professionals will allow them to make healthy, autonomous decisions, these men can then consider ignoring societal values that support the avoidance of health interventions (Rochlen and Hoyer, 2005). For the media, this is a more sensitive and demanding request than encouraging men to purchase a new television or car, for example, trying to entice macho men into wearing a seatbelt (Rochlen and Hoyer, 2005; Kotler and Armstrong, 2003). Goffman (1974) believes that the effect of campaign messages on behaviour change can depend partly on the framing of messages and the way it is relayed by journalists. Therefore, social marketers need to ensure that the health

behaviour being promoted is more advantageous than the unhealthy behaviour, reducing the intangible costs or negative demand (Rochlen and Hoyer, 2005).

The WHO (2007) conducted a review to assess the effectiveness of programmes seeking to engage men. They found that the most effective and promising campaigns used positive messages showing what men can do to change, affirming that they could change and showing men changing or acting in a positive way (WHO, 2007). The “Real Men, Real Depression” campaign uses the tag line “it takes courage to ask for help”. This is an example of a method that appeals to men’s competitive and success orientations, characteristics that are frequently associated with traditional male role values and therefore the avoidance of help seeking (O’Neil, Good, and Holmes, 1995). However, the media can often be contradictory as they often replicate dominant masculine norms which can tacitly reinforce unhealthy male gender stereotypes while encouraging individual men to become healthy (Robinson and Robertson, 2010). Some author’s recommend that the media appeal to multiple masculinities, rather than just the dominant form and take into account marginalised and disadvantaged groups (Robertson and Williamson, 2005; Smith, 2007; Smith and Robertson, 2008). Nonetheless, it is also important to ensure that consistent messages are provided about health, disease prevention and treatment to avoid confusion (Cock and Holden, 2008).

Other authors suggest that it may be useful to highlight to the men that there are other men, similar to themselves, who successfully seek help and benefit from its use (Rochlen and Hoyer, 2005). Randolph and Viswanath (2004) state that there is evidence to suggest that campaigns that use testimonies from cancer survivors, celebrities and sports personalities have an effect in raising awareness and short term uptake of screening. However, Buckley and O’Tuama (2010) contradict this as the men in their study found such advertisements frustrating. Their study explored men’s behaviours and attitudes to health matters. It focused on men over 50 from socially disadvantaged areas as they recognised that these were the men with the poorest health outcomes. As a result, they recommend campaigns be targeted locally and use testimonials from men who the target group can associate with in terms of life experience (Buckley and O’Tuama, 2010). This concept is also supported by the WHO (2007) who suggested actively recruiting men from the local community who have already adopted positive health behaviour is most effective.

2.3.2.4. Assessing the impact of media activities.

The major strength of mass media is its ability to reach a wide audience and this also presents the greatest challenge for evaluation (Wellings and Macdowall, 2000). Nonetheless, if no monitoring component is built in, there will be no way of knowing if the campaign was effective (Breckon, 2005). Therefore, comprehensive evaluation of communications campaigns is necessary to justify any public health investment (Bauman, Smith, Maibach and Reger-Nash., 2006). The “social diffusion model” which has been used in evaluation of media campaigns is based on the belief that if mass media interventions work, it is more likely to be because it activates a process of change in social norms rather than directly changing behaviour (Wellings and Macdowall, 2000). However, it appears that there is a need to further develop conceptual frameworks of how to accurately market health to men and measure its success.

As part of a community approach to improving population levels of physical activity, a marketing campaign was conducted which included a dedicated print, radio and television campaign as well as additional marketing activities. The aim of this media campaign was to raise awareness of physical activity and to create awareness of the “10,000 steps” brand. The results of the evaluation suggest that 95% of respondents had heard about the campaign and an increase in recall of “general” physical activity messages was reported (Brown, Mummery, Eakin and Schofield, 2006). Another study, the Wheeling Walks intervention combined an intensive media campaign with environmental changes. This project reported significant increases in physical activity amongst those most sedentary members of the cohort when they were contacted 3, 6 and 12 months after the intervention (Reger-Nash, Bauman and Booth-Butterfield, 2006). The “Safe Kids Week” campaign aimed to educate parents about scald and burn safety and was effective in changing behaviours. A random digit dialling telephone survey was conducted to measure parental knowledge and behaviour. Fourteen percent of parents recalled seeing, hearing or reading about scald and burn prevention and exposed parents were 2-3 times more likely to test water temperatures to unexposed parents (McArthur, 2003). Almost half of respondents who recalled media reports on Vitamin D could not replicate its content yet 6-8% of respondents reported change in their sun protection behaviour as a direct result of the media report (Langbecker et al., 2010). This highlights the

difficulty in evaluating the effectiveness of campaigns in changing behaviours. Snyder and Hamilton (2002) suggest short term changes in behaviour in the 5-9% range may result from exposure to mass media campaigns. Although it appears that mass media campaigns alone produce limited behaviour change, they do show significant changes in behavioural intentions and self efficacy (WHO, 2007). A study which supports this evaluated the impact of exposure to radio messages about sun protection with rural farmers and found that those who heard the messages perceived themselves as knowledgeable about sun protection. They were also more likely to have positive sun protection practices. This highlights that radio was an effective channel to reach farmers (Jones et al., 2001). Also, an evaluation which looked at the effectiveness of the National Tobacco Youth Campaign found that 9% of respondents claimed to have learned something new from it (The Social Research Centre, 2007). To conclude, typically media campaigns are often only one part of a larger community wide intervention (Bauman and Kospell, 2005; Redman, Spencer and Sanson-Fisher, 1990). Redman et al. (1990) suggests that by including media strategies into multifaceted programmes, covering the whole community they are more likely to be effective.

2.3.3. Engaging men

Although gender inequalities in health have been identified for some time now, the main concern for health professionals is how to effectively engage men with their health. A recent WHO report highlights some key features for successful interventions with men (WHO, 2007). They propose; using positive and affirmative messages, encouraging men to reflect on the cost of hegemonic masculinities, using evidence based formative research, ongoing monitoring and evaluation. Additionally, it is suggested that health professionals need to recognise that men are not a homogenous group and how developing interventions that reflect men's different life experiences is necessary. Finally, it is recommended that successful interventions use a wide range of social change strategies, community education, media policy development and advocacy for implementation (WHO, 2007).

The NMHP provides very useful information for health professionals engaging with men in Ireland to promote their health (DOHC, 2008). These principles are a

combination of findings from four key papers (University of Bath, 2005; Department of Health and Ageing, 2005; The Flinders Model, 2005; The Report of the Primary Committee, 2005). They suggest; adopting a positive approach to men's health work, creating non-threatening male-friendly environments, making services and programmes easily accessible, using language that is positive and solution focused, consulting and involving men in programme development and delivery, finding a "hook" and looking for ways that will appeal to men and adopting a hands on approach making sure there is a clear focus to the work. They also recommend planning small and realistically and striving for higher standards of best practice by improving availability of information from evaluations (DOHC, 2008).

Despite such clear recommendations, the challenge of identifying what works with men and translating this into workable strategies remains largely unanswered (Wilkins, 2005). Richardson and Carroll (2009) found that one of the key difficulties of writing the Irish NMHP was to make explicit, evidence of best practice with regard to engaging men available. The following subsections will discuss what has been done to date to redress the health disadvantages experienced by many vulnerable men in society. In the context of engaging men the following subsections will discuss; how to recruit men for health programmes, the need to adopt a male friendly approach, the importance of the facilitator's approach, the potential of men's health programmes and the evidence base for men's health promotion.

2.3.3.1. Recruiting men for health programmes

Research has found that despite using various recruitment strategies, women are much more likely to show an interest and attend interventions that promote health because in the past, health has been viewed as "women's business" (Thomas and Williams, 2006; Murphy, Murtagh, Boreham, Hare and Nevill, 2006; Gilson, McKenna, Cooke and Brown, 2007; Verdonk et al., 2010). Nonetheless, Bonhomme (2004) argues that women can play a crucial role in increasing men's utilisation of health services. It has been suggested that "women are often gatekeepers for men's health particularly with regards to issues such as diet, help seeking etc" (Conrad and White, 2008, pg 33). This is supported by a study targeting men's partners which highlighted that communicating with a man's loved one, combined with a reminder

system was associated with an increase in preventative healthcare screenings (Holland, 2005). The literature examining the provision of health services exclusively for males is ambiguous. The DOHC (2008) suggest that it may be worthwhile exclusively targeting men and Gray et al. (2009) supports this approach as men in their weight loss programmes reported that the fact that the group was male only facilitated their attendance. However, Robertson et al. (2009) contradict this as they found that men in their study stated that their willingness to attend was not determined by the fact that the programme was targeted towards men only. The key factors identified by Robertson et al. (2009) as affecting a man's decision to attend a health programme include; the convenience of the programmes location and timing, age related issues related to life course dynamics and the supportive social format of the programme. While the "Well Men Services" in Scotland found that similar factors encouraged and inhibited men's attendance. These included; the individual's motivations and health beliefs, perceptions about service characteristics and social circumstance and networks (The Scottish Government, 2008).

The NMHP states that one of the most effective methods of recruitment is when someone, whom a man trusts, recommends a specific service or programme (DOHC, 2008). This method of recruitment is referred to as snowballing and can be employed when the target group of men are difficult to reach (Sarantakos, 2005). Also, the way in which a programme is advertised is very important as this is how men will initially judge a programme. A recent Irish study advertised their men's health project to men over 30 and the men commented on how this reassured them and prevented them from being put off or intimidated by different fitness levels (Centre for Men's Health Research, 2009). Robertson, Hacking and Robinson (2009) support this as they found that men were put off participating in their health project as they felt that the programme might be pitched too high or be too competitive. Therefore, recruitment for certain types of health programmes, such as physical activity programmes rely on participants being highly motivated to improve their fitness level which can be problematic for health professionals (Abildso, Zizzi and Reger-Nash, 2010). Participants at the PRC-HAN Physical Activity Conference suggest ways to overcome this problem. They suggest that recruitment of men for physical activity programmes include; including exercises with weights, building competition, appealing to a man's sense of athleticism and teamwork and their past

participation in sport (Belza, 2007). In addition, Conrad (2007) provides an example of how it may be necessary to draw on masculine stereotypes in order to encourage men to engage in health promotion activities. He described how they advertised men's health clinics in a local health centre and only one man booked in. The group rethought their marketing strategy to prevent the service from being shut down. They redesigned the posters to display a large glass of beer saying "free" on the top and "health checks for men" in smaller print underneath and found that the demand for services quickly increased (Conrad, 2007, p.152). Therefore, reframing masculinity, vulnerability and male independence through the media can offer long term promise in prompting men to seek help (Courtenay and Keeling, 2000).

It has also now become apparent that health professionals need to be innovative and unearth a suitable "hook" that will appeal to men and this requires creative thinking and evidence based techniques (Sadovsky and Levine, 2005). Throughout the literature there appears to be recognition of the need to use "incentives" in order to get men and boys to access and engage with health services but their effectiveness is somewhat inconclusive (Robertson et al., 2009). Some of the incentives used by the Bradford Health of Men team include; time off work, free condoms and special events etc (White and Cash, 2005). While the incentives offered by the "Working our ways to health" programme included a gym pass, pedometer, leaflets and guidance books (Robertson et al., 2009). Another study demonstrates how they developed promotional material which included a letter of invitation signed by a popular sportsman and found that this was also a useful technique to engage men (Youl, Janda, Lowe and Aitken, 2005). In Ireland, a community organisation used a similar approach when developing an intervention that was relevant to the needs and interests of men as they realised that past interventions were more likely to attract women. They decided to partner with one of the community learning programmes established in Premier League Clubs in England and Scotland. They felt that men's passion for football could act as an initial hook to engage interest and then act as the vehicle to facilitate learning in a range of areas (Centre for Men's Health, 2009). While other research has found that screening events, health checks and well man clinics aimed at promoting men's health have also proven successful at targeting men (Kierans et al., 2007; Ballinger, Talbot and Verrinder, 2009). This is because men are more likely to use services that are fast and convenient and therefore

screening could be used as the initial “hook” to engage men. Furthermore, the Well Men Services in Scotland found that men tended to favour more mediated services with clinical tests such as blood pressure and cholesterol (The Scottish Government, 2008).

It is necessary to highlight that the successfulness of screening programmes does rely on attracting, identifying and treating those at particular risk of a disease (Bankhead et al., 2003; Brosnan et al., 2009). Research has found that 62% of men who attended a health night, stated that they were more inclined to visit a health professional as a result of men’s health nights or session they attended (Verrinder and Denner, 2000). This is supported by McKinlay et al. (2005) who found that as a result of going to the evening, men were more likely to attend a doctor, even though cost and appointment times were still a barrier for them (McKinlay et al., 2005). MOTs are another example of health screenings designed to provide men with an opportunity to have a detailed review of their current health status and receive advice and discuss the different aspects of their health and wellbeing. The benefits experienced by the men involved in the MOTs range from reassurance that everything is alright with their health to referral to their GP for further investigation of their results (Conrad and White, 2007). Educating men in the community about the symptoms, diagnosis and treatment of disorders can assist in alleviating anxiety, can provide the impetus for men to attend their GP and can assist men and their families in choosing treatment options (Cock and Holden, 2008). The advantage of health checks is that they are flexible and can be provided in any location where men convene such as community centers, workplaces, pubs etc and also act as an initial point of contact or incentive for men to engage with community workers. This is supported by Wilkins (2005) who states that although screening takes place in the community, once health professionals can advise and encourage men to visit their GP, this type of approach can be effective.

As previously mentioned, much of the research highlights how the location of a health programme can be a factor which influences a man’s decision to participate (Robertson et al, 2009; McKinlay 2005, Conrad and White, 2007; Witty and White, 2010). Research has suggested that recruitment is enhanced if it takes place during work time as little effort is required to attend and sometimes these groups can be seen as a social outlet (Conrad and White, 2007). White, Conrad and Braney (2008)

concur with this as they found that male participants who took part in a workplace weight loss programme all felt that having the sessions during work hours was a crucial factor in their decision to attend (White et al., 2008). Following an independent evaluation of the “Working our Way to Health Programme” it was suggested that holding programmes in venues where men carry out normal activities seemed to provide a less stressful environment than statutory health settings (Robertson et al., 2009). Researchers argue that in order to reach men, particularly vulnerable men, less traditional settings such as pubs, sports venues, betting shops, barber shops etc need to be utilised (Conrad and White, 2007; Khutan, 2006). One study recognised that men are more likely to engage in non traditional venues so they took services to pubs and adopted a light hearted focus to communicate health messages in which 130 men participated (Khutan, 2006). Also, the venues used in the North Staffordshire men’s health project (for example, pubs) were successful as they made men feel relaxed and were near to home (Linnell and James, 2010).

Finally, it is recommended that careful consideration is given to the time to ensure that these services do not coincide with live football matches or racing which are often viewed in pubs (Khutan, 2006). Witty and White (2010) concur with this following their intervention with men at rugby games in the UK. They found that men were unlikely to engage with health professionals after games had commenced.

2.3.3.2. Adopting a male friendly approach

All those involved in the mission to improve men’s health need to use innovative, ingenuity and imaginative ways to facilitate their work and engage men (White and Robertson, 2010). King, Sweeney and Fletcher (2005) suggest that men will rapidly assess whether the programme is suited for their needs. As a result, the initial point of contact and initial impression of men is crucial to further engagement. Gray et al. (2009) found that men are reluctant to enrol in weight loss interventions and that this may be due to the fact that programmes fail to recognise gender issues. They designed a programme to address the problem of male obesity in which men were recruited through GPs. Following pre programme assessment, men were invited to attend a weight management group for 12 x 60 minute sessions, in which they were formally weighed. In order to make the programme male friendly, specific changes

were made which included; increased emphasis on portion size and nutrition, “masculinisation” of advice about exercise, use of humour, increased use of quizzes and games, using sandbags to give men the tactile evidence of their midpoint weight loss, a full session devoted to alcohol and de-emphasis of the link between food and emotion (Gray et al., 2009). In addition, qualitative findings from interviews with the staff and service users involved in the Preston Men’s Health Project outline the key markers of successful outreach delivery as follows; competent, well trained teams, flexible working practices, access and integration with community and institutional networks, integrated projects and partnership work and bottom up engagement strategies (Kierans et al., 2007). Finally, it is important that health professionals are flexible and have an understating that what might work with one group of men may not work as efficiently or perhaps at all with another group (Buckley and O’Tuama, 2010).

2.3.3.3. Approach of the facilitator

White and Cash (2005) suggest that the way in which services are structured and the personal attributes of the health workers are important when trying to overcome some of the difficulties that men experience when using traditional services. This is supported by a study which found that the attitudes and skills of the programme facilitators were singled out for strong praise by men (Robertson et al., 2009). The North Staffordshire Men’s Health Project which began in 1995 and is still ongoing adopts a user involvement approach which provides them with an insight into the men’s life forging a symbolic relationship between staff and men which makes the process of engaging hard to reach men easier (Linnell and James, 2010). Watson (2000) believes that health professionals need to incorporate vibrancy and humour into their work with men. This is supported by Robertson et al. (2009) who found that non threatening humour was a method of reaffirming that participation and subsequent lifestyle changes can be part of what it means to be “still lads”.

Those men from deprived areas who engaged in the North Staffordshire Men’s Health Project said that they would only use health services that were caring, friendly and non judgemental (Linnell and James, 2010). Lloyd (2001) reported that the gender of the health professional was not the primary factor in terms of men’s

willingness to engage but their skills and attributes. The report compiled on the use of arts in men's health work in Walsall suggested that those working with men should have a significant understanding of the lives and lifestyles of the target group. It is also recognised the workers need to adopt positive approaches to facilitate men's engagement, acknowledging their own difficulties in engaging with the target group as well as men's difficulties in engaging with services. Their skills and attributes should include; motivation, patience and persistence, confidence arising from experience in working with the target group and the ability to integrate learning into their own practice development (Khutan, 2006, pg 45). Kierans, Robertson and Mair (2007) also reported the strategies they adopted to engage hard to reach men in the Preston Men's Health Project. They suggested the following criteria; taking time to build rapport and trust, meeting with men on their terms, staff not wearing uniforms (for example, nurses) and asking direct and honest questions assisted in breaking down the barriers and supported men with their health (Kierans et al., 2007).

It can take time to develop a relationship with men in which they feel comfortable speaking about themselves (Cornwell, 1984). Research has found that even at the beginning of a study, when using qualitative interviewing techniques people only revealed their "public accounts", and it was not until they were interviewed several times that they began to regard the research as part of their lives and revealed their true feelings and beliefs. Therefore, building a relationship with men is an essential starting point to any work undertaken by health professionals (Cornwell, 1984).

2.3.3.4. Potential of men's health programmes

Interventions aimed at addressing physical activity, dietary habits, smoking and reducing men's risk of cardiovascular disease are commonly cited in the literature but these are often not well attended by men (Jenkins et al., 1997; Pallonen et al., 1994, Stanton et al., 2004; Cook et al., 2004; Williams and Lewis, 2002; McCrone et al., 2001 and Pritchard et al., 2002). According to Lombard, Deeks, Ball, Jolley and Teede (2009) low intensity, local community based interventions have the potential to support lifestyle changes but need to be tested on diverse groups. It has been reported that these community based interventions are effective but effect size is

modest. Nonetheless, qualitative findings suggest that men do benefit from community based interventions (Fishbein, 1996; Department of Health and Ageing, 2010; White and Cash, 2005; Campbell, Shah and Gosselin, 2009; Golding, Foley, Brown and Harvey, 2009).

Gray et al. (2009) suggests that by offering a flexible programme that educates men on how to avoid weight gain and which allows men to take ownership of their weight management it may encourage them to adopt healthier lifestyles. However, sometimes these programmes are more about the unanticipated benefits experienced by men rather than the physical benefits. For example, the Preston Men's Health Project found men built up their own peer networks of support, in which they shared information on issues such as weight and diet and supporting each other in health screenings (Kierans et al., 2007). Additionally in Ireland, men experienced huge unanticipated benefits from participating in the Wellman Programme run by Glasgow Celtic which was adapted to meet the needs and interests of men in Dublin (Centre for Men's Health, 2009). The programme ran four hours a week, for 10 weeks and a health screening was conducted pre and post. The topics covered included; health talks, cookery classes and soccer skills. Although the reach of this programme was relatively small (n=30), it was effective at getting through to the target group of unemployed men, over 30 years of age, from the inner city. More importantly, the confidence that men acquired from gaining new skills positively impacted on their overall sense of wellbeing and this cannot be underestimated (Centre for Men's Health, 2009).

There is increased awareness that men benefit from specific community work and educational approaches to promote health (Golding et al., 2007; Men's Health Forum, 2005; DOHC, 2008). Williams (2003) suggests that increasing educational outreach efforts targeting men and changes in cultural institutions and social structures are needed to promote positive health behaviours. In Ireland, the Co. Meath VEC targeted unemployed men for their part time programme in computer maintenance and support skills. In total, 12 men enrolled, and eight completed the programme. The programme was delivered by an experienced tutor over six months. In addition to completing the programme, all men gained confidence, increased self esteem and participated in work experience (AONTAS, the National Adult Learning Organisation, 2005). Another similar model, which has a strong emphasis on

education and which aims to get men more interested in the maintenance of their health, is The Men's Educational Group Appointments (MEGA). Men are recruited based on being due their yearly physical examination (Campbell, Shah and Gosselin, 2009). However, this programme excluded those with hearing and learning impairments and non English speaking individuals. It could be argued that this excluded those most in need of the intervention. The MEGA approach capitalises on the potential benefits of group dynamics in an effort to educate men about preventative health (Campbell et al., 2009). Eighty one percent of men who participated in MEGA reported that it was very worthwhile and the remainder stated that it was worthwhile. The findings from the evaluation also illustrate the potential utility of the group model for improving patient education regarding health maintenance among men (Campbell et al., 2009). This type of group work has been found to be efficient as it enables men to learn from each other and provides social support (Robertson et al., 2009; O'Brien et al., 2009).

Robertson et al. (2009) agree with the group work approach suggesting that peer support has been found to not only encourage men to attend a programme but also feel more satisfied with the experience. O'Brien et al. (2009) highlight that membership of a group enabled participants to share a common goal with other men (for example weight loss or healthy eating) in an environment which had been negotiated as "male". The type of group activity provided by the Men's Sheds gives men the opportunity to talk about things that they may not feel comfortable talking to their wives or partners about. It is also an opportunity to spend time with other men in a healthy and productive manner (Department of Health and Ageing, 2010). Furthermore, Linnell and James (2010) found that those men regularly involved in the North Staffordshire Health Project became an informal steering committee and valued advocates for men's health while also providing an effective approach to making the services more accessible and sustainable further highlighting the benefits of group work. Therefore, Young (2007) suggests that it is vulnerable men that need to be incorporated into activities such as advocacy work in order to expand and develop men's health as it is men from marginalised communities that are the most powerful representatives of their own troubles. On the other hand, a study which sought the perspectives of men from socially deprived areas found that this cohort perceived those men who participate in health programmes as sitting around like a

load of women and going against gendered norms (Coles et al., 2010). There is also much debate in the literature about whether groups of strangers are preferable to groups of friends or work colleagues (Wilkinson, 1993; Kitzinger, 1994; Morgan, 1997; O'Brien, Hunt and Hart, 2009). However, one study did find that it was important that groups were composed of men from similar socio economic backgrounds and that men were also of similar age (O'Dowd and O'Keeffe, 2004).

Men's Sheds are another example of a health promoting activity which can be used to promote the psychosocial health and wellbeing of men. Men's Sheds are an updated version of the shed in the backyard where men, young and old, come together learning new skills such as woodwork and where they also learn something about life from the men they work with. Those who become a member of a Men's Shed have a safe and busy environment in an atmosphere of old-fashioned mate ship (Australian Men's Shed Association, 2009). Ballinger, Talbot and Verrinder (2009) explored men's experiences of participating in Men's Sheds and how these experiences impact on their health and wellbeing. They suggest that many of the men who attend sheds are retired or at risk of social isolation and that the sheds have the capacity to provide them with a sense of purpose (Ballinger et al., 2009). Golding, Foley, Brown and Harvey (2009) concur with this as their research found that community organisations such as Men's Sheds have the capacity to address many determinants of men's health, for example; social exclusion, unemployment, stress etc. They offer an opportunity for informal learning, social interaction, health promotion and the provision of a source of enjoyable and meaningful activities (Ormsby, Stanley and Jaworski, 2010). Furthermore, they provide an opportunity to do things that they would not normally do and a chance to get out of the house. Men also reported a sense of accomplishment and pride having produced quality pieces of work. Finally, all of the men reported that they had met new people and enjoyed the male companionship and camaraderie in the shed (Ballinger et al., 2009). Men cite improved mental health, increased social interaction and support, a sense of purpose and feeling valued as a result of giving back to the community (Department of Health and Ageing, 2010). Ormsby et al. (2010) found that men perceived the sheds as more than a place of work and referred to companionship, the relaxed atmosphere and a place of social gathering. To conclude, Granovetter (1973) suggests that meaningful engagement is crucial to maintaining strong personal and social ties,

which are likely to increase reciprocity and a sense of belonging. Taken together, the evidence from the Men's Sheds Programmes reinforces the assertion that there is a direct link between men participating in community organisations and their sense of wellbeing.

2.3.3.5. The evidence base for men's health promotion

It should be noted that there is a lack of evaluation of health promotion programmes that exclusively target men (DOHC, 2008). It is therefore necessary to examine and assess the features of any health promotion efforts to improve men's health that can support existing services (WHO, 1998b; DOHC, 2008; Smith and Robertson, 2008). Difficulties in measuring the success of men's health programmes arise from the subjective nature of health and the fact that results of some interventions may not be seen for years (Conrad and White, 2007). The evaluation of community programmes is a complex process and usually involves a lot of staff and a variety of activities. Therefore, monitoring the implementation of the programme is of particular importance (Bracht, 1999). Across the literature there seems to be little consensus on the conditions necessary for health researchers to conclude that an intervention has produced a significant impact on population health (Glasgow, Klesges, Dzewaltowski, Estabrook and Vogt., 2006). To help programme planners, evaluators, funding agencies and policymakers plan, evaluate, and implement health programmes, Glasgow et al., (2006) designed an evaluation framework (REAIM) that identifies the translatability and public health impact of health promotion initiatives (Centre, 2009). REAIM is used to plan well rounded interventions and this increases their chances of success in the real world settings (Green and Glasgow, 2006; Klesges, Estabrooks, Dzewaltowski, Bull and Glasgow, 2005). The overall goal of the REAIM framework is to encourage policy makers, programme planners, evaluators, funding agencies to pay more attention to these key elements that can improve the sustainable adoption and implementation of effective evidence based health promotion (Belza, Toobert and Glasgow, no date). According to Rosanne Farris and her associates, programmes that sanction imitation are the ones that have the greatest public health impact, are inexpensive, efficient and easy to implement in a non research environment (Farris, Will, Khavjou and Finkelstein, 2007).

2.4. Conclusion

Although there has been an increased interest in the area of men's health this has brought its own difficulties for health professionals who engage in health promotion work with men (Smith and Robertson, 2008). It has become clear through the current review of literature that improving the health of men, particularly vulnerable men, is a complex issue that requires input from a variety of disciplines, in a variety of settings, as well as at different levels. It is important to remember the variety of factors that influence men's health (for example; gender, socio economic status etc) when planning, implementing and evaluating health strategies, as these can often be neglected (Ostlin et al., 2007). As highlighted in the first section of this review, the broader determinants of health, for example, economic opportunities in society appear to have a great influence on the health status of men (Smith and Robertson, 2008). Many men in Ireland experience marginalisation due to rapid social and economic change and their reintegration into community and social networks is essential in terms of improving their health. Although the establishment of best practice in promoting men's health is limited, this review investigated the effectiveness of some of the main strategies to promote the health of men, specifically the community development approach, using the media to promote the health of men and finally engaging men with their health. However, it is evident that there is still a gap between research findings and the implementation of evidence based strategies to engage men and improve men's health (McGinnis and Foege, 2000). This may be due to the fact that many debates have taken place as to what constitutes success in health promotion since evidence may be anecdotal or difficult to quantify.

To conclude, it is evident that engaging men in health promotion activities in the community is a dynamic process, but can offer significant benefits to men once the wider determinants of their health are considered. It is necessary to develop methods and theories that can improve the design and evaluation of community based programmes thus highlighting best practice with regard to engaging men (Wagner et al., 2000). Therefore, the purpose of this research is to answer the following research questions.

1. What are the individual components of programme design associated with effective engagement of vulnerable men in community based health promotion? (Chapter Three)
2. How effective is a print media campaign as a tool to communicate health messages to vulnerable men? (Chapter Four)
3. What are the factors that contribute to successful partnership work in community based health promotion with vulnerable men? (Chapter Five)

***Short
Programmes***

3.0. Introduction

One of the limitations of the existing literature on men's health has been a tendency to overlook the best ways of engaging vulnerable men in community based health programmes. During the consultation process for the NMHP, it was highlighted that there is an absence of health promotion initiatives that specifically target men (DOHC, 2008). It is therefore important to improve health professional's understanding of how to effectively engage vulnerable men, in particular, and to address the wider social determinants of their health. The CMHP sought to build upon current knowledge and experience in this area and examine factors that underpin men's engagement and disengagement in community based health programmes. The second component of their strategy, delivery of short programmes, will now be discussed in detail. Two main programmes were offered during the course of this research which included; a Men's Health Programme which ran for six weeks and a subsequent ongoing Physical Activity (PA) programme in which data was collected for the first 18 weeks. The CMHP applied the learning's from the Men's Health Programme to the PA programme with a view to improving engagement. This chapter will present both programmes in terms of the approaches used by the CMHP to maximise engagement, the methods of investigation, results, discussion and finally conclude with recommendations for engaging men in future health programmes.

3.1. Overview of Men's Health Programme

Following on from the health needs assessment (HNA) and health check (see Introduction Chapter for more detail), a Men's Health Programme was developed to engage this group of vulnerable men and address the issues identified. This programme was delivered on a weekly basis, for one hour, after a lunch was provided free of charge to men. The same programme was delivered in parallel in two locations (Urban Group, Cathedral Parish Centre; Rural Group, Tullow Mart) to accommodate both urban and rural men who previously participated in the HNA. Table 3 below outlines the aims and objectives of the Men's Health Programme as identified by the CMHP.

Table 3: Aims and objectives of Men's Health Programme

Aims	To deliver a health programme that meets the needs of the target group as identified on week one.
Objectives	<ul style="list-style-type: none">• To engage a cohort of men to consistently attend the programme over the six weeks.• To begin the process of personal capacity building among this cohort so that they may be empowered to engage in their own health and lives.• To support men to improve their knowledge about the factors that influence their health.• To support men to explore and understand how the messages they received throughout their lives have influenced their behaviour.• To support men to be proactive about their health through delivering the message that many men are proactive about their health and it is wise, courageous and absolutely appropriate to look after oneself.• To support men to be proactive about their health, delivering the message– “Don’t wait until it’s too late” to go to your GP.• To offer men coping strategies to avoid isolation.• To use this programme as an initial step for further work with this group.

The researcher provided the CMHP with a copy of the REAIM planning tool (See Appendix 3.1) and this was used during the planning phase of this programme. The philosophy that underpinned the programme delivery, according to the planning tool, was as follows; it is important not to assume that men do not know, but discover what men do know, think and feel about their health and/or behaviours, to celebrate men’s participation in the programme and offer them an opportunity to increase their awareness and knowledge of their health via experiential methodologies and finally respect their right to discover and learn at their own pace.

3.1.1. Strategies adopted by the CMHP to maximise engagement

The potential barriers to engaging men and how these were to be overcome were also explored by the CMHP during the planning process. They identified a number of barriers which included; the physical barrier of getting to the location, the move from opportunistic health checks to firm commitment to a programme, male conditioning (for example, attending a health programme, which is considered women's business, being busy with what they believe are other priorities and embarrassment of having time to attend as they are unemployed), not knowing anyone or having to go alone and finally simply not knowing what the health programme was about.

In order to overcome the identified barriers the CMHP gave due consideration to the following factors; location and venue factors, the facilitator, recruitment, meaningfulness of the programme and ongoing contact with men.

Location and Venue Factors

The timing of the programme coincided with a time when the target group would be convening for another purpose (collection of social welfare payment and livestock sales). The programme commenced shortly after the closing of the social welfare office and the finishing of the animal sales at the rural mart. The venues selected were both within a short walking distance from where the men convened. A free lunch was provided for all men at both venues. This was a hot dinner at the rural venue in keeping with what farmers normally ate for lunch at the venue.

Facilitator

The lead facilitator was targeted and contracted by the CMHP to facilitate the Men's Health Programme. He had considerable experience in the area of men's health, community development and facilitation of men's groups. The lead facilitator was supported by a co facilitator who was a member of the CMHP Steering Committee. The co facilitator brought their own experiences of facilitation, their knowledge of the larger project (CMHP), their local knowledge of the men and the locality and

also acted as a direct link between the men and the CMHP, giving regular updates and providing feedback.

Recruitment

A letter was sent to all men on the database from the HNA (n=162), five weeks prior to the commencement of the programme (see Appendix 3.2). This was followed up by a phone call and text message two weeks and one week prior to the commencement of the programme, respectively. An agreed dialogue was used for the phone call to support the building of trust with the men (see Appendix 3.3).

Meaningfulness of the Programme

At the initial point of recruitment, a clear link was been made between the HNA, health check and the Men's Health Programme. The purpose of making this connection was to highlight the relevance of the programme to their health and lives so that they might see the need to attend.

The CMHP made the decision not to plan the programme in detail but rather to discuss options with the men themselves on the first week i.e. what they wanted to gain from attending. Therefore, during the planning phase for the Men's Health Programme the CMHP defined the following parameters for the programme. The programme would be flexible to the needs and interests of the men, focus on personal capacity building so that men may engage with the CMHP in the future, focus on the issues identified during the HNA, focus on providing the men with a further positive experience of being engaged by a service provider and finally focus on exploring possible follow on health initiatives with interested men.

Following on from the discussion with men on week 1 of the programme, the components of the programme were finalised; childhood messages and how they affect men, diet, exercise, reducing risk of ill health and finally a discussion of their learning's. The mode of delivery that was chosen was experiential learning in order to support men to engage in their learning.

Ongoing Contact with men

A strategy to maintain ongoing contact was developed and implemented as follows by the CMHP;

- The lunch provided prior to the programme initially acted as an icebreaker for both the men and facilitators while also supporting an informal point of contact each week.
- After week one of the programme, all men on the database who did not attend were contacted again by letter and invited to attend the remainder of programme (weeks 2-6) and to bring along their friends who may benefit from attending.
- From week two, all men in the groups were contacted by text weekly and each text was signed by both the lead and co facilitator along with the contact number of the co facilitator.
- After week four (Town group) and week three (Rural group) all men who had attended previously received a phone call as numbers reduced to four in each group.

3.1.2. Methods of Investigation

The timeframe for the programme delivery and investigation is outlined in Figure 2 below.

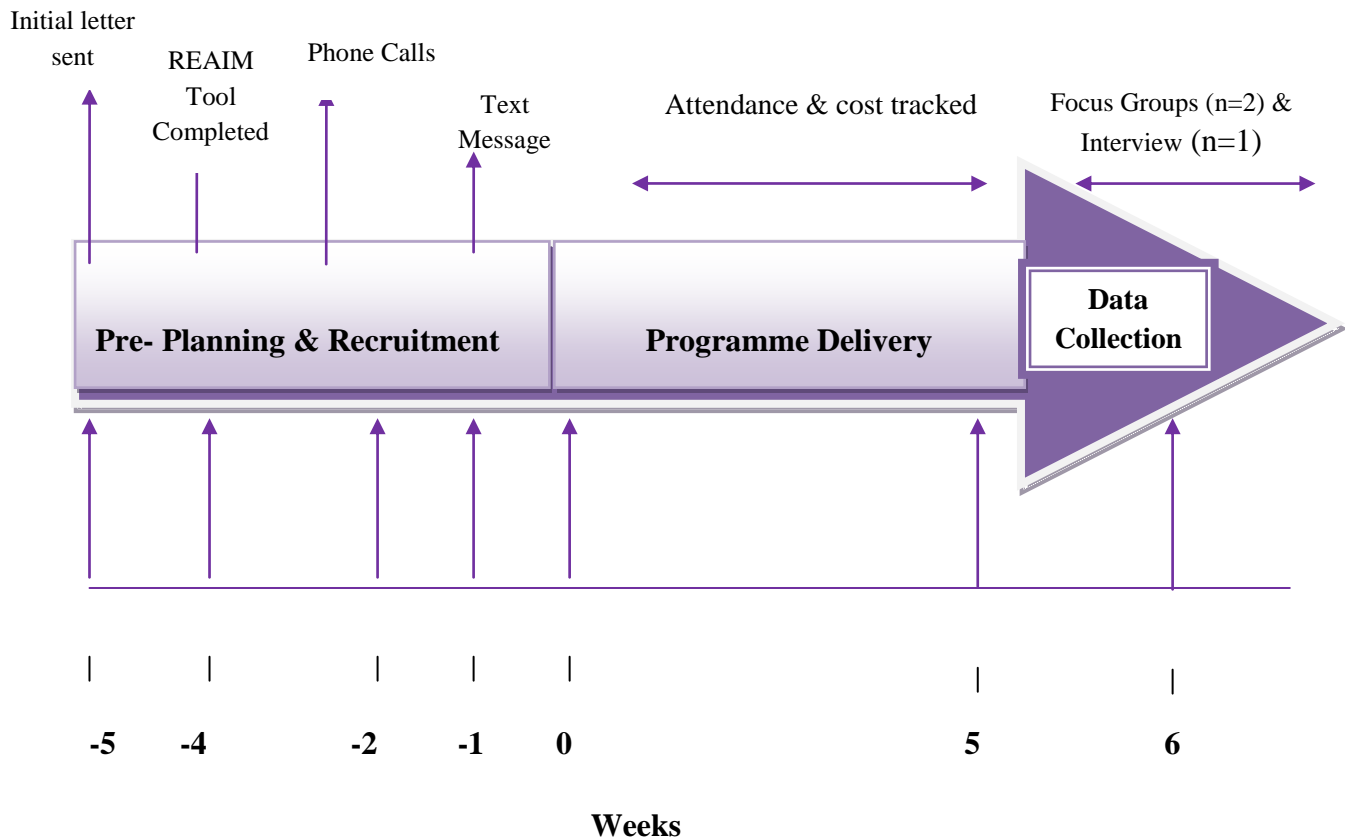


Figure 2: Timeframe for the programme investigation

3.1.3. Determining Engagement

Analysis of planning tool and attendance

Following completion of the REAIM planning tool, the CMHP forwarded this to the investigator for analysis. Adherence to the programme was measured by attendance and defined during the planning process as a measure of success. Weekly attendance was recorded by the co-facilitator and also sent to the principal investigator.

Participant Focus Groups

On the final week of the programme (Week Six), two focus groups (urban and rural) were conducted with the men who participated at the respective venues. Given that the programme content was fluid and designed to meet the needs of men as they arose, it was felt that qualitative research was the most appropriate methodology. The aim of this was to provide men with the opportunity to share their experiences of the Men's Health Programme and their aspirations for further development and implementation of the strategy. Focus groups are unstructured interviews with small groups of people who interact with each other. They have the advantage of making use of the group dynamic to stimulate discussion, gain insights and generate ideas in order to pursue a topic in greater depth (Bowling, 2002). Courtney and Keeling (2000) state that focus groups are an effective method to develop an understanding of the needs of men and to apply a gender informed approach to improving their health. Since these focus groups were conducted after the programme they are referred to as a post research method, which explains trends and variances, reasons and causes, attitudes and opinions (Sarantakos, 2005).

In the urban setting, the focus group lasted approximately 40-45 minutes with seven men in attendance. In the rural venue, there were five men in attendance and the focus group lasted approximately 20-25 minutes. With permission, the focus groups were recorded to ensure all information was correctly interpreted. The topic guide for the focus group looked at issues such as; why men decided to attend, the impact of the programme, their assessment of the programme and recommendations for future programmes. The full topic guide used for this focus group can be found in Appendix 3.4.

Interview with Facilitator

At week six of the programme, a semi structured interview was conducted with the facilitator that lasted approximately 50 minutes and was conducted in the rural venue. Again with permission, the interview was recorded and transcribed verbatim for analysis. A semi structured interview was chosen as it gives the researcher the opportunity to probe fully for responses, clarify any ambiguities, inconsistencies or

misinterpretations (Bowling, 2002). The aim of this interview was to learn about the facilitator's perspective on the practices used to engage the men in the programme. Specifically, the topic guide looked at the following; the facilitator's background in men's health, what worked with the men, what men gained from attending and his recommendations for engaging vulnerable men in the future (See Appendix 3.5).

3.1.4. Data Analysis

Recordings of both the interview and the focus groups were transcribed verbatim as this provides an excellent record of naturally occurring interactions and offers a highly reliable record that the researcher can return to (Silverman, 2001). The principle of Grounded Theory, most commonly applied to qualitative research, was used for data analysis of the qualitative responses (Richards and Morse, 2007). Grounded Theory originally developed by Glaser and Strauss (1967) and is concerned with the discovery of theory from the data that is systematically obtained and analysed. The task of the researcher is to understand what is happening mainly through observations, conversations and interviews. According to Parahoo (1997), grounded theory adopts the inductive approach as it relies on the data to formulate hypotheses. It involves constant comparison in which the researcher can gather additional information to allow for reviewing, refining, developing and clarifying the meaning of categories for the theory until saturation is reached (Glaser and Strauss, 1967). Grounded theory was seen as appropriate because this research was less about evaluating the programme and more about examining how to engage vulnerable men.

A line by line content analysis was carried out on the transcripts using simple data reduction techniques (Miles and Huberman, 1994). This is where texts are reduced and integrated into a summary form (Cohen, Manion and Morrison, 2000). Notes were taken in the margins when searching for themes until data saturation was reached. The responses were then coded, with codes subsequently arranged into suitable categories of themes. Table 4 outlines the Glaser and Strauss (1967) method for data analysis which was used as a guide when analysing the qualitative data obtained in this research. A second person was not used to check the content analysis because according to Morse (1997) using a second person to code or check

the transcript may in fact violate the process of induction because the first researcher has a wealth of knowledge from conducting and observing the qualitative data collection that the second researcher does not have.

Table 4: Method for data analysis

Stages	Purpose
Codes	Identifying anchors that allow the key points of the data to be gathered
Concepts	Collection of codes of similar content that allows the data to be groups
Categories	Broad based group of similar concepts that are used to generate theory
Theory	A collection of explanations that explain the subject of the research

3.1.5. Results

The following section will present an overview of the results with a specific focus on the profile of men who attended, factors that contributed to engagement, the effectiveness of the Men’s Health Programme, recommendations for future work with men and the cost of the programme delivery.

3.1.5.1. Profile of the Participants

The CMHP engaged with 164 men through a HNA and health check; 162 of these men (n= 70 rural and n= 92 urban) were eligible to be recruited for the Men’s Health Programme. All 162 men were invited to attend and encouraged to bring someone along with them whom they believed would benefit from attending. A total of 26 men (mean = 48.5 years) registered for the Men’s Health Programme in their area (urban, n= 15, mean= 47.3 years; rural, n= 11, mean= 50.3 years). Most of the men who registered, both in the urban (n=13/15) and in the rural areas (n=9/11) had previously participated in the HNA and health check. Demographic information was only available for those men who participated in the original HNA and is outlined in Table 5 below.

Table 5: Demographic profile of the participants (n=22)

	Urban (%) (n=13)	Rural (%) (n=9)	Total (%) (n=22)
Level of Education			
▪ Primary education only	15.4	11.1	13.6
▪ Some or completed secondary	61.5	44.4	54.5
▪ Some or completed third level	23.1	44.4	31.9
Employment Status			
▪ Full time	15.4	0	9.1
▪ Part Time	7.7	11.1	9.1
▪ Unemployed	69.2	11.1	45.5
▪ Retired	7.7	22.2	13.6
▪ Self Employed	0	55.6	22.7
Source of Income			
▪ Employment	7.7	44.4	22.7
▪ Social Welfare	76.9	11.1	50.1
▪ Pension	7.7	22.2	13.6
▪ Other	7.7	0	4.5
▪ Farm Subsidies	0	22.2	9.1
Living Alone	30.8	0	18.2
Marital Status			
▪ Married	61.5	77.8	68.2
▪ Separated/Divorced	15.4	0	9.1
▪ Single	23.1	22.2	22.7

The majority of men who attended the programme were Irish (91%). Despite the fact that the majority of men were married (61.5% urban; 77.8% rural), 38.5% of men at the urban venue were either single or divorced/separated and 22.2% of those at the rural venue were single. With regard to employment status, the highest percentages reflect the venues where the HNA were conducted. In the urban location (social welfare office), 69.2% were unemployed compared to the rural location (farmers mart) with 55.6% of men self employed, predominantly farmers. Additionally, 76.9% of men who attended the urban venue were social welfare recipients. Therefore, based on the demographic profile of the men who attended the Men's Health Programme, it is believed that the target group of vulnerable men did respond to recruitment.

3.1.5.2. Engagement Analysis

a) Attendance

The average attendance was eight (range 5-10) and five (range 4-9) in the urban and rural venues respectively. Three men at the urban venue and one man at the rural venue completed the full six weeks of the programme. The attendance record influenced the level of contact by the CMHP with men, whereby men were contacted at week four of the programme when attendance fell. However, despite this resource intensive contact, attendance did not improve over the final two weeks.

During the planning process, the CMHP Steering Committee predicted (using the REAIM planning tool) that 20% of their target population would attend the programme. When asked on a scale of 1-10 (1= not at all confident, 10 extremely confident) how confident they were that the programme would successfully attract 20% of their target population, the Steering Committee responded with a six. As can be seen from Table 6 below, 16% of the target responded to recruitment for the Men's Health Programme in the urban and rural areas.

Table 6: Breakdown of the number and representativeness of men

	Urban	Rural	Total
Total target population	92	70	162
Number who registered at week 1	15	11	162
Proportion of target group who responded to recruitment	16%	16%	16%
Number who participated (average of 6 weeks)	8	5	14

b) Factors that Supported Engagement

The results that emerged following the analysis of the qualitative data attempt to capture some of the factors which facilitated and inhibited men's engagement in the programme. There will also be a particular focus on effectiveness of the programme and men's recommendations for future programmes (See Figure 3).

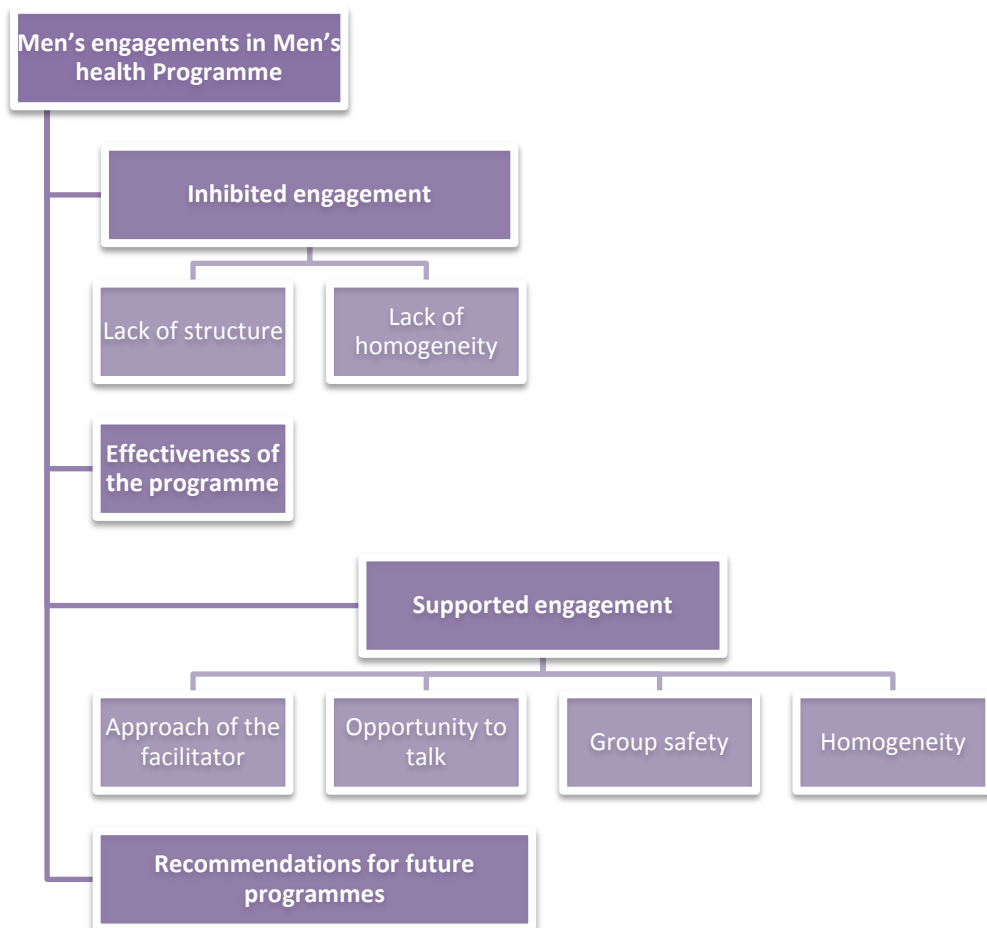


Figure 3: Themes emerging from qualitative data analysis

Homogeneity within the Group

Initially, when the facilitator was asked if the CMHP had successfully reached their target group of vulnerable men, he responded with a resounding yes but he did suggest that more vulnerable men were reached in the urban setting. With regard to engaging men, there were a number of references to the importance of homogeneity within a group. The facilitator stated that in order for men to participate and feel safe in a group there needs to be some common ground. He believed that the urban

group worked much better because all men were in a similar situation and had the common theme of unemployment which connected them to other men in the group, despite being diverse in terms of ethnicity, age and class. The facilitator stated that;

“What kept them together was what was common in all of their heads that they were in the same situation (unemployed)”.

However, of note was the fact that men from the urban group declared that they would not have attended the sessions if they had known a friend or someone else in the group. This was an interesting finding and when this was put to the rural group they suggested that they would have liked to have known someone else in the group.

Group Safety (Ground Rules)

An important piece of work for the facilitator, to effectively engage men, was the setting of ground rules. The facilitator suggested that it was much harder to make a less homogenous group safe. It emerged that week one was crucial in establishing a sense of safety in the group. He stated that;

“The first group (session) is the really difficult one and the really crucial one and I put a lot of energy into that, just trying to set the rules, trying to get it clear for people that it can be safe. And in the main that works”.

Approach of the Facilitator (patience and persistence)

A number of approaches were adopted by the facilitator to successfully engage men during this health programme. The facilitator believed that patience and persistence are two very important qualities to possess when working with men. The facilitator echoed throughout his responses the importance of allowing every man to talk. One such strategy he used to include the quieter men was to invite them to talk about what it was in life they enjoyed. He found that this strategy was useful as it gave men the opportunity to see that they had similar hobbies and likes to other men in the group.

“I come from a very simple thought that in any group there is a huge amount of knowledge and wisdom and really it is a question of letting men hear themselves talk and hear others talk”

The facilitator believed that every man has a certain amount of knowledge and wisdom to bring to the group and that his role was to facilitate men in expressing this wisdom and also the inclusion of those who say nothing.

Opportunity for men to talk

The vast majority of men responded positively to the programme and the opportunity to talk about issues that they would not normally discuss. Furthermore, men commented that they enjoyed the experience, found it beneficial, very relaxed and casual. Men reflected;

“You’re able to talk whereas it’s not the way you would usually talk at all. Maybe in the pub when you have a few jars in you, you’d rattle off something but this way you can actually remember what you said.”

“We come here and talk, if someone wants to get something off their chest its safe and you feel great after doing it”

Another observation, highlighted by the facilitator, was the powerful feeling men get when they hear themselves talk and others listen to what they are saying. He reiterates that this can be very empowering for men and can help them develop as a person, which is essential to the overall improvement of a man’s health and wellbeing. He acknowledged that the urban men were much more prepared to talk about themselves and their struggles openly during the sessions and this was also evident to the researcher during data collection. It also emerged from the focus group with the urban men that there was a range of issues evident including; financial worries, isolation, depression and poor health. The facilitator remarked that this group of men were extremely marginalised and some of the “men lacked basic social skills including the ability to have a conversation with others”. He also observed that the level of interaction was much better than that in the rural group. However, one man highlighted that he did not like the nature of this type of group work as he wasn’t attending to make friends but to learn about his health.

c) **Factors that Inhibited Engagement**

Homogeneity

As previously mentioned, the facilitator recalls the rural group being much less homogenous than the urban group and he discussed the negative influence that this had on the group. It emerged that vulnerable men (both economically and in terms of their health) did attend the programme but did not stay. The reason for this, as cited by the facilitator, was due to the fact that there was too much diversity within the group and no common ground. For example, he recalls a prominent farmer attending the group on the same week as a man who had not worked for years, as a result of ill health, and whom was very angry about this. The facilitator believed that both men ended up dropping out as “they both felt intimidated and out of place”.

Lack of Structure

The biggest issue to emerge, with regard to structure, was to do with the flexibility of the attendance over the first few weeks. A dislike emphasised by the rural group was the fact that the conversation ran out quickly or went off on a tangent. Many of the men, in both venues, expressed that they did not like having to explain their story each time a new man joined. Some men felt that this disturbance impacted on the amount of work they completed over the six weeks.

“You explained your story, then the next week someone else joined the group, you say it again. Because there was no structure on it, it felt like we were going around in circles”.

From synthesising the data it has emerged that men had very different ideas of what to expect from the programme. The facilitator made an observation that the Carlow Men’s Health Project suggested something to these men. He believed that men expected a project and not such a flexible programme that they had control over. The men also concurred with this stating that they were expecting a more concrete programme. They suggested that the programme should be more specific and practical so that they would reap some sort of tangible benefits as a result of participating. One man relayed how he had expected more of a lecturing type situation in which he would learn more about health issues. Furthermore, rural men suggested that the reason for some of the other men dropping out of their group was due to the different expectations about what the programme would entail. Despite

this the facilitator suggested that, after years of experience of working with men's groups, he was against the stereotype that men need structure. He stated how he told the men that the programme was

“Us here together and there was jaw dropping silence for a bit. You can interpret this two ways; one is that men need to be told and men need activity and stuff and they won't talk. That's a perspective, it's also a stereotype. It's not my experience, I sit in groups all of the time with no agenda, even a looser agenda not even with a health tag on it, men's development groups, personal development where it's absolutely free fall. So, I am against the stereotype that men need structure, that's just my experience”.

3.1.5.3. Effectiveness of the Programme

Although there was no specific measure of effectiveness, there were a number of references to the benefits experienced by the men having participated in this programme. Men from the urban group suggested that their awareness of the importance of looking after their health had been heightened. For some of the men it appears that this heightened awareness translated into changes in their dietary habits, alcohol intake and attendance at the GP. One man stated that “what we have learned, we have learned from our group and our facilitators”. The facilitator also highlighted some of the benefits he witnessed such as; a heightened sense of contact and cohesion. He suggested that the programme was an opportunity for some of the men to come out of isolation and be heard by other men in similar situations, which he believed to be a powerful experience.

“To be heard by a group of men is a really powerful acclamation, it's really impressive. I know when it happens to me the impact is really encouraging”.

3.1.5.4. Resources

As with any intervention it is necessary to consider what resources are required. It is evident from the previous sections that the planning, recruitment and delivery of this programme was intensive in terms of “time input” by members of the CMHP but this figure is difficult to estimate. Additionally, each week a member of the steering committee participated in the sessions. Although cost and resources are not an integral element of the REAIM framework, it was felt that if this research is to

inform future programmes, it is an essential element for consideration. Table 7 displays a breakdown of the costs by venue. If the programme costs are broken down by the total number of participants registered (n=26) it emerged that the programme costs approximately €143 per person for six weeks and €3,716.63 in total. This does not include the significant investment in terms of planning and recruiting participants. Therefore, this figure is likely to underestimate the total costs.

Table 7: Breakdown of cost for Men’s Health Programmes

Item	Urban	Rural	Total
Facilitator	€1,382.46	€1,382.46	€2,764.92
Venue	€152	N/A	€152.00
Food	€239.71	€560.00	€799.71
Total	€1,774.17	€1,942.46	€3,716.63

3.1.5.5. Recommendations for the Future

There were a number of suggestions put forward by the men and the facilitator that the CMHP could reflect on for future work. One of the major findings was that many of the men would have preferred if the programme had been run at night or later in the evening. Men cited various reasons for this which included; fewer constraints at night and also the opportunity to sit around for longer with other men in the group, making it a more social outlet. It was also highlighted that the time of year was not very conducive to farmers and that the autumn time would be more appropriate. Some of the men did propose that the programme may also need to run for a few more weeks in order for changes to be implemented and observed. The facilitator also agreed with this as he suggested that in order to impart the knowledge that results in behaviour change, a longer time frame is needed (both in terms of hours and weeks).

Screening featured high on the agenda for this cohort of men with men suggesting beginning the programme with a physical health screening, on an appointment basis

and then the opportunity to review this with a follow up screening a few months later. One man suggested that they be given some sort of diet and physical activity plan and that this would be followed up to ensure motivation levels remained high and that progress had been made. There was consensus amongst the urban group with regards to having the input of specific guest speakers focusing on one health issue per day. One recommendation that generated resounding agreement was as follows; there should be 30 minutes talk from specific speakers (e.g. a nutritionist). This would then be followed by the opportunity to process the information obtained and speak in the group about ways of incorporating the suggested changes into their lives.

The facilitator was asked what it would take to bring this group of men together again the researcher was met with a sense of uncertainty. When prompted with the idea of a PA programme, he suggested that it would have to be targeted and tailored to this specific group of men. The idea of a series of short lectures (half an hour input on PA followed the opportunity to process what they have learned) was also supported by the facilitator. In addition, the need for the facilitator to feedback to individual men with key suggestions on how they could incorporate physical activity into their daily lives was recommended. The facilitator believed that this type of experiential learning would benefit men through having the opportunity to learn from other men in the group.

As previously mentioned, the homogeneity of the group appeared to really impact on the work and development of the men, therefore the facilitator recommended that future groups be as homogenous as possible. He believes that social class is a very striking factor that segregates men. If this could not be achieved there would need to be a common ground and he again highlights the example of unemployment acting as a bond between the men in the urban group. At this point he also highlighted that if the group has a member with strong leadership qualities that this should be utilized and would have huge benefits to the other men in the group.

3.1.6. Discussion and Conclusion

This Men's Health Programme incorporated a capacity building and personal development approach to allow men to become more actively involved in improving their health and wellbeing. As can be seen from the results section, a total of 26 men attended the Men's Health Programme which equates to 16% of the target population. The average age of men was 49 years and average attendance over the six weeks was eight in the urban venue and five in the rural venue. Qualitative findings suggest that a number of factors supported men to engage namely; homogeneity in the group, ground rules and the opportunity to talk. Lack of structure emerged as the main reasons cited which inhibited men's participation. Furthermore, a number of recommendations for future programmes also emerged from the qualitative data.

The REAIM planning tool was a very useful means to prompt the CMHP to consider the key issues which might affect men's engagement in the health programme. By completing this, the CMHP were able to identify barriers to engagement, make relevant changes and adopt strategies to ensure the Men's Health Programme was unique to their target group. The CMHP showed a good awareness of the factors which might influence a man's decision to attend the health programme some of which have previously been identified in the research i.e. convenience, location, timing and supportive social format of the programme (Robertson et al., 2009). The CMHP subsequently adopted strategies to overcome these identified barriers. Firstly, they decided to offer men a free lunch as an incentive to attend and the use of incentives is widely recommended in the literature when trying to engage men (White and Cash, 2005; Youl et al., 2005; Centre for Men's Health, 2009). However, there is little evidence to suggest how effective this actually was as a "hook" to get men involved.

Furthermore, a non-traditional venue was chosen for the Men's Health Programme as research found that these are more effective at reaching vulnerable men than health services (Conrad and White; Khutan, 2006). Also, the timing of the programme coincided with something the men were attending anyway (cattle sales and collection of social welfare payments). The average attendance at the Men's Health Programme over the six weeks was low both in the urban and rural venue.

Despite the ongoing, resource intensive contact with men (i.e. letters, phone-calls and texts), it appears that attendance did not improve. The Irish NMHP found that men quickly assess their comfort zone and decide whether or not a particular group would meet their personal needs and this can result in a drop off in attendance rates (DOHC, 2008). The demographic profile of the group may explain the poor attendance level to some extent. As previously mentioned, 69% of men at the urban venue were unemployed and the detrimental effects of unemployment on health are well documented. When a man becomes unemployed he finds himself in an environment where he feels he should not be for example, in the home minding children (Bezruchka, 2009; Mathers and Scholfield, 2008; Bartley, Sacker and Clarke, 2004; Morris Cook and Sharper, 1994). Furthermore, anecdotal evidence from the NMHP suggests that it is acceptable for women to attend a community programme during work hours but men are less likely to do so as they feel they are supposed to be at work (DOHC, 2008). This is supported by the comments of men from the urban group, who despite the majority being unemployed, would have preferred evening sessions citing fewer constraints as their reason. Previous research has found that even those programmes that run in the evening or at weekends do not appear to attract men and therefore it is not possible to attribute low attendance rates to matters of convenience alone (Wilkins in White and Pettifer, 2007).

Although it could be argued that the number of participants recruited to the programme was relatively small, the demographic information highlights that the CMHP were effective at reaching their intended group of vulnerable men. Furthermore, it should be noted that small numbers are more favourable for this type of group work or experiential learning (Centre for Men's Health, 2009). The demographic information also highlighted that 39% of urban men and 22% of rural men were single or separated/divorced. One of the original objectives was to offer men coping strategies to avoid isolation and according to the facilitator, the Men's Health Programme provided the opportunity for some of the men to come out of isolation and experience a heightened sense of contact and cohesion. This is referred to by Taylor and Field (2007, pg 59) as the "less tangible aspects of community life such as trust, cooperation, a sense of social support and participation". In general, men have fewer supportive social networks and this further augments poorer health

among men, therefore health programmes such as this one may be an effective strategy to improve the health of men (Baker, 2001; Adler and Newman, 2002).

From the focus groups, it emerged that the majority of men decided to attend the men's health programme in response to the health checks which were used as a "hook" when conducting the HNA. This highlights how health checks can be a successful means of increasing men's awareness of their health and furthermore prompting them to take a proactive step towards improving their health and wellbeing. This has also been suggested by other researchers who found that men are more inclined to visit a health professional as a result of taking part in a health screening (Kierans et al., 2007; Ballinger and Verrinder, 2009; Bankhead et al., 2003; Brosnan et al., 2009; Verrinder and Denner, 2000). Additionally, when men were asked for their recommendations regarding future programmes, screening featured high on their agenda. Men appeared to want something concrete such as a before and after screening so that they could measure tangible improvements.

The facilitator observed that men shared their own past health experiences and this in itself educated others in the group. Men also agreed that what they had learned they had learned from each other. Previous research highlights how group work enables participants to learn from each other and provides an opportunity for social support (Golding, Foley, Brown and Harvey, 2009). The men also commented that the relaxed and casual approach of the group facilitated these discussions. A similar finding was reported by Campbell, Shah and Gosselin (2009) who reported high satisfaction amongst males participating in men's educational group appointments (MEGA). They discovered that male group dynamics have a potential beneficial influence on individual patient education. Research supporting this found that, when men come together to share their experiences of things that often seem banned from common discussions, others in the group support them in their private struggles with their feelings by admitting that they have the same problem (North Western Health Board, 2003; Campbell et al., 2007). The Men's Sheds in Australia provide men with a similar opportunity to talk about things that they would not feel comfortable talking to others about, as well as the opportunity to spend time with other men in a healthy and productive manner (Department of Health and Ageing, 2010). Nevertheless, one of the men from this study did stress that he did not like the nature of group work. Similar research which sought the perspectives of a group of men

from a socially deprived area supports this finding as participants perceived men who participated in health programmes as sitting around like a load of women and thus going against gendered norms (Coles et al., 2010). It may be possible that men feel that if they were to attend a health programme it could result in them losing their sense of masculinity and this could be put forward as another reason for low attendance.

Careful consideration was also given to the facilitator chosen to deliver the Men's Health Programme as the literature suggests the skills and attitudes of the health workers are extremely important to engaging men. The extent to which a man will engage in a health programme depends on how well they are able to engage with the facilitator running it (Robertson et al., 2009). Therefore, taking time to build rapport and trust with men is an essential starting point to any work undertaken with men and is also essential to ensuring men feel comfortable speaking about themselves (Cornwell, 1984). As highlighted earlier, the facilitator stressed the importance of a homogenous group suggesting that social class was the most important factor which determines this. The facilitator of this Men's Health Programme observed that men in the urban group were far more prepared to talk about their struggles openly and therefore the level of interaction was much better. This again could be due to the level of homogeneity within the group. O'Dowd and O'Keeffe (2004) support this stating that it is important that groups are composed of men from similar socio economic backgrounds and similar age. Age also emerged as an issue for some men who took part in the MEGA programme. They stated that groups should consist of men of similar ages yet other men in the group liked the opportunity to hear about the health issues relevant to other age groups. Additionally, Conrad and White (2006) suggest that if men do not feel safe in their surroundings they will not actively engage with the group and therefore will not improve their health and wellbeing (Conrad and White, 2006). An evaluation of a parenting programme with fathers found that men need to feel safe in order to have conversations that would not be possible in any other circle and suggested that the establishment of confidentiality and respect was crucial (NWHB, 2003). The facilitator of the Men's Health Programme showed a good awareness of this, emphasising that the setting of ground rules in week one was an important task and the safety and comfort was reiterated by men involved in their focus group.

Another issue to emerge regarding group safety was around knowing someone else in the group. During the planning phase the CMHP identified “not knowing anyone else and having to go alone” as a barrier to men’s participation. However, men in the urban venue contradict this assumption stating that they preferred not knowing anyone else in the group with one man going as far as to say he was “not here to make friends”. It is difficult to ascertain why men in the urban group were adamant that they preferred not knowing anyone but one could suggest that this could be due to the shame or embarrassment about having the time (as a result of unemployment) to attend such a “health” programme. It is also possible that men were afraid to acknowledge their vulnerability and need for help to others particularly someone they are acquainted with. This again may be due to gender conditioning as they might see attending a health group as going against the traditional masculine role. However, when put to men in the rural group they said they would like to have known someone attending. The men involved in the “Working our Way to Health” programme concur with the men from the rural group as they stated that what motivated them to take part was the fact that they knew other participants (Robertson, Hacking, and Robinson, 2009). However, it is possible that this phenomenon is unique to the unemployed men in the urban setting or the nature of the work being completed.

While the men highlighted a number of benefits they experienced as a result of participating in the group, conflicting opinions emerges on the need for structure. As previously mentioned, the CMHP felt it was important to be flexible to the needs and interests of men and felt that following discussion with the men on week one, they would incorporate men’s ideas into the content of the remaining five weeks. The facilitator also stressed during his interview, that after years of experience working with men, that he was against the prejudice that men need structure. Yet, on the other hand the majority of men suggested that they did not like the lack of structure particularly in relation to the flexibility of attendance over the first few weeks. Men felt that they had to relay their stories on several occasions and it appears that this in itself may have affected attendance. Furthermore, they stated that they would have preferred if there were practical and tangible benefits to participating in the programme i.e. measurable changes and thus this explains why men recommended a physical activity type programme with pre and post measures. It appears that there is

conflicting evidence available in the literature regarding this issue. King, Sweeney and Fletcher (2005) reported that some men prefer informal environments that have little structure while other men desire context where their specific concerns are addressed. This finding is supported by the Irish NMHP which suggests that men need a clear focus to their work, need to know what is expected of them and also that men respond better to task oriented programmes which meet their needs (DOHC, 2008; King et al., 2005). Following a weight management intervention with men from a deprived area of Scotland, Gray et al. (2009) suggests offering men a flexible programme that allows men to take ownership. Nevertheless, it must be acknowledged that this programme did have a clear focus with an emphasis on exercise and nutrition. This is further supported by the fact that most men cited the health screening as the main motivation for attending the Men's Health Programme.

Both the men and the facilitator suggested that the programme may need to run for longer (both in terms of hours and weeks) in order for behaviour change to be observed. Furthermore, research has found that initially people only reveal "public accounts" of themselves and therefore it can take time for them to feel comfortable openly discussing their health (Cornwell, 1984). Therefore, programmes with a focus on empowerment and personal capacity building may need to be run for longer than six weeks. The facilitator of this Men's Health Programme also advised that if the group has a member with strong leadership qualities that these should be utilised by the CMHP and this would have huge benefits to other men in the group and also in promoting activities to other men in their social networks. As previously mentioned, men also suggested that future programmes should look at conducting a health screening pre and post intervention so that participants can assess if measurable improvement have occurred. This further supports the group's requests for structure and tangible outcomes to their participation in a health programme. This approach was successfully adopted in another Irish study with men from disadvantaged areas of Dublin but this can prove to be a costly intervention and therefore may not be realistic for most community groups (Centre for Men's Health, 2009).

During the current economic climate cost is an essential factor which determines an agencies capacity to adopt a programme. Therefore, it was felt that a further breakdown of the costs associated with the Men's Health Programme was necessary

to enable other agencies to determine the cost effectiveness of this programme. The programme cost €3,716.63 in total, which breaks down to €619.44 per week and €146.74 per person for six weeks. However, it is necessary to highlight that this is possibly underestimated, particularly when average attendance is considered and therefore it appears that this health programme was not very cost effective. Furthermore, it was quite resource intensive in terms of partners time input. An examination of the costs which will determine the sustainability of a project is necessary especially during the current economic climate. Therefore, community workers will need to give careful consideration to the costs and time input necessary for running specific programmes and may need to incorporate cost effectiveness into evaluations.

As the qualitative evaluation was conducted at the end of the programme and since behaviour change was not measured, it is difficult to measure changes in health behaviour. The weakness of this investigation was that there were no specific measures of effectiveness so this had to be based on attendance, feedback from the men and the facilitator. Lack of structure emerged as a major issue for men despite the facilitator stating that he felt men did not need structure. Although it is possible that this finding may be exclusive to vulnerable men some past research does support it. Therefore, future programmes need to have tangible and concrete benefits which can be used as a “hook” to engage men. A number of recommendations emerged from both the narratives that reflect what health professionals might need to do in order to successfully engage and maintain men’s participation in a similar health programme. In particular, reference was made to the safety that is established within the group and also the homogeneity of the group. It remains to be seen whether this type of programme would be suitable to replicate in other communities. Nonetheless, one of the key objectives of the CMHP was to use this programme as an initial step to engage further with this group of vulnerable men. Therefore, following feedback from the researcher, the CMHP applied what they had learnt from the Men’s Health Programme and used this when designing the subsequent Physical Activity Programme.

3.2. The Physical Activity (PA) programme

There were several factors which influenced the CMHP to implement a PA programme. Foremost, the health checks highlighted that many of the men were overweight and had high blood pressure placing them at risk of coronary heart disease and other chronic health issues. Men also identified physical inactivity and lack of and poor access to physical activity facilities as a priority during the HNA. Also, during the Men's Health Programme it emerged that men would like an opportunity to become physically active and to take part in a low level programme with tangible benefits. In light of these findings, an examination of the current literature was conducted by the researcher and it emerged that men represent the largest demographic group whose health is most affected by physical inactivity (Towers, Flett and Seeback, 2005). Also, the County Carlow Sports Partnership (2007), one of the partners in the CMHP, conducted a sport and physical recreation needs analysis and found that there was too much emphasis on competition rather than simply just participation for enjoyment and health. This also recognised that barriers to physical activity exist for certain groups and recommends that social inclusion be high on the agenda of community groups to bring about positive change and break down the barriers that currently exist (County Carlow Sports Partnership, 2007). Therefore, the literature in itself provided a rationale for the CMHP to target those men least likely to have access to or want to avail of a PA programme (Lunn, 2007). The CMHP took the literature, the results of the HNA and the learning's from the Men's Health Programme into consideration and they anticipated that this PA programme would meet both their requirements and that of the target group.

The REAIM planning tool (See Appendix 3.1) was again used by the CMHP during the planning phase of the PA programme. The philosophy which underpinned the health programme was also applied to this PA programme. Table 8 outlines the aim and objectives of the PA programme as identified by the CMHP.

Table 8: Aim and objectives of PA Programme

Aim	To improve the health and wellbeing of vulnerable men via a social physical activity programme.
Objectives	<ul style="list-style-type: none">• 15 participants committing to the programme.• Participants to attend weekly activity sessions with the facilitator• Participants to undertake prescribed exercise 2-3 times on their own between meetings with the participants.• Participants to actively engage with facilitators between sessions so that he is in a position to address any barriers that may prevent their continued participation in the programme• Dissemination of relevant advice during the programme i.e. nutrition, hydration, preventing injuries

3.2.1. Strategies adopted by CMHP to maximise engagement

In addition to the potential barriers for engaging men in the Men's Health Programme, the CMHP highlighted the following issues which limited the number of men who became aware of the PA programme; time, funding and the number of hours that the members of the steering group could allocate to the programme. The CMHP adopted a number of strategies to maximise engagement namely, a variety of recruitment strategies, registration evening, the design of the programme and the facilitator.

Variety of recruitment strategies

The CMHP devised an action plan to extend the reach of the PA programme, from the original database, to strategically recruit other vulnerable men in Carlow. The promotional activities relating to the advertisement of the PA programme encompassed a number of different channels. In addition to a letter posted to those 162 men on the database (Appendix 3.6.), a promotional poster (Appendix 3.7.), developed by the CMHP was distributed to various organisations throughout Carlow (Appendix 3.8). Two articles were published in local newspapers (Carlow Nationalist and Carlow People, Appendix 3.9 and 3.10 respectively). Finally, snowball recruitment was also used whereby men were encouraged to invite other male friends or family to participate in the programme. This method of recruitment

can overcome any suspicion men may have with regard to engaging in a programme (DOHC, 2008).

Registration evening

All recruitment strategies used invited men to attend a registration evening. This gave men the opportunity to get to know the CMHP and to find out more about the PA programme. It was also an opportunity to get to know other potential participants and it provided an opportunity for the CMHP to assess the possible risks of exercising for the men. This was based upon their answers to the Physical Activity Readiness Questionnaire – PAR-Q (Appendix 3.11). If the need arose, the man was referred to a General Practitioner (GP) to obtain a clearance cert prior to commencing the programme. The GP fees were covered by the CMHP, therefore removing any financial barriers that may prevent men from attending.

The programme

The PA programme was delivered, on a weekly basis (Tuesday at 4.30pm), free of charge to men in a local sports club, conveniently located in the centre of town. The programme consisted of 40 minutes of cardiovascular and 20 minutes of core exercises or circuit training. The facilitator also developed individualised programmes and men were encouraged to do two sessions' in between weekly meetings. Refreshments (e.g. fruit and water) and health information (e.g. importance of hydration and nutrition for exercise) were provided to the men each week.

Originally, it was anticipated that the programme would last for six weeks but following consultation with the men it was decided to extend the programme. The CMHP were also made aware that there was going to be a high profile event run, by the MHFI in conjunction with Men's Health Week, 2010. This event would consist of a 3km, 5km or 10km challenge that man could choose to walk, jog or run. The CMHP felt that this MHFI event would be a suitable target for men to aim for. This idea was put to men and it was agreed that the programme would be extended until

September 4th. The CMHP then decided that this would be a good opportunity to invite more men onto the programme and they advertised a second registration evening. On the day of the MHFI event men were collected by bus and brought to Dublin. The men's registration for the event was covered by the CMHP and they were also provided with complimentary refreshments and t-shirts. On return to Carlow that evening the men were also taken to a local hotel where they got a three course meal. Again, all costs were covered by the CMHP.

Experienced facilitators

As a result of extending the programme a change in personnel occurred. The original facilitator could only commit to the initial 6 weeks and therefore a new facilitator was identified and took over in week 8. Both facilitators involved in delivering the PA programme had experience of structuring physical activity in different settings but were aware that a completely different approach was required when working with men. The initial facilitator came from a fitness instructor background while the subsequent facilitator was from an athletics background. At least one male member of the CMHP was also present at the PA programme each evening. It was felt that if the PA programme was to evolve, based on the needs of men, it was important that the men had a mechanism to feedback to the CMHP. The CMHP member involved was a consistent point of contact between the group and the CMHP.

3.2.2. Methods of investigation

In order to comprehensively investigate the PA programme, a combination of qualitative and quantitative data collection methods was used. The concept of triangulation was deemed most appropriate to investigate how to effectively engage with men. Triangulation describes the process of looking at a phenomenon from more than one standpoint, providing the researcher with improved accuracy and knowledge of the issue (Silverman, 2004). Furthermore, triangulation enhances the credibility and validity of the results by giving a more balanced and detailed picture of the situation (Creswell and Miller, 2000; Golafshani, 2003). The main methods

used included; pre tested questionnaires, observations, semi structured interviews and finally follow up phone calls with those men on the database who did not attend the PA programme. The following section will give an overview of each method and a rationale for choosing same. Figure 3 displays the timeframe for data collection and programme delivery

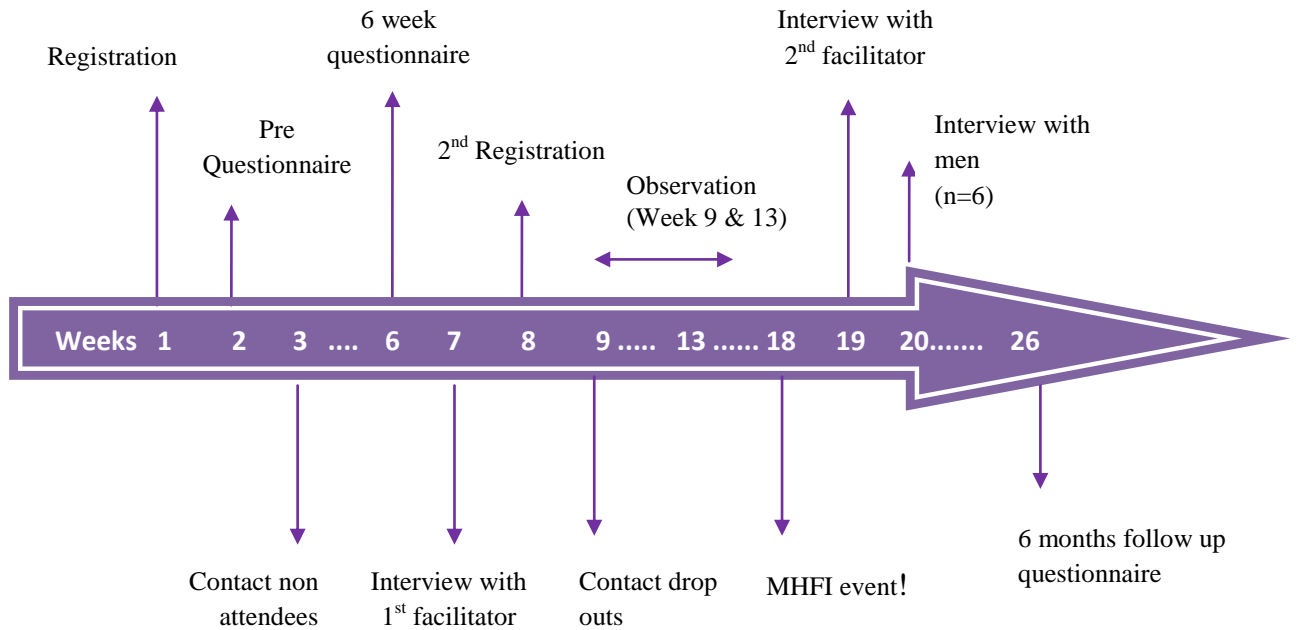


Figure 4: Timeframe for investigation

3.2.3. *Determining Engagement*

Attendance and cost

Attendance at the PA programme was tracked by a member of the CMHP who attended the programme and passed onto the researcher. The County Carlow Sports Partnership also monitored the costs of the PA programme as the funding came from the Irish Sports Council.

Pretested Questionnaires

In order to measure the effectiveness of the PA programme a questionnaire which consisted of three sections; demographic information, the International Physical Activity Questionnaire (IPAQ - short version) and the EQ-5D quality of life questionnaire was administered. A copy of the complete questionnaire can be found in Appendix 3.12. The questionnaire was administered to the men at three time points, baseline, after the initial six weeks and again after six months. However, the CMHP were concerned that if the questionnaire was administered on the first night of the programme, it would counteract the development of the relationship they wanted to achieve with the men. As a result, the questionnaire was adapted and administered to men on the second night of the PA programme. The IPAQ questions originally read, “in the last seven days”, and questions were then adapted to read, “before starting this programme”. To reduce the problems associated with poor literacy, an interview based questionnaire, where the researcher completed the questionnaires for the men was chosen. Some authors recommend using this approach, facilitated by a trained researcher to reduce the inadequacies associated with self completion, such as poor quality answers, skipping questions etc (De Backer, Kornitzer et al., 1981; Rzewnicki, Auweele et al., 2003; Biernat, Stupnicki, Lebedzinski and Janczewska, 2008). The first two measures (baseline and 6 weeks) were completed at the site of the PA programme, while the 6 month follow up was conducted over the phone. On average, the questionnaire took approximately 3-5 minutes to complete.

A long and short version of the IPAQ questionnaire was developed to measure several domains of physical activity and this was then evaluated in 12 countries (Craig et al., 2003). The short version of IPAQ was chosen as most appropriate for this programme, measuring physical activity levels over the last 7 days. It comprises of 7 questions about frequency and duration of walking as well as daily activities that require physical efforts of moderate and vigorous intensities (Cheung, Oemar, Oppe, and Rabin, 2009). Nonetheless, research has highlighted some difficulties with this questionnaire such as respondent’s difficulty in distinguishing between moderate and vigorous intensity activities and over estimation of physical activity levels (Hallal, Fernando-Gomez, Parra et al., 2010). Despite some weaknesses of the IPAQ questionnaire the measurement of physical activity was not central to the programme

objectives. Health related quality of life refers to an individual's perceptions of their own functioning and wellbeing (Szabo, 1996). For the purpose of this study, it was decided that the EQ-5D self report questionnaire was a suitable measure for quality of life (<http://www.euroqol.org/>). This questionnaire allows participants to conduct a self classification and self rating of five aspects (mobility, self care, usual activities, pain/discomfort and anxiety/depression) of their own health. It also includes a visual analogue scale which allows participants to rate their health on a scale of 1-100. Finally, a demographic questionnaire was designed by the Men's Health Research team in Waterford Institute of Technology and incorporated a number of questions from previously validated tools. This covered general demographic questions such as; age, marital status, employment status, education, income etc.

Observations

Another method of data collection used during the PA programme was unstructured observations. These are often used to understand and interpret behaviours, observe how a programme was organised and how participants interact with each other and the facilitator. According to Mulhall (2002, pg 307) "the way people move, dress, interact and use space is very much part of how particular social settings are constructed". The rationale for using this technique was to record information on the physical environment and the behaviour of men without having to rely exclusively on retrospective and anticipatory accounts in their interviews (Foster, 1996). Observation also provided the opportunity for triangulation to validate and compare information obtained from the other sources. However, despite the advantages of observation, it is also subject to limitation as it is "filtered through the interpretive lens of the observer" making it subject to bias (Foster, 1996, pg 61).

It was decided that less structured observation would be most appropriate as it suited the overall theoretical approach to the research (grounded theory). This is where the theory tends to emerge from, or be grounded in, the data (Glaser and Strauss, 1967). In the case of the PA programme, the researcher entered the field and participated in the programme with the men. This was done to ensure that the structure and functioning of the programme was not compromised (Sarantakos, 1998). This gave the researcher the opportunity to discuss the programme with the men and the

facilitator delivering the programme. The researcher had no predetermined ideas of what was going to be observed but this changed as data was gathered and the researcher gained experience in the setting. This approach is recommended by Mulhall (2002). However, the researcher did want to observe activities such as the level of interaction between men and the facilitator and the group. It was also felt that observing the mood of the men, types of communication, the social atmosphere and the approach of the facilitator would enable the researcher to establish how the men engaged with the programme. Extensive notes were taken at two different time points during the PA programme and a summary of observations were compiled at the end of the session.

Semi structured interviews

Semi structured interviews were also used to evaluate the facilitator's and men's experience of the PA programme (the method for conducting interviews described in 3.1.3.1. was replicated here). At the end of the initial six weeks, the first facilitator who was leaving was interviewed. Then at the end of the data collection period (week 19) the second facilitator was interviewed. Both interviews were conducted at the site of the PA programme and lasted between 20-35 minutes. These interviews covered topics such as the facilitator's experience of delivering the programme, what type of men attended, approaches used to engage the men, how men developed and recommendations for the CMHP. A copy of the topic guide can be found in Appendix 3.13.

Ormsby et al. (2010) suggest that more qualitative research that seeks to identify men's perspectives, as conveyed by the men themselves is needed. They propose that this canvass of experiences will enable those working with men to have an enhanced understanding of their needs (Ormsby et al., 2010). Therefore, interviews with a number of men (n=6) participating in the PA programme were conducted (Week 20). This was done to obtain a range of perspectives on various aspects of the programme such as reasons for attending the programme, the benefits of participating and the factors that contributed to or reduced the success of the programme (See Appendix 3.14. for the topic guide). All of the men in attendance on week 16 were invited to attend and 6 of them volunteered to be interviewed. Men

were invited to interviews which took place in the club house adjoined to where the PA programme was facilitated. The length of the interviews ranged from 25-40 minutes. Again, interviews were recorded with the permission of participants and transcribed verbatim.

Telephone interviews

Follow up contact with those men on the database that did not attend the PA programme was conducted to establish the reasons why men did not attend, in order to effectively improve and plan future programmes. Although, the men on the database were only a small sample of the overall target group, it was felt that this was a crucial component of the research and would help inform future programmes organised by the CMHP. This was an important component outlined in the REAIM framework. Telephone interviews were also conducted with those who dropped out of the PA programme. It was anticipated that men would find it easier to respond by phone to an external researcher as phone interviews have the “impersonal quality of self administered questionnaires and the personal qualities of face to face interviews” (Bernard, 2000, pg 234). At least two attempts (at different times of the day) were made to contact all the men that did not attend or dropped out of the PA programme. If no contact was made by telephone, these men were recorded as did not answer or an error with the phone number. The interview was based around three key topics; why they decided not to attend the programme, why they dropped out of the programme, what type of programme they would be interested in attending and finally if they wished to be contacted by the CMHP about future initiatives.

To conclude, since a combination of qualitative and quantitative methods were used to investigate this PA programme, it minimised the problems associated with each method and therefore improved the quality of the data collected. Furthermore, the triangulation of data increased our understanding of the programme implementation and therefore it was easier to identify best practice around implementing a programme to engage vulnerable men. Besculides et al. (2006) support this and state that a mixed methods approach is clearly a promising strategy for identifying best practice in current programmes.

3.2.4. Data analysis

3.2.4.1. Quantitative

Data obtained from the questionnaires were analysed using the statistical package SPSS (version 15.0). In order to analyse the data from the IPAQ questionnaire, an average MET score was derived for each activity and categories (high, moderate and low) were generated in accordance with the IPAQ Scoring Protocol (2005). Those in the high activity category engage in at least 1 hour a day of at least moderate intensity exercise. The moderate category corresponds to half an hour of at least moderate intensity activity on most (5) days of the week. The low active category reflects activity levels less than the above. The total time spent sitting was also recorded. Total weekly PA (expressed in MET minutes/week) was calculated by adding the MET/mins/week for each intensity (vigorous, moderate and walking). The data cleaning and processing rules established and recommended by the IPAQ Research Committee were followed. Any variables that exceeded 180 minutes were truncated to be equal to 180 minutes. Each of the five dimensions that make up the EQ-5D questionnaire was divided into 3 levels of perceived problems (1-no problem, 2-some problems, 3-extreme problems). The user guide suggests dichotomising the levels into no problem (level 1) or some problems (level 2 and 3). In order to present the visual analogue scale a measure of the central tendency and a measure of dispersion was calculated. Descriptive and inferential statistics were carried out using the 95% confidence interval for the latter. After testing for normality, the Wilcoxon Signed Ranked test was used to compare total scores across three time points. Analysis of demographic information predominantly used frequency testing.

3.2.4.2. Qualitative

The qualitative data interviews and observations made were analysed as per method described earlier (see section 3.1.4).

3.2.5. Results

The researcher used elements of the REAIM framework as a guide when planning the methods of investigation for the PA programme. Results from the interviews and questionnaires conducted with participants, the observations made by the researcher, and interviews with both facilitators will now be presented. The information obtained from the men on the database who did not attend and those who dropped out will also be reported.

3.2.5.1. Profile of participants

Education, marital status, employment status, source of income and housing were used to establish the demographic profile of the participants (see Table 9). Although 24 participants attended the programme, demographic information was only available for 20. Only a small proportion of participants (21%) had third level education with the majority of men having second level education (63%). Almost half (46%) of the men were separated or single. Not surprisingly given the locations of the HNA, the majority of participants were unemployed (40%) and recipients of social welfare (55%). However, it is worth noting that only five men from the original database actually attended this physical activity programme. The following table outlines the demographic information for those men who attended the programme.

Table 9: Demographics of those who attended PA programme

(n=20)		(n=20)	
<u>Education</u>		<u>Marital status</u>	
• Primary	16%	• Married	54%
• Secondary	63%	• Separated	15%
• Third	21%	• Single	31%
<u>Employment Status</u>		<u>Source of Income</u>	
• Unemployed	40%	• Employment	20%
• Employed (F/T)	15%	• Social Welfare	55%
• Employed (P/T)	5%	• Pension	20%
• Self employed	5%	• Other	5%
• Retired	25%		
• Unable to work due to illness/disability	10%		
<u>Housing Status</u>			
• Paying a mortgage	35%		
• Owner occupier	45%		
• Parents House	10%		
• Renting Privately	10%		

3.2.5.2. Engagement Analysis

a) Attendance

The data collection for this research took place for the first 18 weeks of the PA programme. This culminated in the MHFI event on September 4th 2010 in Ardgillan Castle, Dublin. A total of 24 participants registered during the course of the 18 weeks. Attendance was measured at each session by the CMHP service provider present on the particular day. Twelve of the participants attended over 70% of the programme. The attendance at the programme varied from 8 to 17 men. The average overall attendance was 66% over the initial 18 weeks and one man did not miss any session. Those men who withdrew from the programme did so for a number of reasons but many of the men who dropped out did in fact return to the programme in the latter weeks. Of those men who had dropped out of the

programme the main reasons were gaining employment, the time of the programme, the inconvenience of summer months and injury.

b) Men who did not attend

An additional component of reach which was measured for the PA programme was the reasons why men did not attend the programme. The demographics of the men who did not attend the PA programme were as follows. Almost a fifth of the men (17.4%) only had a primary school education, 51% were employed (either self employed, part time or full time), while 40% were social welfare recipients. Fifteen percent of the men who did not attend were not born in Ireland. Those men (n=96) who answered the calls were initially asked the reasons why they decided not to attend the programme.

Repeatedly, men emphasised that the time of the course (4.30pm) was a barrier to attending as it did not suit with work commitments. Overall, men stated that the evenings and weekends would be a much more appropriate time to target men. Other responses included not hearing about the PA programme, the location was too far from their residence (predominantly rural men) and some men had the perception of a marathon type programme and felt that they would not be able for it due to age, health problems, injuries etc. Men found it very difficult to describe what type of programme they would be interested in attending. A lot of men mentioned that they would not have the time or interest in committing to a group programme and that they were happy to continue exercising themselves. However, those men who did describe the type of programme that they would attend referred to a fitness or weight loss programme. Finally, many mentioned that they had enjoyed the health screening and made lifestyle changes as a result and felt that this type of activity would be more beneficial. The majority of men (n=74) stated that they would be interested in being contacted by the CMHP for future initiatives.

c) Initial expectations

All of the men stated that they did not know what to expect from the programme prior to attending, particularly in relation to the intensity of physical activity. Some men said that they would just attend on the first day and see what it was like. One participant said that he had thought to himself “I am not going to stay with it, I am only going to go over today to see but I know in my heart I am not going to stay”. When this participant was probed as to why he felt this way, he relayed that he had never walked or been physically active before. Another participant felt that you would have to come up and see what it was all about on the first day, before making an informed decision on whether or not to commit to the programme. It appeared that initially men were somewhat apprehensive about what the programme would entail. One man recalls coming into it with an open mind “not really expecting too much either way”. There was evidence from virtually all of the men interviewed that their reason for attending was to improve their fitness levels. One man stated that “I attended it just to get more fit” while another discussed how he “had been out of exercise for a good while so I thought it could be a good way to get back into it”. Interestingly, one participant asserted that although his reason for attending the programme was primarily to increase his fitness, it was also an opportunity for him to get out of the house, instead of sitting at home watching television.

One of the participants appeared particularly overwhelmed when asked about his initial feelings. He seemed amazed by the whole set up of this PA programme and described how he walked around on the first day with the rest of the men, “it was fabulous, I liked it and I said I am not going to miss this”. With regard to the diversity of the group some felt this was off putting initially, while others saw this as a positive feature.

“From the crossbreed of people there, I didn’t think it was going to be for me because it was more older gentlemen but no it was fine, it turned out grand”.

“I was delighted that I had come, particularly when I saw the people who were here, a mixed group”.

d) Factors that supported engagement

Approach of the facilitator

As highlighted in the Men's Health Programme, the approach of the facilitator is key to engaging men. On the first day of the programme the facilitator stated that he broke the group into three subcategories of younger men, middle aged men and older men. He stated that the baseline fitness levels of the younger men as reasonably good stating that they required very little encouragement as he believed they still possessed the typical competitive nature that men have. He stated that the younger men were "mostly in reasonable physical conditioning and had been previously physically active". He believed these men were using the programme to kick start them back into action. The older men were described as having very low stamina and were for the most part sedentary. Both the facilitator and the researcher observed that they were quite shy at first about being there and did not communicate very well but yet were "always very responsive to any requests or instructions". The largest sub category was the middle aged men, most of whom were overweight and had been out of physical activity for some years. They were described by the facilitator as;

"most willing and {the} least apprehensive, they were very aware of what had got them to this point and were very willing to do something about it. Their ability levels based on a very basic fitness test were very low, they were all in poor physical shape yet made no excuses for it".

It was also highlighted that the broad range of fitness levels presented a challenge in pitching one session to include all participants. However, the men felt that the first facilitator was very good and "pitched it just right", which can be difficult. The approach of the facilitator and his ability to communicate with the men also seemed to be fundamental in order to progress the men further each week and keep them engaged with the programme. It appears from discussions with men that they slowly worked on improving their fitness levels, starting with 25 minutes and slowly increasing the duration and intensity each week. Another participant referred to the fact that the facilitator encouraged the men to exercise themselves during the week. He stated that he personally felt motivated by the fact "that you were going to be asked so you may as well do a bit". While another man was motivated when the facilitator kept track of the time and encouraged them to keep improving their time.

He stated that the facilitator was there with “his watch and when you’re passing by he will tell us our time”. This was also observed by the researcher as a moment when the men and the facilitator engaged in friendly banter. Men appeared to want to keep improving their lap time.

It also emerged that the facilitator stressed to the men on numerous occasions the importance of men not comparing themselves to others and how it was all at their own pace. The initial facilitator included a short information session on the basics of exercising such as correct clothing, stretching to prevent injury, hydration, diet etc as suggested in the Men’s Health Programme. He felt that it was important for men to be introduced gradually to these small changes in order to avoid confusing men with lists of information or instructions. He also discussed how he provided each of the sub groups with a sheet outlining what they needed to do for the coming week, which contained boxes to tick once a session had been completed. He felt that this would also give them positive visual feedback. Men were encouraged to leave the sheet somewhere where it would be seen daily, such as the fridge door, which coincidentally would be a source of a lot of poor eating. All of these strategies adopted by the facilitator were mentioned by the men as factors which kept them motivated and thus engaged in the PA programme.

Positive group dynamics

The men referred to the positive group dynamic which appeared to be a motivating factor for men to continue attending the programme each week. From the researcher’s observations, the dynamics of this group appeared to be one of the most successful aspects of the programme. One man stated that he found the group “nice and friendly” and “we all seemed to gel and get on well”. It was promising to note that men felt reassured by the people involved in the planning and delivery of the programme as well as the group of men exercising. The group appeared to have evolved in the sense that at the beginning, everyone was shy and there was little dialogue between men. One man referred to it as “a family atmosphere and you can come down and have a skit and a laugh”. This was also reinforced by the facilitator who said that;

“Towards the end it didn’t feel like I was going to work because it was good fun, the group worked so well together it was similar to training football

teams where they are there because they enjoy it and not because they are being forced”.

Participants appeared to talk as much about the social aspect and the relationships they had formed, as they did about the lifestyle changes they had made. “I am after meeting a lot of friends and I look forward to every Tuesday”. One man felt that it was the social aspect that made the group so enjoyable “everyone seems to get on well and have a bit of a laugh about things”. Another noted how he liked “meeting the lads and just walking around having the chat and that”. Despite the fact that this man didn’t know anyone else before starting the programme, he felt it was a “fabulous” opportunity to meet new people. It was promising that men saw the programme as a social outlet as well as an opportunity to keep fit. “You ask anyone, its great enjoyment, you’re meeting great friends”. All of the participants appear to have met new people and developed friendships with people they would have previously referred to as associates;

“Even some people from the town itself, I would have known but wouldn’t have been known to be associating with. I would now look on as friends whereas before this {PA programme} I would have looked on them as acquaintances”.

“I played football against some of the lads and if they saw you on the street they wouldn’t talk to you, now it doesn’t matter at all, you’re talking”.

Finally, some of the men commented on the fact that training with other men tends to motivate you, gives it the competitive edge. One man said that

“It pushes you. Like I would be running normally by myself {and} I would be bored. When you’re doing it with other people it pushes you”.

Sense of achievement/Pride in oneself

Men were very proud of what they had achieved for themselves as a result of participating in the programme and this may have facilitated engagement in the programme. Also, the use of the target event was a very effective strategy as men had something in which to aim for. A sense of achievement for some of the men was their participation on Saturday, September 4th 2010, in the MHFI event. One of the men said “I think some of the men who couldn’t go were disappointed when they heard how well we had got on”. Only one of the men interviewed did not get to attend the event as he had a family wedding and said “I was raging that I missed it”. There was consensus amongst participants that although the event was a challenge

due to the hilly course, it was a very enjoyable event. One participant recalled how he had gone to a similar event in the past as an individual. He commented on how he liked the fact that they were going as a group and how this was very motivating “you kind of say if they can do it, it shouldn’t be any bother to me”. Another participant said that it “was the best experience, it was exciting”. This older man recalls the excitement of how he and another member of the PA programme had “slogged up” the hill and as they approached the finish line began to jog. He was overwhelmed with pride when they crossed the finish line. The applause he received from spectators seemed to really add to his moment of joy. This particular moment was also recalled by his walking partner and both men seemed delighted with the response they received. Another man described how he overcame the challenge of the tough hilly course.

“Half way up I started doubting myself, why am I doing this fitness thing, why am I running. I was saying to myself will I stop at the 5km and forget about it because I knew I had to go around and do it again. But when I got up to the top eventually I got my breath back as I was coming back down, so then I said, no, I am continuing on and I kept going. I was trying to slow myself up getting ready for the hill again, but the adrenalin was going I actually ran faster than I ever did and when I passed the line, it was a great feeling”.

From interviewing this cohort of men an amazing sense of joy emerged when they spoke about the MHFI event. Two of the older men have their medals and numbers hanging up for all to see. “My wife has my medal hanging up for all to see, she got the number laminated”. He recalls how she says “to the kids and grandkids look what granddad did”. A lot of the participants felt that more of these events would be useful in motivating people to remain active. Although on this occasion men said that they “were treated as royalty” and one man said that “Katie Taylor would not be treated as well”, it did not appear that men expected this at future events. Finally, one man suggested using such events to profile the PA programme and CMHP.

3.2.5.3. Impact of the programme

Effectiveness refers to the impact of the programme on important outcomes. The measures of effectiveness which were used for the PA programme were primarily qualitative and included feedback from participants, facilitators and service providers

involved in the programme. The quantitative measure of effectiveness was the questionnaire which measured physical activity in the previous seven days and quality of life.

a) Changes in physical activity and quality of life

This section will present the results of the data analysis carried out on the questionnaires. There was no difference in total MET physical activity levels, the five indicators for quality life or the time spend sitting across the three time points (pre intervention, post intervention and 6 month follow up). It is acknowledged that the physical activity data should be interpreted with caution due to several factors including the small sample size, the inconsistent participant attendance and the CMHP's request to postpone the pre-questionnaire until the programme had commenced.

There was however a difference in the visual analogue scale (VAS) measure of quality of life from pre intervention to post six month follow up ($z=-3.21$, $p < 0.001$). Inspection of the median values showed an increase in self reported health status from pre intervention (62.5) to post six weeks (80.0) and a further increase at six month follow up (85.0). Both the increases from pre intervention to post six weeks ($z = -3.21$, $p < 0.001$) and from pre intervention to post six months ($z = -2.74$, $p < 0.006$) were significant. However, no statistically significant difference was found between 6 weeks and 6 months ($z=-0.239$, $p<0.881$).

b) Lifestyle changes

Men identified a range of lifestyle behaviour changes they had experienced since commencing the PA programme. Men typically cited increased physical fitness, dietary changes and weight loss. All of the men commented on both their own increased fitness and the increased fitness levels of others in the group during the researcher's observations. It appears that almost all of the men were physically inactive or did not meet the recommended PA guidelines before starting the programme. One man described how following hospitalisation two years ago he

never got back into the habit of exercising. He said it was very hard to get back into exercising and stated that it was the PA programme that had given him the “impetus to get back active”. Another man described his journey as;

“I was going from zero to where I am now crossing the finish line of a 5km run. It stands to you 100%. I used to play golf and you would be tired after 12 holes, I can do 36 now without thinking about it”.

“I look forward to a Tuesday but I am doing my exercises in between. I come up here on my own 3-4 times a week which I wasn’t doing at first. Only in the last month I have been doing that, and I find it great. I was doing a lap and a half day one, now I can do five laps no problem, I don’t feel tired after it”.

“I am probably fitter than I have ever been; normally I would run a 3km whereas now I am gone to a 10km”.

Another participant described the programme as “really, really magic”. He went on to say he never walked at all but says that as a result of the PA programme he now “comes out of the house and instead of driving to the shop, I would walk and its maybe two kilometres down and I would walk back again”. He stated that he now walks every day and “never miss it”.

One man remarks how he is doing a lot more now than what he was doing before the programme. On a Tuesday night prior to this PA programme he would “be at home looking at the telly, getting ready for 9pm to go over and drink. Now I only go out the one night”. This man also referred to the positive impact the programme has had on his mental health stating that “your mind is a lot easier”, “it’s confidence”.

The facilitators were also asked to discuss the fitness changes they observed over the course of the programme. The first facilitator said that in the initial six weeks that the fitness levels improved beyond his expectations. Initially the facilitator broke the group into the sub categories. He observed that the younger men could jog for a reasonable amount of time (15-20 minutes). The middle aged group had difficulty maintaining a jogging pace and had been instructed to alternate between 2-3 minutes of jogging and walking for approximately 20 minutes. The elderly men could for the most part walk for 20 minutes but were very fatigued by the end. However he reported that;

“By the end of the 6 weeks, the majority of the group were able to jog for 40-45 minutes non stop, with the elderly men walking for this time and in some cases jogging intermittently”.

He also commented that;

“The men reported that it was getting easier for them despite the gradual increases in exercise duration built into the programme. They usually reported that they were feeling better as a result and that they went above the durations set out in the programme because they felt they had more left in the tank”.

Other behaviour changes discussed by men include increased fruit intake. It appears from the interviews with participants that the facilitator provided the men with additional information on lifestyle behaviours such as encouraging them to increase their water and fruit intake. It appears that this was beneficial as some participant’s state that they now “eat a lot of fruit now and I didn’t before”. While another stated that he will “now definitely try to eat one piece of fruit a day.....I am also more conscious of drinking water”. Another man reports how his whole family’s lifestyle habits, especially dietary, have changed since he has commenced the programme. He recalls how he used to love coke, ice-cream, crisps and peanuts and now he and his wife drink a fruit smoothie instead. He remembers how;

“We used to go out every Sunday for the three course meal and drinks. Now she (referring to wife) says you’re after being on that yoke (referring to PA programme), she goes down and buys ham, cabbage and that and cooks it. That’s all we have no ice-cream. You go to my house since I started this; grapes, bananas, apples, no coke in the fridge. Nothing only litres of water”.

Furthermore, participants discussed how they have reduced their weight since they have participated in this programme;

“I could never get down past 14.8 but now I can stand on the scale and I am 14.2. It’s great”.

“I would say I lost nearly two stone. I had to change all my trousers from 36 inches down to 32/34 inches”.

Men were asked if their family or friends had noticed any change in them since commencing the programme. Of note was the fact that all the participants had received positive feedback from significant others in their lives. One of the participants had been asked what he was doing that had him looking so well and encouraged him to keep doing whatever he was doing. It appeared that this gave him

“a good buzz” and made him happy that he had started the programme. Most of the comments received were in relation to weight loss but one participant recalls how a number of people commented on the fact that “they have seen me out walking again”. Another participant stated that his family are “amazed” because anywhere he goes now, he is walking. His pride was clearly evident as he beamed recalling the praise he has received.

c) Maintaining their PA levels

During the interview the question was put to men regarding what supports they would need to maintain their behaviour change and keep fit and healthy after the programme. It was promising to note that all of the men felt that they would continue to work on their physical fitness since the programme had given them the opportunity to get back into the routine of being physically active.

“I can certainly see myself continuing on with the walking and when I get down a bit more weight I can see myself trying to get back to do a bit of running as well”.

“Absolutely yes, because you have a knowledge of how to warm up properly. Even Eire Og I thought it was a private land strip, you now know its here, it’s a facility. You have links into the Men’s Health Forum group now and website and you get more knowledge of that sort of things, so you would definitely maintain it”.

“I am definitely going to exercise, I know the benefits of it now. I will definitely keep going. It’s in my head. I will be walking everyday”.

Men were also asked what they think would happen to the group of men if the CMHP were to take a step back from the programme. There seemed to be conflicting opinions as to whether the group would continue to come together themselves and exercise. It was felt that most of the men do something on their own so it might not necessarily happen as a group. One man stated that if someone was to take on the role of a leader that this might improve the chances of success. “A lot of the time in a group, it only takes one person to act as a leader for the rest of us to follow”. However, another participant thinks that men would still come down and “would keep walking just to say yeah, I am doing that for the CMHP” who he refers to as “great lads”. One gentleman stated that as far as he is concerned it is a great

programme and he thinks it should be kept on as there are a “terrible lot of people enjoying it” and suggested that “if it ever finishes it will be a disaster”.

Of note is the fact that since data collection ceased, the men have continued to meet weekly (44 weeks) and have become an independent “Carlow Men’s Fit for Life Group” that is based in a local athletics club with more men joining the original 24. This highlights how the group evolved from the initial six week PA programme to become an independent group still going strong after 44 weeks.

3.2.5.4. Resources

The operational costs for the PA programme amounted to €2,700.72 for 18 weeks, including the MHFI event. The funding for this programme came from the Irish Sports Council. As can be seen from Table 10, the programme cost approximately €4.45 per person per week. In addition to the financial cost a lot of human resources were needed during the planning and delivery of the programme. At least one member of the CMHP was in attendance each week and four members of the CMHP attended the MHFI event. This was not included in the assessment of costs.

Table 10: Breakdown of cost for PA programme

Item	Cost (€)
Physical Activity Programme	
• Facilitator	1010.00
• Refreshments	585.71
• GP fees	330.00
<u>TOTAL (18 weeks)</u>	<u>1925.71</u>
<u>TOTAL (per week)</u>	106.98
<u>TOTAL (per person, n=24)</u>	4.45
MHFI event	
• Registration	140.00
• Tee-shirts	180.00
• Bus Hire	280.00
• Seven Oaks Hotel	175.01
TOTAL	<u>775.01</u>
TOTAL (per person, n=13)	59.61
<u>TOTAL</u>	<u>2,700.72</u>

3.2.5.5. Recommendations for future programmes

Participants made some suggestions as to what they felt might improve the PA programme. All of the men were prompted to identify what it was that kept men away from this programme. There appeared to be a general lack of knowledge amongst this group as to the reasons why men stayed away or how more could be attracted to such a programme. Some of the men suggested that it may be laziness but said that you could not take men by the hand and make them attend. Others felt that it could be due to the fact that men think it is too late to join when the group is well established and advanced. He stated that if other men saw the diverse group who take part in the programme weekly that this would encourage men to think “well if he can do it there is no reason why I can’t”. One suggestion was to photograph participants with their medals after events such as the MHFI event and publish it in the local newspapers, to invite new members. A number of men also

suggested that it might be useful to run two sessions at different times and days to attract people who may be employed. This would also allow men to attend two sessions weekly if they wished.

With regard to the delivery of the programme it was felt that although the core exercise and circuits introduced by the two facilitators were welcomed, one participant felt that it might be useful to use these intermittently each week to avoid men becoming bored. Another participant recommended that as the name suggests, the Carlow Men's Health Project may need to look at broader aspects of health rather than just physical activity. Some participants had experienced the health screenings provided at the MHFI event and felt that "maybe some time during the programme someone could come along and do something like that, or maybe give a talk about nutrition or health in general".

Two of the men interviewed commented on the fact that some men had dropped out during the course of the eighteen week programme. One man felt that this was disappointing due to the fact that the programme was very well organised but suggested that during the current economic climate many of the men who were out of work when the programme started may have had to take any work that came their way. One man felt that it was "lousy" that people dropped out or didn't show for two or three weeks at a time and felt that people should have a genuine reason if they were to miss the programme. He felt that any future registration days should ensure that men are committed to attending when they sign up.

3.2.6. Discussion and Conclusion

As can be seen from the results section, the CMHP achieved their first objective which was 15 men committing to the programme. In fact, 24 men registered with 12 men attending over 70% of the programme. Again, a number of factors supported men to engage in the PA programme, namely the approach of the facilitator, the positive group dynamics and men's sense of achievement. It also emerged that men made positive lifestyle changes as a result of participating in the programme. Despite no measurable increase in physical activity levels, quality of life did increase. Another positive finding was the fact that men seemed dedicated to

maintaining their new lifestyle behaviours. These results will now be discussed in more detail with relevant literature and some comparisons will also be made with the previous Men's Health Programme.

Research has found that recruitment for PA programmes is generally difficult as participants have to be highly motivated to improving their fitness (Abildso, Zizzi and Reger-Nash, 2010). This was supported by men who stated that laziness on behalf of men might have caused people not to attend. Also, only five men from the original HNA (n=162), two of whom attended the Men's Health Programme attended the PA programme despite the fact that they reiterated that it was this type of programme that would engage them. This highlights a discrepancy between what men say they want and what men will actually attend, reinforcing the challenge of engaging men. It was more difficult to estimate the reach of the PA programme because, as previously mentioned, numerous recruitment strategies were used. One suggestion put forward by participants to enhance future recruitment was to photograph participants after events such as the MHFI event and publish in local papers. It was felt that this type of strategy might be useful in getting men to attend as they might say, "if he can do it so can I". Sarantakos (2005) and DOHC (2008) believe that referral and snowball recruitment are effective particularly when dealing with vulnerable populations. Coles et al., (2010) also support this as they found that men from socially deprived neighbourhoods dislike and ignore idealised images of fit, young men with muscles. Therefore, the aforementioned strategy that uses images of local men might be more effective when trying to engage the target group of vulnerable men.

Nonetheless, when interviewed, both facilitators remarked that a wide variety of ages and abilities did engage with the PA programme. This claim was also supported by the researchers observations and comments made by a number of men during the interviews. Again it could be argued that the number of participants recruited to the programme was relatively small. However, this programme was again effective at reaching the intended group of vulnerable men as almost half (46%) of the men were separated or single, 40% were unemployed and 55% were social welfare recipients. An evaluation of an insurance sponsored weight loss programme using the REAIM model found low programme reach can be improved by recruiting new participants (Abildso, Zizzi and Reger-Nash, 2010). The decision was reached to extend the PA

programme from the original six weeks and the CMHP decided to use this as an opportunity to re-advertise the programme and recruit new members. Although the use of incentives is widely recommended in the literature (Sadovsky and Levine, 2005; Robertson et al., 2009; White and Cash, 2005) the CMHP appeared to concentrate more on removing the barriers to engagement than providing an effective incentive or hook. However, at the time of the second recruitment the CMHP could use the MHFI event as a selling point or “hook” to engage men. This event emerged as an essential part of the PA programme providing structure and a sense of purpose to the men. This is in stark contrast to the Men’s Health Programme which men believed lacked tangible outcomes.

Previous research has indicated that non respondents tend to have a lower socio economic status and use health services less than respondents (Boshuisen et al., 2006). The calls to those men on the database provided a good insight into the reasons why vulnerable men did not attend the PA programme. It emerged that a fear of the programme being pitched for those with high fitness levels was high on their agenda. Robertson, Hacking and Robinson (2009) also found this as they reported in their study that men appeared to be deferred from participating as they anticipated that the programme might be pitched too high or competitive. Men who took part in a similar programme in Ireland commented on how advertising the programme to men over thirty prevented them from feeling intimidated by the different fitness levels that might attend the programme (Centre for Men’s Health, 2009). Therefore, it is important that advertisements are carefully thought out. The CMHP did show good awareness of this and their poster used to advertise the PA programme read “all levels catered for”. It emerged that men of all fitness levels and ages did attend and their needs were catered for by the facilitator.

Another reason cited by those men who did not attend the PA programme was the timing of the programme. This issue was also mentioned by men who participated in the Men’s Health Programme and subsequently highlighted to the CMHP by the researcher. However, because the CMHP were trying to target vulnerable men, who may be unemployed, they anticipated that this time of the day would be suitable and additionally they were restricted by the availability of the venue. As this finding emerged as a barrier to attendance in both programmes, it might be worthwhile holding future programmes at an alternative time such as later in the evenings or at

weekends in order to establish if attendance increases. Robertson et al. (2009) also believes that consideration of the location and timing of a programme are very important when trying to engage men. Many men who did not attend the PA programme mentioned that they would attend more screening type events similar to that held during the HNA. This might suggest that men prefer opportunistic type interventions. Research supports the use of such screening events as they can be successful at enhancing awareness of health and prompting men to attend their GP but only when they target those most at risk (Verrinder and Denner, 2000; Cock and Holden, 2008; Wilkins, 2005). Furthermore, the Well Men's Services who engaged a group of vulnerable men in Scotland found that men favoured medical type services and clinical tests. Additionally, since this recommendation for more screening is a reoccurring theme from men's narratives in both programmes it may need to be addressed by the CMHP.

It emerged that many of the men who attended the programme had not been physically active for many years and did not know what to expect from this programme. One man stated that his initial thoughts were that the PA programme wouldn't suit him because of the "crossbreed of people there" but that it turned out fine. Yet this contradicts the facilitators finding from the Men's Health Programme who suggested that men need to be of similar ages and socio economic background. However it is possible that this homogeneity is more important for personal development type programmes. It emerged that the approach of the facilitator made the process of returning to physical activity much easier for the men pitching the programme just right and motivating them through the use of various techniques, namely; asking them if they had exercised during the previous week and telling men their time as they passed by him having completed a lap. Therefore, the approach of the facilitator is essential as men make rapid assessments about whether a programme is appropriate for their needs and therefore first impressions are crucial (King et al., 2005). Moreover, it appears that the facilitator had a good awareness of both the positive and negative effects that men's competitive nature could have on the programme. The facilitator reiterated to men on several occasions the importance of not comparing themselves to others. Yet, it emerged that men appeared to be motivated by competition with men saying "you kind of say if they can do it, it shouldn't be any bother to me" and "when you're doing it with other

people it pushes you". Watson (2000) supports this describing how competition can often emerge in men's groups and how it can act as a double edged sword often damaging self esteem.

There was no increase in total PA (METminutes/week) following the programme was not statistically significant. However, research has found that self reported compliance is an issue in and of itself because people tend to over report changes in exercise levels (Farag, Moore, Thompson, Kobza, Abbott and Eichner, 2010). According to Rzewnicki et al., (2003) over half of respondents in their study over rated vigorous and moderate activities and over two thirds of them overrated walking time. In effect, the total weekly activity was over estimated by 74% of respondents. However, the measure of physical fitness was not an important measure of this programmes success it was more about the social benefits to participation and finding out what works when engaging men. A limitation which may have caused a higher than expected baseline result was the fact that data was collected on week two of the programme. For the EQ-5D self reported quality of life questionnaire no significant difference in the five indicators emerged. This was done at the request of the CMHP as they did not want to alienate men with copious amounts of paper work. However, there was an improvement in the VAS score ($z = -3.211$, $p=.001$) and this increase indicates that there were other potential benefits associated with participation in the programme. Although this increase cannot be directly attributed to the programme, it is encouraging nonetheless. Furthermore, the qualitative findings highlight the many unanticipated benefits experienced by men.

Many of the men in this study reported vast improvements in different aspects of their life as a result of participating in the PA programme namely increased physical fitness, improved dietary habits and weight loss. Interestingly, unemployed men cited exercising as a means of getting out of the house more often and as a means of meeting people. They also mentioned mood enhancement and increased confidence. Previous studies support this finding and found that men like to engage in activities that get them out of their house and doing things they would not normally do (Ballinger et al., 2009; Robertson, Hacking and Robinson, 2009). Ruxton (2006) also found that men saw the benefits of passing time together in a non competitive way. It has also been proven that there is a direct link between men participating in community organisations and their sense of wellbeing, for example improved mental

health, increased social interaction and support, a sense of purpose and feeling valued (Department of Health and Ageing, 2010). This again suggests that physical activity may not be as important to men as the process of being part of a group. Furthermore, one of the men reported how his whole family's lifestyle habits have changed since he has commenced the PA programme. He recalled their unhealthy eating and drinking habits and how this has now all completely transformed. Past research has highlighted the impact of parental lifestyle behaviours on the health of their children and therefore if men's health practices can be improved positive changes will be experienced by the wider family (Rhee, 2008; Campbell et al., 2007).

Avila and Hovell (1994) found that there is evidence to suggest that an increase in social support for physical activity and of self efficacy can prevent relapse into physical inactivity. Many of the men in this study commented on the positive group dynamics and how this was another factor that motivated their adherence to the programme. They referred on numerous occasions to the social aspect of the PA programme, the positive relationships they had formed as a result of attending and the family atmosphere where you can have a skit and a laugh. This humour was also observed by the researcher and appeared to be a key ingredient in the positive dynamics of the group. Research supports this suggesting the use of humour is crucial to creating a non threatening environment, reaffirming lifestyle changes which can be part of what it means to be "still lads" (Watson, 2000; Robertson et al., 2009; Coates, 2003; Chapple and Ziebland, 2004). Furthermore, Gray et al. (2009) found that use of humour is valuable in forging valuable relationships and allows men to raise sensitive issues that they might otherwise find embarrassing. Additionally, Ormsby et al. (2010) found that companionship and the opportunity to form a social bond was also important to men and this was facilitated by the informal and relaxed atmosphere where sharing a joke with other participants was possible. One of the men in the PA programme stated that he was after meeting a lot of friends and looked forward to every Tuesday. Ballinger et al. (2009) also found that the opportunity to meet new people and camaraderie experienced in the Men's Sheds in Australia was enjoyed by men. Therefore, one could conclude that this programme actually meant more to men than just improving their fitness levels.

It began to emerge throughout the weeks that a number of men had leadership qualities which are essential in any group. When prompted to discuss what they thought would happen to the PA programme and group of men involved if the CMHP were to take a step back there was a positive response. Linnell and James (2010) suggest that men who were involved in their health project became an informal steering committee and valued advocates for men's health while also providing an effective approach to making the services more accessible and sustainable. One of the men suggested that they could use events such as the MHFI event to raise money for either a local charity or local grounds where they could train during the winter months. Another man stated that if someone was to take on the role of a leader that this might improve the chance of the programme being maintained if the CMHP were to take a step back. It was therefore anticipated that the PA programme would be sustained beyond the 18 weeks and this actually occurred. In addition, two of the men put themselves forward to be interviewed for newspaper articles (See Chapter Four) and therefore became advocates for men's health in their locality. Hence, identifying leaders further adds to the sustainability of programmes.

Throughout the programme regular monitoring was conducted by the researchers and members of the CMHP who attended the sessions. This acted as a mechanism for regular feedback to be provided to the CMHP. On most occasions the CMHP responded to feedback and made the necessary adjustments to the PA programme while it was still in progress. Green and Krueter (2005) suggest that correct identification and active engagement with, the target audience is essential at every stage of the programme planning and implementation to create ownership of the intervention. It appears that one of the most successful components of this PA programme was that men were provided with choice at every step of the programme. This was facilitated by the participation of the members of the CMHP in the programme as well as the observations made by the researcher. Furthermore, by monitoring the cost of the PA programme the CMHP were able to assess how cost effective it was. It emerged that the PA programme was much more cost effective than the initial Men's Health Programme. Other research has found that lifestyle PA programmes are generally more cost efficient than structured exercise programmes (Sevick et al., 2000). In addition to being cost effective, programmes have to be

sustainable and this particular PA programme went on to become an independent group, thus eliminating cost to the CMHP. Therefore, it is possible for community groups to deliver cost effective men's health interventions.

3.3. Conclusion

This research gives a detailed description of the processes involved in the delivery of one component of the CMHP strategy, delivery of short programmes. It has emerged that some of the findings and recommendations of the initial Men's Health Programme informed the subsequent ongoing PA programme. These were mainly in relation to the structure of the programme and tangible outcomes for men. A major strength of both programmes was the effort made by the CMHP to remove barriers to engagement. However, it is interesting to note that only a small number of men from the original database attended the programmes, despite identifying the need for such activities. This might suggest that vulnerable men may be more inclined to attend opportunistic events and that the CMHP may need to adapt their approach and move in that direction. Also, when men were asked for recommendations for future programmes, screening appeared to be constantly emerging. This was also reiterated by those men on the database who did not attend the PA programme. Therefore, it could be argued that despite the issues associated with screening, such assessment based activities that take place where vulnerable men convene may be a valuable tool to engage men with their health. It also emerged that men need certain conditions to participate in a health programme. Although this finding may be exclusive to vulnerable men it appears that men need structure in a programme and more tangible outcomes.

Despite the fact that no significant increase was found in the volume of PA, the programme was effective (anecdotally) in modifying behaviours such as diet, alcohol intake etc and improving the quality of life of those who engaged. However, these were minor in comparison to the sense of achievement and kinship experience by men. Therefore, the CMHP should continue to offer community based programmes that target men as a mechanism for achieving the overall aim of the CMHP to improve the health and wellbeing of vulnerable men in Carlow. Future initiatives should look at identifying local champions or leaders from the current group of men

who can serve as advocates and communicate their enthusiasm and support to other men in the community. This may also be a useful means of recruiting new participants.

It is hoped that the findings and recommendations that emerged from both programmes will enable other community workers and health professionals to build on the experiences of the CMHP. Based on the assessment of both programmes the following is a list of effective components of programme design for engaging vulnerable men.

1. Use creative advertisement and recruitment methods as these are necessary when try to engage men. Men in the PA programme suggested using a form of snowball recruitment as others might adopt the “if he can do it so can I” attitude. Particularly for PA it is important not to show images of very fit men as this can seem unattainable for participants. Therefore, using an image of a male from the target group, from the local area is recommended.
2. Identify and use suitable “hooks” or “incentives” to get men to attend programmes. It has emerged that an assessment of health status or health screening might be an effective mechanism.
3. Identify locations and venues which can be easily accessed by vulnerable men. Additionally, make health services available in non traditional settings where men convene i.e. sporting events, betting shops etc.
4. Remove barriers such as cost and time factors for men. It appears that many of the men who the researcher liaised with would have preferred programmes to be run later in the evening. Therefore, it might be worthwhile offering men a choice of times.
5. Target an experienced facilitator as their approach is fundamental to keeping men engaged in an intervention. Facilitators need to pitch the programme appropriately to the needs and abilities of each individual man.
6. Give a clear outline of the programme to the men so that they know what they will be doing. Furthermore, men in this particular study wanted to attend a structured programme with tangible outcomes.

7. Generate positive group dynamics (social support & cohesion). Again the approach of the facilitator here is key to ensuring men are comfortable. The use of humour seemed crucial to men in the PA programme.
8. Ensure sustainability is accounted for by including the men themselves in the long term planning of the programme. If it is not possible to have men on a steering committee it is essential to provide a mechanism for the men to be consulted with.

***Communicating
health
messages to
men***

4.0. Introduction

In order to raise public awareness one must provide a community with information to influence their attitudes, behaviours and beliefs positively (Sayers, 2006). Health messages are also regularly delivered in community based health promotion initiatives or media campaigns to influence the attitudes and behaviours of the target audience (Morris, Rooney, Wray and Kreuter, 2009). The critical factors that influence the success of a media campaign is the channel or medium used, the personal experiences and opinions of the community and environmental factors which have little or nothing to do with the message being communicated (Sayers, 2006). Although the major strength of a media campaign is its ability to reach a large audience this also presents the greatest challenge for evaluation (Wellings and Macdowall, 2000). This chapter describes a series of activities carried out by the CMHP to try and raise awareness of men's health issues and the CMHP.

As previously mentioned, a health needs assessment was conducted during phase one of this research to identify the health needs of vulnerable men. Although this activity served as a means to identify common health issues for men, it was also used as a means to raise the profile of the CMHP amongst men in Carlow. All men on the database (n=162) subsequently received information regarding programmes being organised by the CMHP as well as an information booklet with up to date contact details of local services. Research with men from a socially deprived area of Britain, expressed dissatisfaction with how uninformed they were about local health services. They suggested creating a directory of services, that was comprehensive up to date and easy to access i.e. a laminated information sheet of available services and contact details that could be kept in a man's home (Coles et al., 2010). In addition to this, one member of the CMHP, working for the Men's Development Network, presents a radio show on men's health issues, twelve times a year on South East Radio. On Monday 18th June, between 8:30pm and 9pm, "Coming into View" focused its discussion on the CMHP. South East Radio has 47,000 adult listeners per day. However, the majority of these (41,000) are from County Wexford and the remainder are from neighbouring counties such as Kilkenny and Carlow (Joint National Listnership Research (JNLR), 2010). Finally, the most comprehensive, awareness raising activity conducted by the CMHP was a print

media campaign in a local newspaper, the Nationalist, with readership figures of 14,649 (Audit Bureau of Circulation, ABC). This chapter will focus primarily on the print media campaign which will now be discussed in more detail.

4.1. Overview of print media campaign.

The CMHP recognised from past initiatives that not all men want to participate in an intervention and therefore decided to engage local media to target health messages to vulnerable men. Clements, Parry-Langdon and Roberts (2006) argue that providing men with the means of accessing information anonymously and confidentially may prove more useful than the traditional services that men do not appear to be engaging with. Media campaigns are one method which can be used to reach large proportions of the target population and communicate to, persuade or influence men to adopt or change to a more health enhancing behaviour (Atkin and Wallack, 1990). Newspapers are a useful channel to relay factual information to influence the knowledge, attitudes and behaviours of its readers (Westwood and Westwood, 1999). Anecdotal evidence and feedback available to the CMHP highlighted that the target audience reads a local newspaper called “The Nationalist”. The topics and key messages chosen for the articles were based on the findings from the HNA and therefore were relevant to the target group of men. The CMHP acknowledged the need to make articles come alive and give the human story and image that would make articles more accessible to the reader. All articles prepared by the CMHP contained contact information for at least one member of the CMHP.

The CMHP had previously worked with “the Nationalist” to advertise the PA programme but unfortunately their press release had been edited and the headline changed to read “Run Fatboy, Run! Here’s your chance to shed a few pounds”. The CMHP were upset by this headline and felt it was damaging to men. They felt the need to highlight the inappropriateness of the headline and how it had been completely misinterpreted by the Nationalist. They also discussed the negative consequences that it had for male stereotyping and the PA programme. This prompted two members of the CMHP to meet with the editor to discuss the role of their paper in supporting vulnerable men. The editor agreed to work with the CMHP to publish a six week men’s health series. Final editorial rights remained with “the

Nationalist but it was agreed that significant edits would not be made without notifying the CMHP. It is worth noting that edits were made to only one of the six articles (Article three (Stress) - The image was changed, article was shorted and no contact number was included) and the CMHP were not notified in advance of publication. Moreover, the first article was published a week early by “the Nationalist” which didn’t leave the CMHP enough time to conduct formative evaluation.

At the time the idea to publish articles was being discussed by the partnership, a health promotion graduate began to volunteer with the CMHP. It was decided that this volunteer would play a key role in researching and writing draft articles which would be reviewed by two partners who have experience of working with men. Table 11 outlines the aim and objectives of the print media campaign run by the CMHP.

Table 11: Aim and objectives of print media campaign.

AIM:	Raise awareness of the key issues, identified by men during the health needs assessment
OBJECTIVES	<ul style="list-style-type: none"> • Impart concise, readable and accessible messages in each article • Normalise health issues for men by addressing them publicly • Reach a large target audience within our designated remit • Build a partnership with the Nationalist newspaper that promotes best practice when reporting on men’s health in the print media.

The REAIM planning tool (See Appendix 3.1.) was used by the CMHP to guide their planning activities for designing and publishing the men’s health articles. This enabled the CMHP to discuss the barriers and challenges that may arise and how they anticipated overcoming these barriers. The main barriers identified were regarding the time and resources available to meet the pre publication deadlines and requirements of the research component. Furthermore, there was some concern about the level of journalistic experience amongst partners and the challenges of working with the media because of different expectations. Nonetheless, when the CMHP were asked on a scale of 1-10 how confident they were that they would overcome these barriers, they responded with a 7 (1 – not at all, 10 – extremely).

They believed that having a clear operational plan and playing to their strengths would enable them to complete the articles before the deadlines and ensure time for consultation which they felt was necessary to negotiate how messages would be portrayed. Table 12 displays the final articles published.

Table 12: Article titles and dates of publication

Article Number	Title	Date published	Appendix
1	Don't wait until it's too late to visit your GP	July 20 th , 2010	4.1.
2	Men of Carlow, Get up, Get out, Get going!	July 27 th , 2010	4.2.
3	Stress: A male perspective - Don't let stress take over	August 3 rd , 2010	4.3
4	Getting the balance right when it comes to healthy eating	August 10 th , 2010	4.4.
5	Alone in the crowd: How to avoid isolation	August 17 th , 2010	4.5.
6	Men of Carlow: Know your health score	August 24 th , 2010	4.6.

4.2. Methods of investigation

The methods used to assess the aforementioned aim and objectives was a cross sectional survey of men in Carlow, a content assessment of all articles and feedback from the CMHP.

4.2.1. Survey of respondents

A survey is a structured questionnaire given to a sample of the population, designed to elicit specific information from respondents (Tull and Hawkins, 1993). The survey used in this research was designed by the researcher and was based on an in-depth review of literature to ensure the comprehensiveness of each item (Morris, Rooney, Wray and Kreuter, 2010; Stead, Hastings and Eadie, 2002). Questionnaire based surveys are the most commonly used data collection method in social and health research and seek written or verbal responses to statements or questions

(Parahoo, 1997). A variety of questions were included to give men the opportunity to participate in, and interact with the survey (Parahoo 1997). Before the survey was administered it was piloted with a small selection (n=22) of postgraduate students as this is recommended as an invaluable way of testing questionnaires (McGivern, 2003). This enabled the researcher to ensure questions were not misinterpreted and to explore issues such as content, structure and readability. Feedback was taken into account and some small but significant modifications were made to the structure of certain questions.

The survey covered topics such as; awareness of the CMHP and men's health activities, whether respondents read the Nationalist and saw the articles, the impact of the articles and finally demographic information. It was also hoped that this questionnaire would elicit men's views on the best ways to raise awareness of health issues with men. The survey contained a mixture of open questions, closed questions and scale questions. A full copy of the questionnaire can be found in Appendix 4.7.

Procedure

Although random digit dialling appears to be the preferred and most commonly used survey design in mass media evaluations (Ferris, Robertson, Fabunmi and Mosca, 2005; Huhman et al., 2005; Niederdeppe, Farrelly and Holland, 2004 and Smith et al., 2002), but it was decided that this was not the most suitable method because of the demographic profile of the target group and the difficulty in targeting men by random selection of phone numbers. Therefore, street interviews were decided upon as these enable the researcher to approach people who fit the sample criteria i.e. men. The literature advises that these interviews last no longer than 10 minutes as people will not stand around answering questions for any longer (McGivern, 2003). The pilot study revealed that the survey would take between 3-5 minutes. It was decided that researchers would go to locations in Carlow where the target group of vulnerable men convene to conduct the survey. Participants were opportunistically approached by the primary researcher and two research assistants at various strategically chosen locations in Carlow, over three days. The venues where the

survey was conducted included, two betting shops, outside the main shopping centre, department of social welfare offices, three pubs and local post office.

The survey was conducted by researchers one week following the publication of the last article in September 2010. Men were opportunistically approached and asked if they would like to answer a few questions to assist in a research survey of the CMHP. This non probability sampling was subject to selection bias which means that those who participated may be different to that of the target group of vulnerable men. Research assistants were trained in relation to the sequence and skip patterns of questions, how to approach respondents and how to administer questionnaires. The survey was administered by the researchers in a face to face interview style. There was some potential for interviewer bias present with this type of survey i.e. the error due to the interviewer not following the correct procedure. However, the training was designed in an attempt to offset the potential effect of this limitation. Researchers were provided with article titles and full colour copies of each of the newspaper articles under investigation. The survey was administered to all men who consented regardless of whether or not they read the newspaper. If men did read the Nationalist but did not remember seeing the men's health articles, articles titles were relayed to men. If men still did not remember full articles were shown to men. Articles were also shown to those men who did not the newspaper to find out how appealing articles would have been. For more information on the question sequence, please see a copy of the survey in Appendix 4.7. It was decided that an extra article on prostate cancer (Appendix 4.8.), which was not published, would be included in the questionnaire. This was done to ensure the validity of participant's responses.

4.2.2. Content assessment of articles

The content assessment consisted of three specific elements. These were literacy demand, message content and design. Three standard measures were used to gauge the literacy demand of the six articles. Readability statistics for Microsoft Word 2007 were used to assess the literacy demand of each of the articles, using established readability formulas. The Flesch–Kincaid (FK) reading grade level and the Flesch Reading Ease (FRE) were calculated. In order to do this, articles were copied and pasted into Microsoft Word and tests conducted. The other readability

test used was the Simple Measure of Gobbledygook (SMOG), developed by Harry McLaughlin in 1969. These particular readability tests were deemed most relevant as they provide the widest range of educational level and have the ability to match scores to actual education level. In general, readability calculations are made based on sentence length, number of sentences and the number of syllables per word (MaLaughlin, 1969). As results were displayed in United States grade, ages needed to be calculated. This was done based on the recommendations set out in the Health Promotion Unit guide to writing effective health information. This adds five to the grade level to attain the average age (Health promotion Unit, 2003). Taken together, these readability tests provided a yardstick for assessing the literacy demand of the six article. Also, the number of passive sentences in each article was considered.

Westwood and Westwood (1999) suggest that how issues are presented in the newspaper can influence the response by individuals and subsequent effects on their health status. Hoskins and Mariano (2004) state that there are no simple rules for data analysis as each enquiry is distinctive, and the results depend on the skills, insights analytical abilities and style of the researcher. Therefore, information garnered during the literature review on good practice for developing health messages to men was used to assess the content of health messages. Additionally, the Centres for Disease Control and Prevention (CDC) produced a guide for creating easy to understand health materials and this was also used when assessing the articles. This looks at issues such as; message content, text appearance, layout and design, translation and understandability (See Appendix 4.9.). Table 13 outlines the predetermined set of criteria of good practice used to assess the content of each article. These criteria were developed by the researcher after reviewing the current literature on communicating health messages to men and the CDC guide.

Table 13: Criteria used to assess articles

<p>Message Content</p>	<p>Are the number of messages limited to three or four per article?</p> <p>Is all the information necessary?</p> <p>Is the most important information at the beginning and repeated at the end?</p> <p>Have action steps been identified?</p> <p>Are action steps asking men to go against long standing societal norms or do they allow men make healthy, autonomous decisions?</p> <p>Is the behaviour change being promoted more advantageous than the unhealthy behaviour?</p> <p>Do messages appeal to men’s competitive nature?</p> <p>Do articles appeal to multiple masculinities rather than just the dominant form?</p> <p>Do articles use men who have successfully benefited from behaviour change that the target group can relate to?</p> <p>Do articles use testimonials from men who the target group can associate with?</p>
<p>Design</p>	<p>Is print large enough? Does it use serifs?</p> <p>Is the text justified on the left only?</p> <p>Is information presented in a logical order?</p> <p>Is the style conversational?</p> <p>Are bold, italics and text boxes used to highlight important information?</p> <p>Do visuals explain message found in the text?</p> <p>Do visuals include captions?</p>

4.2.3. Feedback from CMHP

The CMHP partners whose contact details were included on the articles were asked to record the number of phone calls and the types of queries they received from men

who had read the articles. Additionally, those partners involved in the design of articles were asked to feedback their experience of working with the media to improve men’s health. This was done via email. Figure 5 below displays the timeline of publications and data collection.

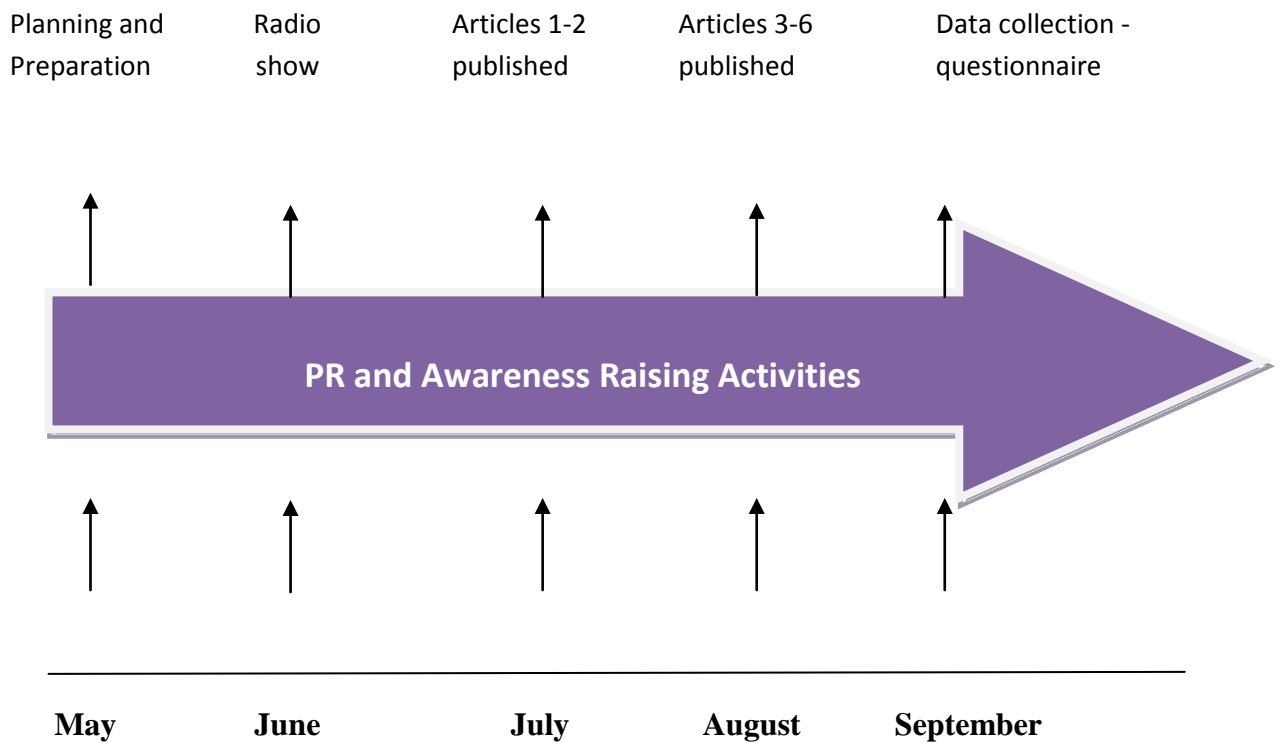


Figure 5: Overview of awareness raising activities and research

4.3. Data Analysis of Survey

To analyse the findings of the survey, the data was entered into the Statistical Package for the Social Sciences (SPSS 18.0). Firstly, frequency tests were carried out to assess how many men gave a particular answer to certain questions. Participant’s characteristics were summarised using descriptive statistical analysis. Chi-square tests were used to test for a significant difference between the demographic information of those men who did or did not either hear of the CMHP

or read the Nationalist. Open ended questions were analysed using the same method of qualitative data analysis discussed in the previous chapter.

4.4. Results

The results of the survey for which a total of 276 men responded will be presented first followed by the analysis of the articles. Although contact with CMHP was monitored, no additional contact was made with the CMHP as a result of articles.

4.4.1. Profile of respondents

As can be seen in Table 14 age, education and employment status were used to establish the demographic profile of the participants. As can be seen there was a good range of ages surveyed in the study with the majority of men (24.6%) in the 18-29 years age bracket. Most men surveyed had second level education (51.4%) but a relatively high proportion had primary school education only (16.3%). Not surprisingly, given the current economic climate, over a third of the men (35.8%) were unemployed and only a fifth of men were employed full time (19.9%). This demographic information is comparable to that of the men who took part in the HNA discussed previously in section 1.3.1.

Table 14: Demographic Information of responding men

Demographic Indicator	N=276	Percentage (%)
AGE		
18-29	68	25%
30-39	62	23%
40-49	51	19%
50-59	45	16%
60-69	36	13%
70+	14	5%
EDUCATION		
Primary only	45	16%
Secondary	142	51%
Third level	89	32%
EMPLOYMENT STATUS		
Employed (F/T)	55	20%
Employed (P/T)	31	11%
Self Employed	23	8%
Unemployed	99	36%
Looking after home	2	1%
Retired	40	14%
Unable to work due to illness/disability	4	2%
Other	22	8%

4.4.2. Awareness of men's health activities

Initially, men were asked had they heard of the CMHP and almost a fifth of men (18%) responded “yes” and 81% responded “no”. Those men who responded “yes” were then prompted to discuss what they knew about the CMHP. Most of the men stated that they had either heard about a PA programme or health screenings which had taken place locally for men or else had read about it in the local newspaper. Many of the men believed that the CMHP was an initiative to improve men's health.

For those men who had not heard of the CMHP (81.5%), they were asked if they were aware of any men's health activities which had taken place in Carlow over the past twelve months. Some 12% of men stated that they had, with the majority of these recalling a walking group, articles, flyers to get fit and health screenings.

Those men who had not heard of the CMHP or recalled any men's health activities unaided were then prompted to recall men's health promotion activities which the CMHP had carried out over the previous 12 months. As can be seen from Figure 6

below the four activities prompted to respondents included; the health screening, the radio show, the Men’s Health Programme and the PA Programme. The two activities most frequently recalled by men were the health screening and the physical activity programme (20% and 27% respectively).

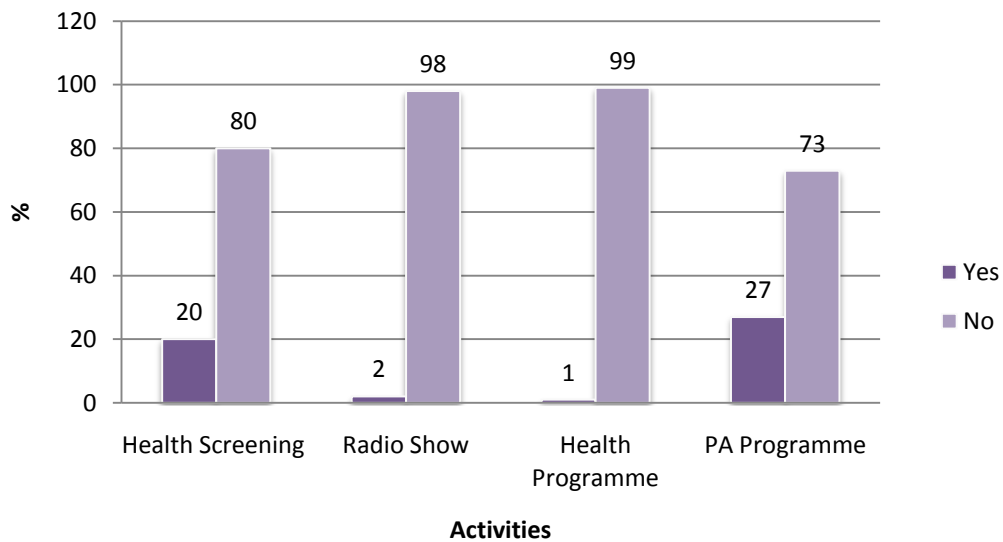


Figure 6: Men’s responses when activities prompted (N=276).

4.4.3. Recall of articles

The next question put to men was to determine if they read the local newspaper which contained the men’s health articles. Just over half of the respondents (57%) read the Nationalist newspaper. Chi-square tests were carried out to test for significant differences between demographic information and readers and non readers of the paper. No significant differences were found ($P>0.05$). Men who stated that they had read the Nationalist ($n=158$) were then asked if they saw any men’s health articles and 32% responded “yes”. Those men who responded “yes” were asked what articles they had seen and only six men could remember and name the articles unaided. Articles recalled included the physical activity article ($n=3$), the GP article ($n=2$) and the healthy eating article ($n=1$)

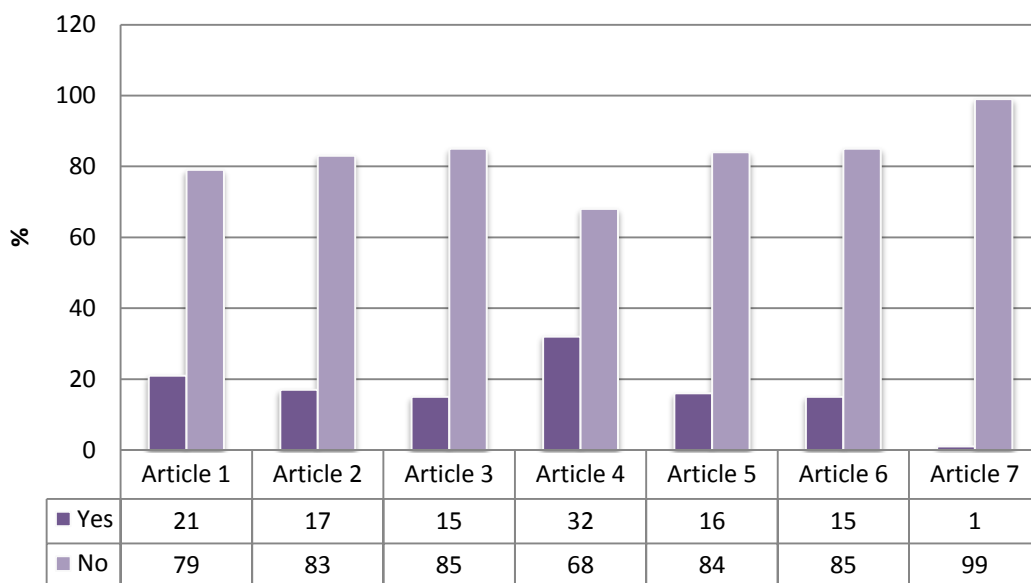


Figure 7: Men’s health articles recalled (n=152)

Figure 7 illustrates those men who could not cite articles they had seen without article titles being prompted. The physical activity (Article Four - 32%) and the GP article (Article One - 21%) were the most frequently recalled. Only two respondents stated that they had seen the prostate cancer article, which as previously mentioned was not published and only included to test the validity of other responses.

4.4.4. Impact of the articles

A number of questions were asked in order to determine the impact of the articles on those men who read them. These questions, which will be displayed in Table 15, examined how much of the article did men read, the usefulness of the articles and changes to knowledge attitude and behaviours as a result of articles.

The most frequently read articles were the topics of physical activity, visiting the GP and nutrition. The majority of respondents who read the articles on physical activity (35%), visiting your GP (33%) and nutrition (46%) did read the articles thoroughly. The articles that were least read (just flicked through and none of it) were the articles on knowing your health score (48%), isolation (44%) and stress (57%).

Table 15: How much of the newspaper article did you read?

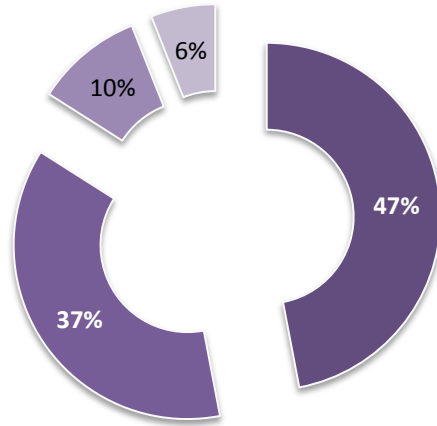
Article	All of it thoroughly	More than half	Less than half	Just flicked	None of it
GP (n=33)	33% (11)	31% (10)	12% (4)	12% (4)	12% (4)
Stress (n=25)	20% (5)	20% (5)	24% (6)	32% (8)	25% (1)
Isolation (n=23)	22% (5)	22% (5)	12% (3)	35% (8)	9% (2)
PA (n=49)	35% (17)	24% (12)	15% (7)	22% (11)	4% (2)
Nutrition (n=26)	46% (12)	15% (4)	12% (3)	19% (5)	8% (2)
Health Score (n=23)	30% (7)	13% (3)	9% (2)	39% (9)	9% (2)
Prostate (n=2)	0	0	0	50% (1)	50% (1)

4.4.5. Ratings of article usefulness

As can be seen from Figure 8 below, respondents were asked to rate the usefulness of each of the articles they had read. Figure 8 (A-F) shows the number of participants who read each article and responded to this question. As mentioned previously, the PA article (n=47) and GP article (n=30) were the articles most frequently read by participants. The PA article also had the highest ratings in terms of usefulness.

A

Article 1 – GP (n=30)



■ Very Useful ■ Somewhat useful
■ Not very useful ■ Not at all useful

B

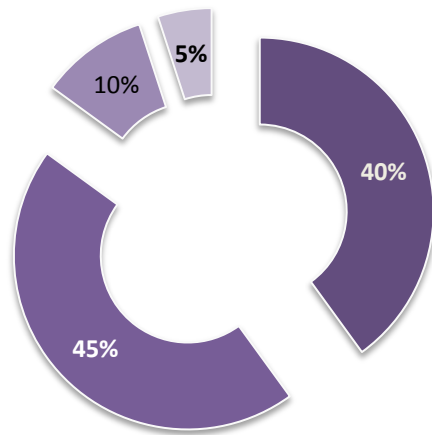
Article 2 – Stress (n=25)



■ Very Useful ■ Somewhat useful
■ Not very useful

C

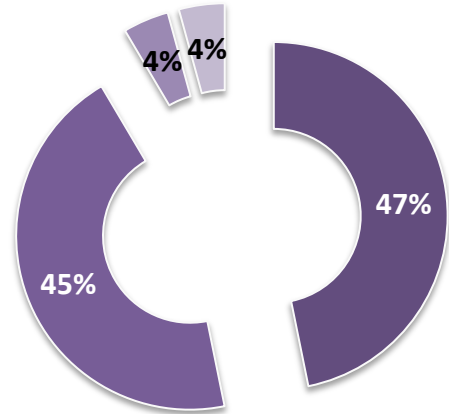
Article 3 – Isolation (n=20)



Very Useful
 Somewhat useful
 Not very useful
 Not at all useful

D

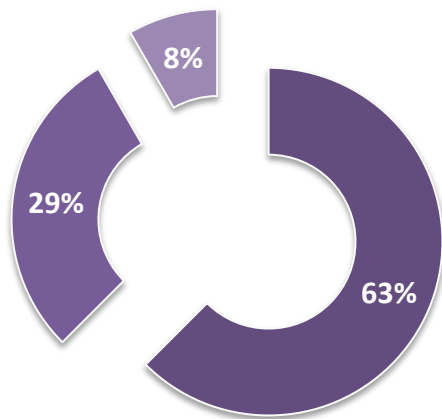
Article 4 – PA (n=47)



Very Useful
 Somewhat useful
 Not very useful
 Not at all useful

E

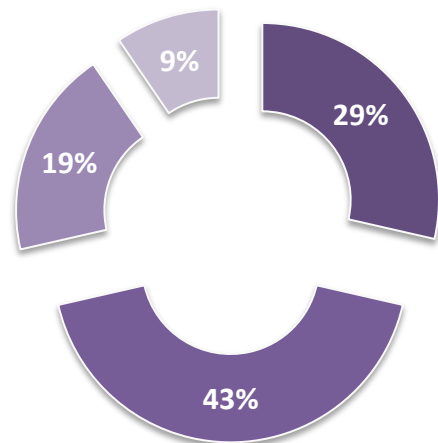
Article 5 – Healthy Eating (n=24)



Very Useful
 Somewhat useful
 Not very useful

F

Article 6 – Health Score (n=21)



Very Useful
 Somewhat useful
 Not very useful
 Not at all useful

Figure 8: Men’s ratings of article usefulness

In an attempt to measure the impact of the articles, the following three questions were put to men; did any of the articles make you think differently about your health? Did you make any changes as a result of reading these articles? And have you learnt anything new from reading these articles. Figure 9 outlines men's responses to these questions.

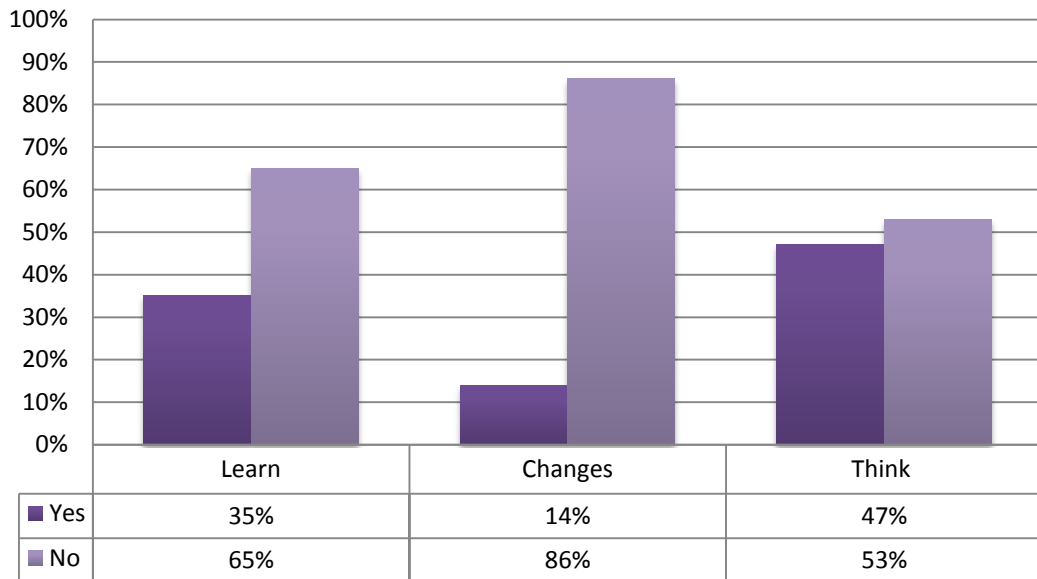


Figure 9: Behaviour and attitudinal changes

Did any of the articles make you think differently about your health?

Almost a half of participants (47%) suggested that the newspaper articles had made them think differently about their health. When men were encouraged to discuss this further, the two most common responses were that they were more aware of the need to increase their physical activity and more conscious about going to the doctor sooner and more regularly. Furthermore, two of the men stated that they had found the article on isolation and mental health very interesting.

Did you make any changes as a result of reading these articles?

It is evident from Figure 9 that the majority of participants (86%) did not make any changes as a result of reading these articles. Of the 14% who stated that they had

made changes, the most frequent responses were walking more, eating healthier and going to the doctor for a check up. One man also stated that he was trying to get to know more people as a result of reading the article on isolation.

Have you learnt anything new from reading these newspaper articles?

Over a third of participants (35%) suggested that they had learnt something new from reading the articles. When prompted to discuss this further many men stated that they had been made more aware of their health and the importance of eating healthily, exercising and getting regular check-ups from their doctor. In addition, some men stated that it had made them more aware of facilities available for men in Carlow as well as the physical activity initiative being delivered by the CMHP.

4.4.6. Opinions of men who did not see articles

For those men who do not read the Nationalist newspapers, they were shown all articles published and asked the following questions; if you had seen this article in the paper, would you have read it? After seeing the articles, do you think they would have got your attention? And do you think that newspapers are a good way to inform men about their health? As can be seen from Figure 10 most of the respondents answered yes to all three questions. Those men who answered “no” gave their reasons and made recommendations to improve future awareness raising activities. It must be acknowledged that these figures are subject to social desirability bias. This will be discussed in more detail later in the limitations section.

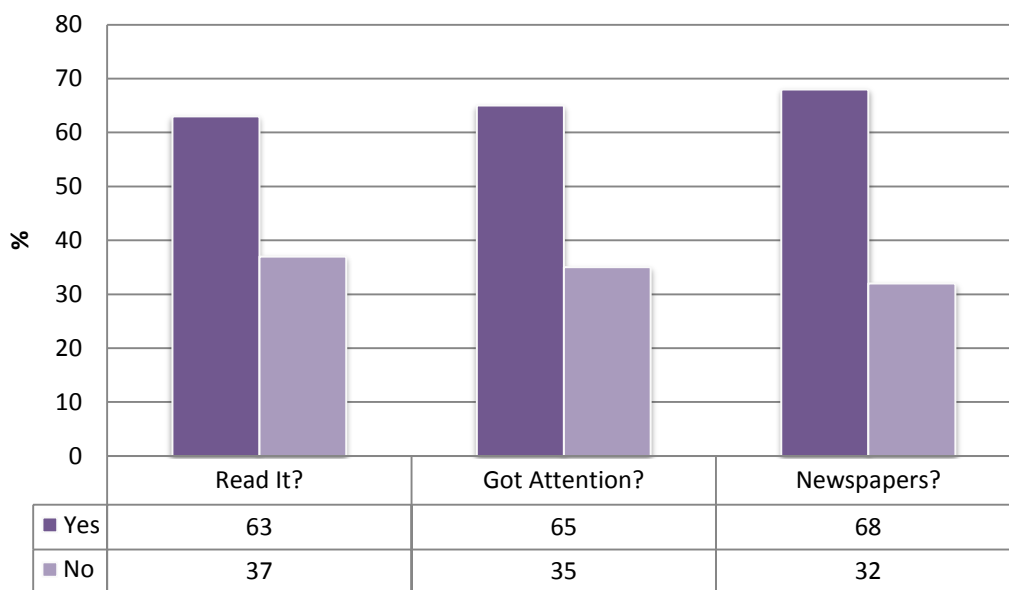


Figure 10: Opinion of men who did not see articles

4.4.7. Recommendations for reaching men with health messages.

All men were asked for recommendations for reaching men with health messages. Men suggested that although newspapers are effective at communicating messages to men the location of the article is very important. Many of the men recommended that articles should be strategically located in the sports section, back page or page three of the newspaper. Men also suggested that articles need to catch the reader’s attention with large headlines and by having no advertisements around the articles.

Men were then prompted to suggest other ways, aside from newspapers, to get men’s attention regarding health issues. Many of the men cited other media channels i.e. radio, television and the internet with sites such as Facebook, car and sports sites commonly mentioned. The internet can also help overcome literacy problems. However, a number of men did acknowledge that it is up to each individual man, while another man stated that he “only reads up on a health problem when someone close to you is sick” as he doesn’t like to read articles about health as they make him worry unnecessarily.

Finally, many of the men also suggested distributing health information in doctor and dentist surgeries, having something in pubs or betting shops (i.e. beer mats, leaflets etc) or at sports venues and gyms where men convene. Although men

commented that the articles were important and needed, even if only to make a small number of men more aware, many acknowledged that it is difficult to convey health messages to men and that education is key to improving men's health.

4.4.8. Article analysis

As previously mentioned, all articles were assessed based on their literacy demand, message content and design, the results of which will now be outlined below.

Literacy demand

As previously mentioned, readability tests were conducted on all six articles to assess literacy demand and the results of these are displayed in Table 16 below. According to the guidelines available for interpreting readability tests, the passive sentences percentage should not be higher than 15% as active sentences improve readability (Redshaw, 2003). The passive sentences percentage for the six articles ranged from 5%-9% and therefore were acceptable. These guidelines also suggest that the Flesch Reading Ease score should not be lower than 60. The results of the reading ease for the articles ranged from 59.5-64.1 and therefore Article Six (59.5) was just under the recommended limits. In addition, it recommends that the Flesch-Kincaid Grade Level score be no greater than 5 - 7 (for younger readers), 5 - 9 (general readers) or 7 - 12 (industry or technical readers). Because of the target group of vulnerable men one may assume that reading levels may be somewhat lower than "general readers". However, three of the articles had scores of 9 or above (Article Three - 9.0, Article Five 9.2, and Article Six 9.6). Fitzsimmons et al. (2010) used the following to interpret the SMOG scores; easy (4th - 6th grade), average (7th - 9th grade) and difficult (10th-12th grade or >12th grade). This classification was also used to interpret the SMOG scores and of interest is the fact that all of articles published were in the difficult category. Article Five on isolation had the highest SMOG score of 13.4.

Table 16: Readability of articles

Measures	Article 1	Article 2	Article 3	Article 4	Article 5	Article 6
Passive Sentences	5%	9%	9%	7%	7%	8%
Flesch Reading Ease	64.1	61.3	61.3	62.4	60.3	59.5
Flesch-Kincaid	8.1	8.9	9.0	8.9	9.2	9.6
Average Age	13-14	14-15	14-15	14-15	14-15	15-16
SMOG	10.9	12.0	11.3	11.3	13.4	12.8
Average Age	16-17	17-18	16-17	16-17	18+	18+

Message content

The CDC (2009) recommends that health communication be designed so that people are able to grasp the main idea and know who the material is aimed at just by looking at it. In the first article published it was not very clear that the target group was men as the headline read “your health matters”, however following input from the CMHP subsequent articles read “men’s health matters” which made it somewhat easier to identify the target group. Each of the articles explained to the audience why behaviour or attitude change was necessary and provided the reader with key action steps for changes, which as previously mentioned were displayed in a text box. Article One used phrases such as “do not wait until things get really serious before reacting. Get checked early on; it could save you money, needless worry and even your life”. This type of message highlights how the activity been promoted i.e. attending your GP early is more advantageous than not doing so. Also a number of the articles used testimonies from locals which highlights to male readers that there are others similar to them who have already adopted a positive health behaviour. One participant involved in the PA programme who was interviewed for the article on PA stated “I have also lost close to a stone weight in the weeks I have been here”. One could argue that the first four articles are asking men to go against their traditional masculine norms by using phrases such as “for some, getting a medical can be seen as a weakness or an unmanly thing to do”, “traditionally men didn’t have to worry that they weren’t getting enough exercise”, “many men are reluctant to

discuss their insecurities, concerns or feelings of failure”, “healthy eating is predominantly seen as a woman’s thing”. Furthermore, the researcher observed that none of the articles used humour to portray messages to men

Design

All of the articles used a good size serif font (12+) in the main body text apart from Article Four on healthy eating which used san serif text. A larger size font was used for the article headings and the main body text was displayed in narrow columns with justified text. The use of visuals was a common theme across all six articles. It is of interest that the first article “Don’t wait until it’s too late to visit your GP” outlines the reasons why men do not attend the GP. The researcher believes that the image used in this article is not very conducive to the target group and feels that the image used in Article Six “Men of Carlow: know your health score” might be much more relevant. The image in Article One is of two very attractive young people in a clinical setting whereas the image in Article Six looks like a much more comfortable, non traditional setting with the professional dressed in casual clothing. The image used in the Article Two “Men of Carlow: Get Up, Get Out!, Get Going!” is a member of the target group walking around a local sports complex and the use of this type of photos have been recommended in previous literature with vulnerable men. Of interest is the choice of visual in the third article on stress. The image appears to be of a professional dressed in a suit and readers may instantaneously associate this with employment and job related stress. However, many of the target group are vulnerable, unemployed men and therefore this image may not be as relevant or catch the attention of the target group. Following consultation with the CMHP it emerged that this image was edited by the newspaper and outside the control on the CMHP. This again highlights the need for men’s health advocates to partner with the media to enhance reporting of men’s health issues. All articles used a text box to highlight key action steps and important information but also contained advertisements. Finally, contact information for a member of the CMHP, primarily the chairperson was available in each of the articles apart from Article Three on stress. However, as previously mentioned this was edited out by the newspaper.

4.5. Discussion

This chapter presented an overview of the awareness raising activities of the CMHP with a specific focus on the locally based, print media campaign. Knapp, Stohl, Reardon (1981) suggest that individuals tend to tune into information about diseases and conditions that they feel are personally relevant, as well as those with a good fit between message, recipient and sender. This campaign aimed to raise awareness of key issues identified by men in the initial HNA in addition to raising the profile of the CMHP. It is well accepted in the literature that men are more difficult to reach and harder to engage in health promotion activities than women. Research has shown that women are also more likely to recall media reports compared to men (Langbecker, Youl, Kimlin, Remm and Janda, 2010; Covello and Peters, 2002). Furthermore, Banks (2001) suggests that women are more likely to seek health advice from peers, magazines, books and television than men. In addition, he believes that middle class men are more likely than lower class men to access and respond to health promotion information from leaflets and advertisements (Banks, 2001). Caburnay et al. (2003) support the use of local newspapers suggesting that they can be influential in small communities as people are more likely to actively and thoughtfully process information.

A survey was designed to measure men's awareness of the profile of the CMHP and their activities as well as the impact of the print media campaign. A total of 276 men responded to the survey. Almost a fifth of the men had heard of the CMHP with the most common activities recalled by men being the PA programme (27%) and the health screening event (20%). Over a half of respondents (56%) had seen at least one of the articles. The article most frequently recalled was the article on physical activity. Respondents stated that the articles had made them think differently about their health (47%) or prompted them to make a behaviour change (14%). Men also made a number of recommendations on how to reach men with health messages. Additionally, an analysis of the articles was conducted, using an adapted version of the guidelines set out by the CDC (2009) for creating easy to understand materials. From analysing the articles it emerged that the CMHP did adhere to many of the guidelines set out by the CDC, however readability tests were high and thus not favourable to the target group of vulnerable men.

When surveyed, 19% of men stated that they had heard of the CMHP and a further 12% stated that they were aware of men's health activities in Carlow. However, it is not possible to attribute all men's health activities recalled by this 12% to the CMHP activities alone, as other men's health activities may have been also running in Carlow. At this point in time the CMHP did not have a logo or a tag line so it is possible that although respondents recalled men's health activities in Carlow they may not have associated them with the CMHP. The PA programme (27%) and health screenings (20%) were the activities most frequently recalled by men. Over half of men surveyed read the local newspaper that the articles were published in and 32% of these had seen the articles. Chaiken (1976) suggests that recall may be lower for reports communicated via television and radio, compared to print media, which allows for more individualised exposure time to content. More recent research highlights that well targeted social marketing campaigns can reach between 45% and 88% awareness of messages (Agha and Van Rossem, 2002; Truitt, Hamilton and Johnston, 2002). Thirty percent campaign awareness is generally regarded as a starting point in the behaviour change process (Macdonald, Venn and Tones, 1996). However, only six men could remember the names of the articles unprompted but when men were shown articles the physical activity (31.8%) and the GP (24.4%) articles were most frequently recalled.

Next men were asked questions to assess the impact of the articles. It emerged that men read the articles on physical activity, visiting the GP and nutrition more thoroughly than the articles on knowing your health score, isolation and stress. The majority of respondents found the articles either somewhat or very useful. Of note was the fact that the PA programme and PA article (Article Four) were recalled by men most often. This was the only article which used a photo and quotes from a local man participating in the PA programme. Additionally, a number of survey respondents mentioned that they knew the man in the picture and this may have assisted recall. Hubley and Coperman (2008) suggest that well chosen pictures enhance the visual quality of print media and also arouse interest, attract attention and convey messages and ideas. Research also suggests that it is important to portray to men that there are other men similar to themselves who successfully engage with their health (Rochlen and Hoyer, 2005). Buckley and O'Tuama (2010) support the approach adopted by the CMHP recommending that campaigns be

targeted locally and use testimonials from men who the target group can associate with in terms of life experience. This idea is further enhanced by research conducted by Coles et al., (2010) which found that men disliked idealised images of the masculine body as fit, young and having muscles. In addition, the picture used in the article on stress (suited professional) may not have appealed to the target group of vulnerable men, predominantly unemployed. Vigorito and Curry (1998) found that magazines aimed at male audiences generally display men as the productive breadwinner and therefore adheres to the traditional masculine norms. Therefore, it may not have been the most effective or meaningful image for the target group.

Since long term behaviour changes can take some years, research usually focuses on the short term impacts of the campaign and as previously mentioned, this research was conducted one week after the final article was published. (Cavill and Bauman, 2004). The NSMC (2007) suggest that enabling men to interpret media messages critically to make informed decision to change their behaviour is a challenge. Three questions were used to assess knowledge, attitude and behaviour change as a result of reading the articles. Thirty five percent of men suggested that they had learnt something new from articles, almost half (47%) felt the articles had made them think differently about their health and finally 14% suggested that they had made behaviour changes. Goffman (1974) states that the effect of campaign messages on behaviour change depends partly on the framing of messages and the way it is relayed by journalists. This study indicates that the print media campaign prompted small but important improvements in knowledge and attitudes which research suggests is necessary for subsequent behaviour changes (Cavill and Bauman, 2004; Redman, Spencer and Sanson-Fisher, 1990; Finnegan, Viswanath and Hertog, 1999). This may have been enhanced by the fact that key information was summarised or bulleted in a text box.

As can be seen from the results section, those men who didn't see any articles were asked their opinions about the articles and positive responses emerged. Sixty three percent of men said that they would have read the articles had they saw them and 65% said articles would have got their attention. It is acknowledged that these figures are subject to social desirability bias. Men recommended that articles be strategically placed in the sports section or else on the back page or page three in an attempt to get men's attention. Men also suggested a number of other ways to reach

men with health information aside from newspapers. Similar channels for delivery of health information were portrayed by an equally similar cohort of men in Britain i.e. television, radio, billboards etc. These men wanted health information in as many places as possible (Coles et al., 2010). In addition to television, the internet was another medium commonly cited by men when asked how they could be reached with health information. This finding is supported by research conducted by the Men's Health Forum (2011) which found that men are enthusiastic users of new technologies. Nonetheless, research still suggests that those most vulnerable to poor health will have limited access to such technologies (Population Council, 2010). Men also suggested distributing health information in non traditional health settings i.e. pubs, betting shops, sports venues gyms etc. The use of non traditional settings to promote men's health is commonly recommended in the literature (Wilkins, 2005; Conrad and White, 2007; Khutan, 2006; Robertson et al., 2009).

Gazmarian et al. (1999) suggest that reading ability is an integral component of health literacy. Weiss et al. (1992) has found a relationship between people with poor literacy skills and an increased risk of poor health. Therefore, it is essential that health information can be easily interpreted and understood. As outlined in the results section, the literacy demand of all articles was quite high thus suggesting that articles may not have been understood by the target group of vulnerable men and thus may not have had the positive effect on behaviour that was anticipated. This appears to be a common issue in the literature available on literacy demands of health information (Furthermore, according to the latest international survey, one in four or 25% of Irish adults have literacy difficulties. This compares with 3% in Sweden and 5% in Germany (NALA, 2011). Currently, in Ireland up to 30% of children from disadvantaged areas leave primary school with literacy difficulties and therefore newspaper articles may not have been the most effective channel to reach the target group of vulnerable men with health messages. This was also reiterated by men who mentioned that television and radio may be more effective because of low literacy levels.

With regard to the design of articles, the CDC (2009) recommends using serif fonts as it makes individual letters more distinctive and easier to read. All of the articles used serif fonts apart from Article Four. Additionally, all articles used justified text and therefore spaces between words are uneven and the lines are all the same length.

This can confuse readers, particularly those unskilled making it hard for them to differentiate one line from the other (CDC, 2009). Thus, right edge “ragged” or unjustified text is recommended to enhance readability. Furthermore, the use of text boxes was effective in making the important information, the calls to action, stand out and this also added to the appearance of the articles. A number of men did comment on the advertisements placed around the articles suggesting that these can be distracting. If advertisements have to be included editors should try ensure that they too are appealing to men for example, motor and sports related.

Formative evaluation is recommended during the planning of any media campaign, in order to develop the most effective communication channels and messages for the target group (Rootman, 2001). This type of pretesting ensures messages are correctly interpreted and understood and also gives agencies the opportunity to modify messages (Wellings and Macdowall, 2000). Although formative evaluation was considered by the CMHP and suggested by the researcher, time constraints to publish the articles prevented this from occurring and this is acknowledged as a limitation of this research. It was felt that the message content of each of the article should be assessed. There was some information available on good practice for delivering health messages to men with O’Brien et al. (2009) and Coyle and Sykes (1998) suggesting that the media should embrace different ways of displaying masculinity rather than reinforcing traditional notions about masculinity. Some of the statements used in this campaign may have fallen into the trap of reinforcing traditional masculine norms i.e. “healthy eating is predominantly seen as a women’s thing”. In order to enhance changes to behaviour, the CDC (2009) recommends that health articles invite the audiences into the text. When the audiences interact with the information they are more likely to act upon and remember information. For example, asking questions and leaving blank lines “I am going to lose _____ (pounds) by _____ (date). I will achieve this by _____ (exercise, diet). None of these men’s health articles adopted this approach and it might be an interactive way to engage men with their health in the comfort of their own home.

One of the initial objectives of the CMHP was to build a partnership with the editor of the Nationalist newspapers to promote best practice for reporting on men’s health issues. As previously mentioned, there was a discrepancy over the headline used by the editor to promote the PA programme. The CMHP were concerned that the

headline used by the editor may have been offensive and put men off. They felt there was a need to educate those in the media to use their “power” responsibly. However, past research by Conrad (2007) highlighted how they needed to redesign their recruitment poster after one man booked into their clinic. As a result the new poster displayed a large glass of beer saying “free” on the top and “health check for men” and found that demand for services quickly increased. Furthermore, the Irish Cancer Society uses humour in their men’s health MANual. Despite the fact that the MANual has not been formally assessed anecdotal evidence suggests that it is very well received by men. In addition, as can be seen from the previous chapter men appeared to appreciate humour and a “skit and a joke” and therefore this headline may not have been as offensive as first thought. Furthermore, anecdotal feedback from the men who attended the PA programme and who had seen the recruitment article, articulated that they had not been offended. Nonetheless, as previously mentioned the choice of the image and the removal of the CMHP contact number (Article Four) are considerable errors made by editor. Therefore, this does highlight the need for men’s health advocates to work more closely with editors and others in the media to enhance responsible reporting. This is also supported by Caburnay et al. (2003) who believes that editors of local newspapers need greater access to research findings in order to disseminate relevant health information to men in their community.

Bauman (2000) believes that comprehensive evaluations of community education campaigns require the use of a mixture of data collection methods. Quantitative methods are important for describing the impact of the campaign while qualitative methods are useful for developing an understanding of the way the community understands the message (Bauman et al 2006). One of the biggest weaknesses of this particular awareness raising campaign was the lack of formative evaluation conducted. Formative evaluation is crucial to effectively raise awareness in the target population as it highlights the needs, characteristics and most effective channels and messages needed to reach the target population (Leiss, Kline and Jhally, 1990; Vega and Roland, 2005).

4.6. Conclusion

One could suggest that the increased community interest in men's health has been enhanced by greater media attention to gender specific health issues, such as prostate cancer, erectile dysfunction etc. Although, over half of the men in this study did read the local newspapers only six men could remember the men's health articles unaided. Therefore, it may be necessary to incorporate the suggestions of men and strategically place articles in the sports section of the local newspapers. Furthermore, the articles on physical activity and visiting the GP appeared to be the most popular topics recalled by men and thus it is possible that issues such as isolation and stress may need to be discussed under more attractive headings. Also the incorporation of humour into reporting of men's health issues may enhance recall. It appeared that there are a number of different channels which could be used to reach men with health messages. As can be seen from the analysis of newspaper articles there are useful guides available for creating easy to understand health information. However, these fail to recognise gender issues such as the impact of masculinity.

Nonetheless, the following rules for reaching men with a media campaign emerged during this piece of research.

1. Careful planning (REAIM planning tool) is necessary to assess the needs and segment a small and homogenous target group.
2. Allow time to conduct formative evaluation with the target group to establish effective messages that are understood and to identify the most effective channels to reach the target audience.
3. Incorporate media campaigns into a multi component, community based initiative.
4. Build partnerships with local editors to ensure health is placed more firmly on their agenda and ensure that they have access to important men's health research findings.
5. It is necessary to assess all health information in terms of literacy demand, message content and design to ensure messages are easily interpreted by men.
6. Use images and quotes of men whom the target group can identify with. Localisation of stories is crucial as it can make health issues more personally

relevant for men and as previously mentioned enhance recruitment to programmes.

7. Ensure there is an avenue for further contact that can be easily accessible to men i.e. helpline number, websites, support groups etc.
8. Think creatively about how and where to target men with health messages for example beer mats in pubs or the use of information technologies such as the social networking, websites or mobile phones.
9. Build in a monitoring component to ensure the health campaign is achieving its aims and objectives. This can help guarantee that funds are being spent on the most effective channels.

***A partnership
approach to
promoting
men's health***

5.0. Introduction

Partnerships are defined in the Irish context as follows

“A system of formalised cooperation grounded in legally binding arrangements or informal understandings, co-operative working relationships and mutually adopted plans among a number of institutions. They involve agreements on policy and programme objectives and the sharing of responsibility, resources, risks and benefits over a specific period of time”.
(OECD, 1990)

The literature provides a strong rationale for investigating the process of how groups work together as evidence “that partnerships provide successful outcomes for staff, users, financial sponsors and other stakeholders is sparse” (Dowling et al, 2004, p314). The Scottish Executive (2002) suggests that understanding the process of partnership working is essential to discover what makes interventions effective. In order to do this, Sofaer (2000) recommends looking at the members perceptions of the effectiveness, benefits and costs of participation in the partnership and the extent to which members perceive the partnership to be effective in the future. Despite the increase in literature which states that partnership working is a good thing, there are calls emphasising the need for evidence of its effectiveness (Ansari, Philips and Hammick, 2001).

Chapter one summarises the background of the partnership and members involved. The CMHP meet approximately once a month but often more regularly when delivering a specific component of their strategy. Furthermore, because they are located in settings remote from each other, email is a crucial mode of communication. This chapter will focus on the partnership that is the CMHP with a view to investigating its effectiveness and understanding “how” it worked. It will provide readers with an overview of the methods used to investigate the process of partnership working when trying to engage a group of vulnerable men. The categories derived from the qualitative data collection will then be presented along with pertinent quotes and existing literature of effective groups will be used to discuss these findings. Finally, the chapter will be concluded with recommendations for future partnership work to engage vulnerable men.

5.1. Overview of CMHP

The CMHP, a community based partnership, which began in June 2007, is presently represented by Carlow County Council – RAPID, the Health Promotion Department, of the HSE South, Carlow County Development Partnership, St Catherine’s Community Service Centre, the Men’s Development Network and County Carlow Sports Partnership. All partners have their own areas of expertise but regularly come together and work in partnership as the CMHP. When the CMHP started there was a diversity of experience and some members had sparse knowledge and experience in the area of men’s health. Some members had very poor past experiences of trying to engage with men and therefore training occurred very early in the groups development to support members in their mission to engage with men.

5.1.1. Aim and objectives of partnership approach

The following table outlines the aims and objectives for this component of the investigation.

Table 17: Aim and Objectives

<p><u>Aim</u> To explore the process of working in partnership, as experienced by the CMHP, when trying to engage a group of vulnerable men to improve their health and wellbeing.</p>
<p>Objectives</p> <ul style="list-style-type: none">• To investigate the perceived progress made by the partnership over the two year period.• To investigate how the partnership operated.• To explore the characteristics of the partnership.• To identify the challenges experienced by the partnership.• To identify if the CMHP adhered to principles/characteristics of effective partnerships.• To make recommendations for service providers working in partnership to improve the health and wellbeing of vulnerable men.

5.2. Methods of Investigation

As previously mentioned, the purpose of this investigation was to elicit partner's experiences of the CMHP to date and to inform future service delivery. The main methodology used to investigate the processes of the CMHP, was phenomenology. Phenomenology is usually perceived as the study of a "phenomena", the appearance of things or things as they appear in our experiences (Woodruff-Smith and Thommason, 2003). Literally, phenomenology studies describe partner's conscious understanding of experiences from their own point of view. This approach was used particularly when analysing the interviews and focus groups.

Attendance at meetings, content analysis of meeting minutes, semi structured interviews with partners and focus groups with partners were carried out and such approaches have previously been used and recommended in the literature (Becker, Israel, Schultz, Parker and Klein, 2002; Butterfoss, Geng, Gilmore, Krieger, LaChance et al., 2006; Butterfoss, Kelly and Taylor-Fishwick, 2005; Chinman, Anderson and Imm, 1996; Kegler, Steckler, McLeroy and Malek, 1998). By using multiple sources the researcher was able to triangulate the data to improve the insight into the process as "no single source of evidence has complete advantage over all the others" (Yin, 1994, pg 80). Data was collected at different time points, over the 2 years, and this allowed the researcher to make comparisons and also track the progress of the CMHP.

5.2.1. Attendance at meetings and events

Observation is the purposeful, selective and systematic way of watching and listening to an interaction or a phenomenon as it takes place (Kumar, 1996). By participating at various meetings and partnership events (approximately n=8) the researcher was able to gain an insight into the group dynamics, roles, the decision making process and some of the particular issues that arose for the group over the two year period. Extensive notes were written after the meetings and information garnered was used to support the information obtained from other sources, namely interviews and focus groups.

5.2.2. Interviews with partners

Semi structured interviews were chosen as they give the researcher the opportunity to probe fully for responses, clarify any ambiguities, inconsistencies or misinterpretations (Bowling, 2002). This was particularly important in this component of the research as it enabled the researcher to explore partner's perspectives of working in partnership to improve the health of vulnerable men. All partners were asked if they were willing to participate in a discussion with the researcher and times and venues, convenient to the partner, were arranged. Semi structured interviews were conducted with the partners and for the most part were undertaken in their workplace. In year one, five partners were interviewed with 1 partner unable to take part due to personal reasons. In year two, six partners took part in the interviews. Each of these interviews built on the previous until the researcher accumulated perspectives and experiences to gain a broad understanding of the phenomenon (Parahoo, 1997). A flexible topic guide was developed and questions were adapted to each interview but concentrated on the partner's experience of partnership working, how the CMHP worked as a group, challenges they experienced etc. These interviews were conducted in December 2009 (Appendix 5.1.) and November 2010 (Appendix 5.2.) and lasted between 20-50 minutes. Interviews were recorded with the permission of partners. For more information on the topic guide see appendix 5.1.

5.2.3. Focus group with partners

The final method of data collection was focus groups. Focus groups are based on interviewing and rely on interaction within the group around topics supplied by the researcher. It is suggested that the key features which distinguish focus groups from other forms of interview are the insights and data produced by interactions between partners (Parahoo, 1997). Then (1996) states that groups comprising of 6-8 members enables the researcher to engage in in-depth enquiry. This type of exercise can often stimulate a level of discussion about the process of partnership working in the group that may not be possible at any other time (Ball, 2010). Nevertheless, Morgan (1997) suggests that one limitation of focus groups is that the collective approach offers less detail about the experience of individuals and would be

inappropriate for reporting individual behaviour. However, this research overcame this limitation by conducting individual interviews with partners. Focus groups took place in December 2009 (n=6) and November 2010 (n=6) following an annual “social” lunch and lasted for approximately 90 minutes. See Appendix 5.3 and 5.4 for details on the topic guides used.

5.2.4. Data analysis

All recordings of interviews and focus groups were transcribed verbatim. Analysis of data (including memos from observations and meeting minutes) was carried out using the constant comparison method as advocated in the Grounded Theory method. The central feature of Grounded Theory is the grounding of theory upon data, through data theory interplay and the making of constant comparisons (Strauss and Corbin, 1994). Therefore, grounded theory consists of a set of procedures that guide researchers using this approach, relying on the data to formulate hypotheses or theories (Parahoo, 1997). Krueger (1994) recommends that the researcher who carries out the data collection should also analyse the data and this strategy was adopted in this study. Please see Chapter Three (Section 3.14. – Data Analysis for more detail). Emerging themes were grouped into categories and are reported on below. Although labelling the source of the quote during data analysis would have enhanced the learning, it was deemed unethical considering the small number of participants involved in the research. Care was taken to ensure that the identity of CMHP partners was not exposed. The researcher was responsible for compiling and feeding back findings and recommendations to the CMHP after data collection. This gave members the opportunity to reflect both on their progress to date and any changes that needed to be made in the way they worked together and engaged with men.

5.3. Results

This section will present the main findings from analysis of all data collected during 2009 and 2010 (See Figure 10). The main themes to emerge were as follows;

purpose of the CMHP, group dynamics, group membership, factors that contributed to success, challenges and learnings.

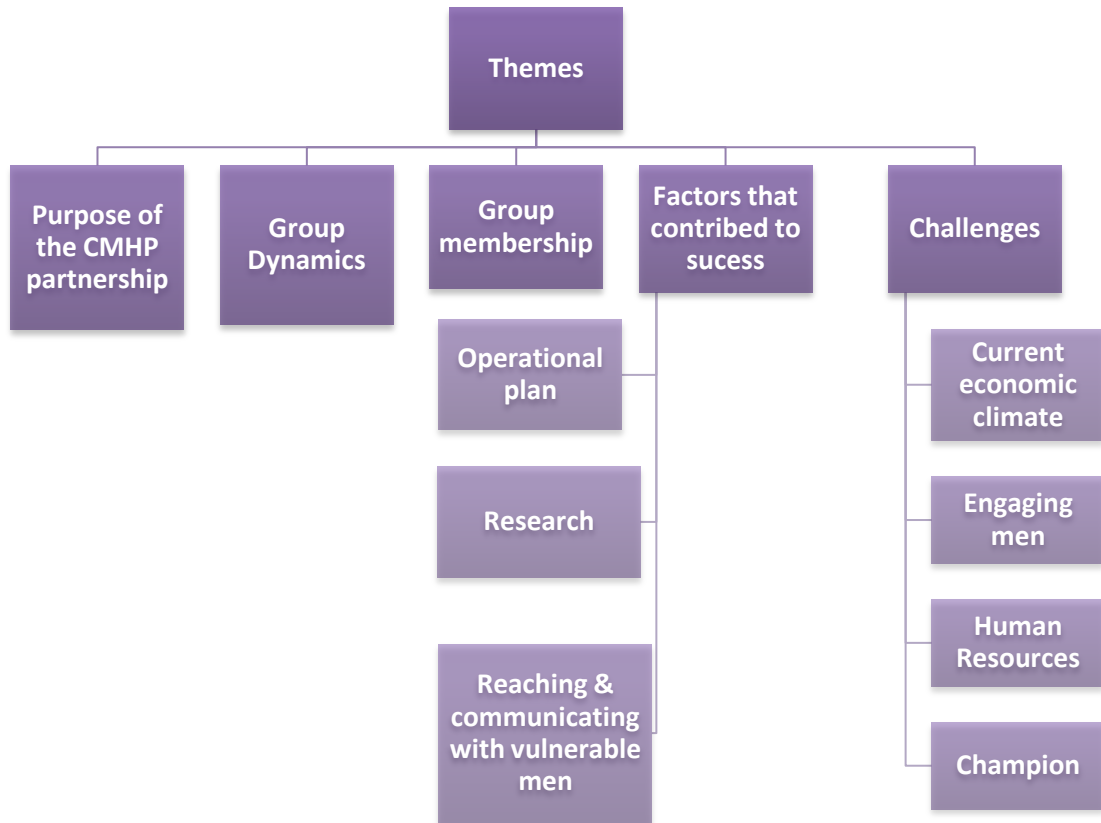


Figure 11: Themes to emerge from qualitative data

5.3.1. Purpose of the CMHP partnership

From synthesising the data it has emerged that the CMHP had a good awareness of the need for and purpose of their partnership, suggesting that the best way forward was to “pool our resources, our experience and sometimes our ignorance”. This integrated approach, where everybody with a remit for community work or part remit for men’s health, supports each other was valued by partners. Many advantages to partnership work emerged, including the variety of organisations and how each representative of an organisation brings something different, either resources or experience, to the table. One of the strengths of the CMHP to emerge was the fact that all partners come from different areas so there is good diversity of

skills and knowledge and the opportunities to learn from each other. Partners explained;

“For me the biggest experience has been learning from others around the group”.

“Sometimes men’s health work can be quiet isolating. So when you actually meet a group of people that are like minded and who want to move in the same direction as you I get quiet energised”.

Partners also had a good awareness of the reason for their partnership, highlighting that there was an evident need, from past initiatives, to focus on those men who would not typically avail of health services. The County Council offered a thorough health screening to the employees. It was subsequently recognised that the men who worked on the roads were the only cohort that didn’t avail of the health screening. From discussions with partners there was consensus that this is where the CMHP was kick started from. At the end of year one, partners had a good awareness of the importance of ensuring that men’s identified needs would inform their work and that they should work at the pace of the community rather than at their own pace. However, it appeared that this was a challenge in reality as other partners felt that;

“we will have to work fast, the most important thing is speed, we cannot procrastinate while the momentum is there among men”.

Despite the CMHP making a genuine effort not to lose contact with the men they had engaged with during 2009, there was consensus that they started year two a bit rushed;

“we felt the need to do something but I don’t think we had paused enough to really get our heads around critical things like what exactly it was we wanted to do, how it was going to be done, roles and responsibilities that type of thing”.

In particular there were numerous references to the Men’s Health Programme which “didn’t develop as planned”. The CMHP felt they had spent an awful lot of resources on this programme and yet did not meet the needs of the men themselves. Some of the partners felt that this programme lost momentum;

“I have always very much viewed this as a learning process as well. Certainly if we were to compare the health programme to the physical activity programme I would automatically say we learned an awful lot from that and we did the next one much better and fair play to us”.

It appeared that the CMHP became even more focused, regarding their purpose, in year two when they began putting structures and systems in place to support the cohort of men identified, in the health needs assessment, during year one. One partner perceived the purpose of the CMHP as being to engage a group of vulnerable men and support them to become an independent and sustainable community group. The functions of the CMHP were summarised as follows;

“we were still trying to target our vulnerable group, we were trying to raise awareness in a variety of ways and we were trying to generate a men’s group of some sort that we could build further on. Also, while doing those operational tasks we were also trying to meet the needs of an evaluation so we could get feedback on how we were doing”.

Although there was consensus on the need to target vulnerable men there was some discrepancy regarding whether the focus would be on urban or rural men. As some of the partners had a remit specific to urban and some specific to rural, this was an issue which did surface during data collection. “I would love to see it more rural based” and “It was disappointing that we didn’t get more men from the rural community”. Some partners felt that since needs were assessed in both venues there was a need to deliver an intervention in both venues. A lot of discussion took place around this issue and the initial Men’s Health Programme was delivered in a rural and urban setting.

5.3.2. Group dynamics

It became apparent that it was not what individual partners did alone it was more about what and how the CMHP worked as a whole. It was encouraging that the CMHP appeared to acknowledge that they were working from a very strong model and at the end of year one felt they had a very positive group dynamic that could be further built on in year two. The group identified that the flexibility and initiative within the group was a massive contributing factor to their success in year one. The vast majority of partners felt that during the first phase, if something wasn’t working, the group identified this and adapted their approach. There was consensus among partners that there was a strong sense of cohesion and that they worked well together both at team meetings and at the organised events;

“I have seen a change in the group, I see a focus, I have seen the group coming together, really working well together”.

Another partner suggested that;

“it is a lovely group and I love being part of it. There is really energetic people there, we have good brains and we are not afraid to roll up our sleeves”.

Predominantly, all partners spoke positively about the CMHP in terms of being proactive, linked up, working well together, having respect for each other and more importantly the positive communication and atmosphere in the group. Some partners illustrated how;

“friendships have formed around the table. I have got to know some people very well so that when we meet I know the names of their kids etc and all that helps when you’re working with people”.

“We have built really positive relationships, it’s going well, it’s a win win situation”.

Although issues of disagreement did not appear to surface in year one by year two some partners were prepared to talk about certain issues that had arisen during that year. The main reasons mentioned for conflict were lack of clarity regarding roles and responsibilities and different personalities;

“One member of the group didn’t stick to the operational plan and it ended up that I had to fill a gap and that really bugged me. The following meeting we discussed the issue and it was resolved within the group so we moved on. I’ve been on other groups where they shy away from that and the whole group becomes dysfunctional. But we did address it and now the boundary has been kept”.

“Within any group you have different personalities and then you kind of say how do I work with this person and that is a challenge. Sometimes it leads to rows and sometimes rows lead to things being sorted out”.

Overall, it appeared that the group had progressed to a point where they could name issues within the group, learn from it and move on rather than allow under currents where sub discussions take place after meetings. However, it did emerge that one partner still appeared to carry some bitterness in relation to one particular issue which had arisen.

It was also suggested by a number of partners that the size of the group is one of its biggest benefits. However, there was a concern that if agencies are lost, as a result

of the recession, or if new members are added to the CMHP, that there would be a change in the group dynamic and that the sense of cohesion that existed may be lost. Finally, it appeared that the CMHP also learned more about how to work in partnership to achieve their goals. It emerged that the CMHP had grown significantly over the course of the two years and had a clearer vision of where they want to go. Partners commented on the fact that they are not afraid to name something if they are struggling with it “we don’t panic, lie down or disappear on ourselves”. Furthermore, it emerged that the CMHP have a better awareness of their strengths “not just organisational strengths but personal strengths”. In addition, the introduction of the operational plans seemed key to this learning;

“I think we have got much better at taking on something that had a clear outcome, looking at how it could be done, putting in whose going to be part of each piece and then working together. We have learned a lot, well I think from being part of this committee”.

“Different personalities, but you learn over the years to try see where someone is coming from”.

5.3.3. Group membership

At a number of meetings and interviews with partners, the suggestion was put forward regarding the need to review membership and there appeared to be some confusion around what would best serve the needs of the CMHP. During the focus group in year one, partners did have some discussion and debate around reviewing the membership of the CMHP and it appeared that this task was put off until year two. There was mixed feelings amongst partners on the value of adding new members. Some of those suggested included the Gardai, Community Welfare Officers, the Irish Farmers Association etc. Despite the proposed, it was apparent that partners had an awareness of the challenges associated with making the CMHP larger. Partners proposed that;

“you could have an endless list of who you could bring on and you might not end up knowing what you are about and shifting the energy”.

Overall, there was a sense that there was a need for a worker who could help the CMHP achieve their aim and work with those men most vulnerable because as previously mentioned no partner had a remit to work exclusively with vulnerable

men in Carlow. Following on from the discussion in year one, the researcher felt it might be beneficial to ask partners about the membership of the group at the end of year two. It appeared that some discussion had taken place, regarding this topic, but no new partners had been added. From the data collected, it appeared that conflicting opinions still surfaced on this matter with some partners suggesting that “a group needs to be evolving all the time, different expertise coming in”. It was suggested that “ideally you would love to bring in a partner who could drive something”. While other partners disagreed and felt that the CMHP should not be inviting members to join the group just for the sake of it. One partner believed that “often times bringing in new partners doesn’t mean bringing in more help, it can mean bringing in more work”. “The size of the group is one of its benefits” and partners feared that the group could become a “talking shop” if it gets any bigger.

In year one, it was also suggested that it might be useful to engage some men identified during the health needs assessment, who may be interested in getting involved in planning and implementing the strategy. It was felt that their involvement might be a motivating factor for other men to get involved. However, there were some concerns and vagueness amongst some partners about the implications of involving men in the CMHP and at the end of year one it again emerged as something that would need further discussion. By year two, no men were represented in the CMHP and the reason cited for this was as follows;

“In terms of getting a man to come and represent men on this table there is a process I think to go from where he is at before we meet him, to bringing him here. This has been a particular learning curve for me. Leaders are beginning to emerge. And when they have emerged and come to the surface then we can invite them but we can’t do it sooner than that. I see it as we are in the process of doing that and now it is looking like a real possibility”.

However, this idea was met with some hesitation from one partner who stated that he would be very slow to bring a man onto the CMHP and may in fact resist it. The following explanation was put forward for this resistance;

“I don’t think people realise the drive and expertise that is inside this room and that might be a bit scary for someone who is not coming from this environment. I think it could have a negative impact on men. You can imagine someone coming in unemployed and there are six or seven professionals talking about operational plans, media driven campaigns etc. So I would be very slow to go down that road”.

Overall, the conclusion was reached that the CMHP is a strategic group that has a good process for two way communication with men, in which information is being picked up all the time, without having men around the table. The CMHP felt that having representatives from the steering group on the ground, at short programmes (Men's Health Programme and PA programme), facilitated a constant point of contact for communication. It was felt that down the line there may be an opportunity to bridge this gap but training would have to be provided for men. In addition, it was proposed that instead of bringing one man onto the steering committee you could bring two as this may prevent men from feeling intimidated by other professionals around the table.

5.3.4. Factors that contributed to success

One of the stronger themes to emerge following analysis of the transcripts was the factors that contributed to the success of the CMHP. At the end of year two, a partner summed up the year as follows “when I look back on the whole year I would say we had more success than we had failures”. A number of sub categories emerged including; reaching and communicating with vulnerable men, introduction of operational plans and the research component.

5.3.4.1. Reaching and communicating with vulnerable men

The CMHP discussed different options for reaching and supporting vulnerable men and there was agreement that to achieve this, there was a need to find new ways of reaching these men. The concept of participation was a strong focus of the work completed by the CMHP and refers to providing men with the opportunity to express their health needs and recognising these needs when designing the strategy. One partner summed it up as;

“not going out there doing things for people it's about supporting people to know what they really need for themselves and again supporting them to address that need”.

“People may have confided or expressed needs or ideas during the health assessment and they should be acknowledged and followed up in some way”.

It was felt that the best way of targeting vulnerable men was to strategically choose venues where vulnerable men convene and offer opportunistic health screenings. There was a sense that the CMHP were satisfied that the proposed cohort of men were successfully targeted and that the health screenings were an intervention in themselves. Some partners commented on their experience further reinforcing the goal of targeting the most disadvantaged and vulnerable men;

“I know from sitting in the mart and in that tent, we had men sat in front of us that were lucky that we were there that day”.

“I observed that they (*those facilitating the HNA*) were struck and even visibly emotional as a result of it. So I imagine that there were a number of different stories and heartache and issues that were more of an emotional nature than of physical health”.

Although in theory empowerment is a very valuable practice, some challenges do exist. One difficulty with providing men with the opportunity to identify their health needs was the restrictions that many funding agencies can place on applications. For example, if funding comes from the Irish Sports Council they may only want their funding allocated to a physical activity intervention. The concern was that this can lead to initiatives been funding driven rather than needs led. One partner reflected that;

“If we become funding led you become restricted as to what the funding says you have to do whereas you’d prefer to be able to go through the needs”.

Another disheartening aspect of empowering the community to identify their needs, as cited by a partner, may be that for years the same issues have been identified in reports and nothing might be happening. It was suggested that this can be very frustrating for a community and it may affect their attendance at initiatives as they may feel that it is a waste of their time and that their opinions are not being considered. However, it appeared that many of the partners felt motivated by the fact that they were making an impact on men’s lives, particularly during the PA programme in year two. One partner suggested that seeing the attendance each week and the impact the programme was having on men was good for the momentum and motivation of the CMHP;

“That type of thing is good for momentum, we are doing something, we are achieving something. It is about getting something back rather than constantly putting in. I think that’s important for adding momentum”.

Another factor which contributed to the success of the CMHP was that there was a constant two way communication process between the target group and the CMHP. All partners felt that speaking to men, finding out how they felt the programme was going and what they felt was needed was very important. One partner stated that “we are kept accountable, we have the information, there is a process of communication”. It emerged that having male CMHP partners participating in the short programmes made this process easier as this enabled the CMHP to keep reviewing what the men were saying and make the necessary changes. The CMHP took pride in the fact that one of the things they did successfully during the year was they “kept in contact with a large group of vulnerable men” and ultimately were really accountable to the men they had engaged with;

“The way we have been doing it this year has been continually talking to men, a two way conversation week in week out. We were picking up information all the time”.

There had also been major learnings with regard to working with men and what type of approach works best. Aside from the one day training, the day to day encounters of the partners with local men has resulted in huge learnings;

“People around the table are much more confident and are a hell of a lot more knowledgeable about how to work with men in the community setting”.

One of the partners referred to an interesting learning for him with respect to engaging men. This was the fact that although men provided the guidelines for the type of programme they would be interested in attending and yet very few of these men actually attended;

“Looking back what I did find interesting was that the information (that underpinned the programmes) did come from what the men said in the HNA but how little number of men from that very large group took part in the 6 week programme. Then from the men’s week programme came the PA programme and they were saying they wanted some more focus with a bit of activity involved in it and then how few men from that group actually joined the PA programme. So I think that is something that is interesting”.

5.3.4.2. Planning tools

At the end of year one, the CMHP spoke a lot about how they hoped to design and deliver their strategy. All partners were conscious of the need to be realistic with what could be achieved. They highlighted that a planning day was on the agenda which would facilitate them in developing a strategy. They discussed how at the end of the day they might have three foolscap pages with their “outcomes, methodologies and practicalities” of how the strategy would be rolled out. At this point one partner proposed that;

“we need to make time to sit down and bring to the table all the information that has been gathered to date, bring our own experience and name the resources we have. Start with all these ideas at the beginning of the day and honing it down to achievable bits at the end of the day. If we all sign up to that document we have a focus”.

The most significant finding to emerge from data collection in year two was the important role the REAIM planning tool and operational plans played in keeping the group focused. It emerged that this planning tool was very effective in terms of getting the CMHP to consider the aims and objectives of the intervention, measures of success, anticipated challenges and methods to overcome identified challenges. Furthermore, the concept of operational plans was introduced to the group in year two and all members refer to the clarity they had around roles and responsibilities. A partner concluded that;

“it absolutely crystallises roles, responsibilities, actions. And I think for a group of people who all have full time jobs we need to know exactly what we are taking on, we need to be realistic and we need to have tasks broken down into bite sized pieces and each of us take on a bit”.

Not only was the operational plan a factor that contributed to the groups success to engage with their target group of vulnerable men but it was also a learning process for the partners involved. One partner suggested that he would use this approach in other areas of his work as “it is a brilliant template”. It also appeared that meetings were much more structured as a result of the introduction of the operational plans;

“it made the work that bit easier as well because we weren’t coming to meetings and saying right where do we need to go now. It was all laid out in front of us”.

“Roles and responsibilities were clearly defined in the sense that people realised that if things were to get done, people needed to put their hands up”.

Overall, there was consensus from the CMHP that the operational plans were hugely beneficial in terms of bringing clarity to meetings, breaking tasks down and keeping the group focused. Furthermore the REAIM planning tool prompted the group to discuss barriers to engage men and focused them to identify strategies to overcome barriers identified.

5.3.4.3. Research

All of the partners referred to the significant part the research had played in the work they have done over the two years. It appears that the research was valued by the CMHP and had been very important in terms of keeping them motivated in the work they were doing. Partners expressed that;

“in a good way it keeps us on our toes in that we know there are different snapshots being captured of different things”.

“In terms of being able to provide evidence for what we have done, how we have done it, the effectiveness of it. It has been tremendously supportive in terms of generating momentum and motivation for the group”.

Although some partners did see the research as an extra piece of work, they felt that it is coming back to them “in terms of supporting us to survive”. This perspective was echoed by another partner who said “we can really use it to support us to stay together and keep doing what we are doing for men”. It emerged that many funding agencies have a poor understanding of how challenging working with men can be and this puts pressure on organisations to have tangible outcomes and benefits to their work without sufficient importance attached to the process. Partners expressed that this can be a very difficult aspect of community development work as it can take some time for changes to be observed and at times it can be very difficult to actually measure change as not all changes will be tangible or physical. Therefore, it was felt that research would be valuable in the future in terms of writing funding proposals.

5.4.4. Challenges

Despite the successful work of the partnership and the ability of the CMHP to work together, a number of challenges emerged in relation to partnership work when

trying to engage a group of vulnerable men, namely; the current economic climate, engaging men, no dedicated men's health worker and the fact that the perceived leader is due to leave the group for some time.

5.4.4.1. Current economic climate

One of the biggest challenges to emerge for the CMHP over the course of the two years was the impact of the current recession on their work. In year one, the CMHP frequently emphasised the effect of the current economic climate on the design and implementation of their strategy. Issues like job security and budget constraints emerged as major barriers for their planning efforts. There was a sense among partners that the “lack of being able to plan” for the next phase acted as a hindrance until they had a better idea on where they stood with their relevant employers. “People around the table are very unsure of where they are going to be in a few months time”. One of the partners explained that this lack of clarity around individual's jobs has resulted in a lot of really good people being disillusioned and as a result enthusiasm and motivation had suffered. This uncertainty about jobs amongst partners continued into year two, particularly since the “community sector is being battered”;

“My work has changed even across the middle of this year in a way that is unrecognisable to myself”.

“My only concern is around the challenges post budget and where ourselves and our organisations are asked to put our resources and how that will infringe on the CMHP”.

There also appeared to be a fear among partners that the workload would increase, as there is a whole new group of men whose circumstances have changed dramatically as a result of the recession and this will lead to men having more specific health needs. Many of the partners believed that as a result of the recession there is a heightened need for organisations such as the CMHP yet the irony is that there is less resources and partners hours are being pulled back;

“the needs are rising and you are becoming busier and that impacts on your work because you end up doing an awful lot more work in the same time”

“I think probably the only challenge I see is that we are going into recession, less money, less opportunity around getting money. The small group that we have is being drawn on to do other things in other parts of our work”.

Others however believe that “not everything is about huge amounts of money”. This shows that the CMHP are committed to improving the health and wellbeing of men regardless of the current economic climate. There was agreement that the CMHP would need to make use of any available resources such as college student placements, college equipment, volunteers and internal facilities. The CMHP were also lucky to have a volunteer in year two and this was described as “brilliant” and appeared to take some of the pressure off;

“Funding is great as it allows you a little more flexibility around what you can do but even without funding as long as you’ve got hours and people who can put into the programme you can still do a lot without funding for the programme costs”.

Finally, one of the partners appeared frustrated by the fact that conversations are continuously taking place about the impact of the recession and does not want to engage in these conversations;

“Lots of people do want to talk that all day. I think it is an incredible distraction to actually getting some work done”.

5.4.4.2. Human Resources

Despite the recognition for the need and purpose of the CMHP, challenges and frustrations also surfaced in relation to partnership work as all partners come from different agencies with different jobs specifications and the CMHP is only a fraction of their work. As previously mentioned, only one member of the CMHP has a job (part time) exclusively working with men and this remit is not exclusively for Carlow, but the whole of the South East. Furthermore, it emerged that when each partner has their own remit and agenda that this can lead to problems completing tasks in accordance with their respective employers;

“I think the weakness has been that there is not a lot of people whose sole job is to work specifically with men”.

One partner hoped that;

“there will be a dedicated men’s health coordinator and worker in Carlow and that there will be a key driver/person in it rather than all of us coming together as little bits of our work”.

At the end of year one, there was a sense within the group that there were some discrepancies as to whether or not the group would continue to work in partnership to sustain the project. There appeared to be a feeling from some partners that if it was feasible it might be best to hand over responsibility to a dedicated men’s health coordinator. A recommendation was made to the CMHP, at the end of year one, to clarify how resources, both human and financial would be allocated. Although this theme also emerged in year two, the CMHP seemed much more aware of the importance of their partnership work and optimistic about sustaining the partnership.

5.4.4.3. Engaging men

Another strong theme which surfaced during the analysis was the intricacy of involving men in community based health initiatives. It is clear that the CMHP have had huge insights into the issues and challenges around engaging men. Numerous partners cited past challenges around engaging men, how they require an awful lot of support and that progress can be very slow. They also reflected on past initiatives they had run and the concern was that, despite being well organised, the attendance of men was very poor;

“The challenge of supporting men can be, at times very difficult, ring one woman and say will you bring five and she will bring ten. With men your ring five and say will you bring one and five won’t turn up”.

“Men stayed away in droves from well organised events”.

Some of the partners also recognised that working with men is not going to be the same as working with women;

“These men need contact, they may need lifts, they need a lot of support to get to these things that we set up for them”.

However, partners did offer some explanations for the poor attendance and suggested alternative strategies for future initiatives. One recommendation put forward was that, in past initiatives, men were not fully informed about what they were buying into and therefore they had different expectations. If men are fully aware and

informed about what a programme will entail they can then make an informed choice as to whether or not the programme appeals to their specific needs;

“We thought we had really good numbers and a good turnout but then there was very quick drop off because the men were coming from different ideas of what was going to happen”.

It also emerged from discussions with a couple of the partners who facilitated the screening that men liked the informal and opportunistic nature of the screening;

“Several of the guys said to me what they really liked about it was the informality of it and the professionalism of it. One man said to me if this was up the town in one of the offices I wouldn’t have gone in”.

At the end of year one, there appeared to be some vagueness regarding the importance of careful planning and the understanding of the time and energy required to engage and sustain men’s participation in programmes. As previously mentioned, there was a sense of pressure within the group to work quickly, in order to keep men engaged. The researcher felt that critical planning time may be lost as a result of these conflicting elements and recommended that the group discuss the barriers that make it difficult for men to become involved and stay involved in an intervention and also the different strategies to overcome these barriers. It emerged that this was taken on board and planning via the REAIM framework and operational plans was introduced in year two.

5.4.4.4. A Champion for Men’s Health

It was acknowledged and observed throughout the two years that the CMHP was made up of “a good team of people and nobody is dragging their hip” and when things needed to be done and actions were identified partners were quick to volunteer. It was clarified during the focus group that tasks were allocated through the operational plans. However, one partner in particular was described as the “fulcrum” and “champion” of the CMHP. In several of the interviews this partner was referred to as a “key person” who “drives” the group and this was also observed by the researcher at meetings. Although this was perceived by all participants positively there was some concern over this partner going out on leave. A number of participants felt that the last time this partner went on leave, the group “did lose

focus”. There was a sense that the group did not want to leave this happen again. “We need to make sure the focus of the groups stay in place over that period of time”. Many of the partners expressed concern about what would happen to the group and felt that it might “stagnate”. One partner highlighted how;

“The organisational skills, project management skills, leadership skills, administrative skills and their focus for the project will definitely be a hard act to follow”.

While another questioned if the group is strong enough to continue without them;

“If a key driver is going out on leave is the group strong enough to be able to continue and develop? If the answer is maybe, don’t know, well then why, why is that the case. That’s not good enough”.

5.5. Discussion

As previously mentioned, the CMHP is in effect a partnership of a number of organisations in Carlow and the South East. According to the NMHP, inter-sectoral and interagency partnership work is fundamental for community development and men’s health (DOHC, 2008). The view of the partners, which emerged highlight how the partnership has developed over the two years. The main themes to emerge were the purpose of the group, group dynamics, group membership, factors that contributed to success and the challenges associated with working in partnership. These will now be discussed in more detail.

It emerged that the CMHP had a very clear focus on the need for and focus of partnership, particularly in year two. Most partners were very optimistic about the partnership approach as a means of working together to improve the health and wellbeing of vulnerable men. The CMHP worked from a strong community development ethos in which they empowered men to identify their health needs and designed and delivered a strategy to improve the health and wellbeing of these men. Research suggests that it is important that all partners have a shared understanding of their aims and vision as conflicting interests can prevent partnerships from having its intended effect on its community (Fletcher et al., 2002; Wilkins, 2005; Butterfoss, 2007; Ball, 2010). At the end of year one, there was some concern as many of the partners felt there was a need for a dedicated men’s health worker and obviously this

was in conflict with the principles of the community development approach mentioned earlier. Furthermore, if a “worker” is brought on board to deliver services it can result in partners feeling their sense of ownership dissipating and therefore their level of participation will subsequently reduce (Alexander et al., 2010). Although this issue had dissolved somewhat in year two, it was still seen as a challenge to partnership working, particularly given the cutbacks associated with the current recession.

Overall, the dynamics of the CMHP were quiet good and the group attributed this to the level of respect members had for each other. Although issues did arise around roles and responsibilities, different personalities and remits for urban and rural areas, partners felt that these were dealt with through respectful dialogue. The majority of partners felt that issues were sorted out within the group, at team meetings and that this enabled the group to move on. This type of approach to conflict resolution is recommended throughout the literature in order to achieve and maintain a healthy partnership (Salto Youth, 2007; Jones et al, 2001; Ball, 2010). However, it did surface that one or two partners still carried some frustration regarding particular issues which had arisen and this might show that issues were not sorted out to all members’ satisfaction. As previously mentioned, the function of a group is not only to complete group projects but to fulfil its members needs (Arrow et al., 2000). Therefore, partners need to complement each other and if this is not happening, a structure may need to put in place to review member’s roles (Deslauriers and Orology, no date).

Furthermore, it is important that working arrangements in which roles and responsibilities are clearly defined are available and it appears that the CMHP had achieved this in year two, through the use of operational plans (Hardy et al., 2003; Johnson and Johnson, 1997). Although the CMHP had a good idea at the end of year one of how they would plan and implement their strategy, it emerged that the REAIM planning tool and the introduction of operational plans was crucial to their success. All partners commented on how the operational plans “crystallised roles, responsibilities and actions” and are “a brilliant template”. It was reiterated that it made the work easier and the meetings were much more structured as “it was all laid out in front of us”. Johnson and Johnson (1997) also recommend the use of operational plans as they can enhance communication, guide the group in the

planning and delivery of tasks and also assist the group when evaluating both the group process and group outcome. Other research concurs with this stating that clear articulation of roles and responsibilities is necessary to focus and give clarity to individual partners and thus avoid conflict (Deslauriers, no date; Hardy et al., 2003 and Ball, 2010; Heenan, 2004).

It appeared that the CMHP worked well together and that people took on what they were able to at a given time. Despite the fact that one partner highlighted that she “would have experienced more leaders come to the table this year (year two)”, this partner was seen by the rest of the group as the “fulcrum” and “champion”. Although research states that partnership work requires everyone to take on a leadership role it can happen that leaders are “presumed” by other partners. There was a sense of apprehension from partners as the perceived leader was due to go on leave. It was felt that the last time this partner took leave that the group had stagnated and lost focus. Another partner believed that if the group was not strong enough to continue without this partner then this was not good enough. Research suggests that partnerships are composed, either on purpose or accidental, “leaders and followers”. Despite the benefits of having a strong leader in place it can hinder other partners, either consciously or unconsciously, from making their full input (Pobal, 2006). It can also paralyse the group, result in loss of momentum, gaps in delivery of activities or completion of tasks and negatively affect group cohesion and dynamics (Alexander et al., 2010; Alexander and MacDonald, 2005). It appears that this is a challenge that the CMHP are facing at the moment and careful consideration of how they propose to manage the situation is necessary.

As can be seen from the results section, it appears that group membership was a theme which emerged over the two years. At the end of the first year, it was suggested that there may be value in adding new partners and although some discussion did take place no new partners had joined the CMHP by the end of year two. There was recognition that one of the strengths of the group was its size and a fear was that if it got bigger it may become a “talking shop”. Research supports this suggesting that problems such as coordinating tasks and procedures, as well as maintaining motivation can be much more difficult to manage in larger groups (O’Neill, Sinnott, Fuller-Love and O’Gorman, no date; Arrow et al., 2000). Furthermore, Wicker (1976) believes that small groups positively affect member’s

motivation, satisfaction and participation leading to the group maximising its full potential. Yet, some partners felt that a group needs to be evolving all the time with different expertise coming in.

In addition, a discussion took place regarding the inclusion of local men, on the CMHP steering committee. The issue of involving members of the target population is commonly discussed in the literature with conflicting opinions on its benefits (Combat Poverty Agency, 1995; Dennis, 2003; Rhodes et al., 2007; Nemcek and Sabatier, 2003). Involving members of the local community is cost effective and an effective mechanism to reach the right people and tackle health problems (South et al., 2010). Some partners identified associated challenges to this which could result in disengagement of men as a result of the level of expertise around the table. The Combat Poverty Agency (1995) support this suggesting that members of the community can experience difficulties in understanding the technical language used by professionals at partnership meetings. Furthermore, it is necessary that prior to reviewing a group's membership that partners agree on the role of the community representative as Nathan and Braithwaite (2010) found that less than half the staff in their study felt that the Community and Health Service agreed on the role of community representatives. Additionally, Bandesha and Litva (2005) found that lay partners felt they had no control over the project or its resources and considered themselves more recipients of the project rather than active shapers or partners in the process. Reid et al. (2008) discussed the challenge of including hard to reach men adequately in partnership work. To overcome this they established a lobby group. However, it is necessary to bridge this gap and involve men directly in order to achieve the main principle of community development, which is empowerment. Therefore, the provision of training to community representatives is crucial if they are to be involved in partnerships (Combat Poverty Agency, 1995).

The biggest challenge to emerge for the CMHP was the effect the current recession was having on them as a partnership and their ability to deliver services to vulnerable men. Partners recognised that there was a growing need for services targeting vulnerable men, particularly those recently unemployed, yet funding has dramatically reduced. Also, because partners may be lost as a direct result of the recession there was a fear that group dynamics and cohesion may be damaged. Finally, the uncertainty of many partners positions has resulted in a lack of being

able to plan which has negatively affected enthusiasm and motivation. There appears to be a lack of information available on the effect of the recession on partnership work at a community level, but it is evident that services are being impacted by severe budgetary constraints.

Throughout the literature there is clear consensus regarding the need to monitor and evaluate the progress of partnerships (Butterfoss et al., 1996; Lasker et al., 2001; Hardy et al., 2003; Pobal, 2006). Although the research component was seen by partners as an extra piece of work it was also seen as crucial to their success and motivation. Research agrees with this recommending that monitoring and evaluation demands are kept to a minimum and do not interfere with the efforts of the partnership to deliver quality services to their target group (Alexander et al., 2010). Partners commented on how “it keeps them on their toes” and “generates momentum and motivation”. Furthermore, the research was seen as very important in supporting the group to survive and be sustainable. Partners highlighted that many funding agencies have a poor understanding of how challenging and time consuming partnership work with men can be (Brown, Butler and Hamilton, 2001; Reid et al., 2008). Therefore the CMHP feel it is necessary to have “tangible outcomes and benefits to their work”, such as this research.

The results of this piece of research should be interpreted in light of a number of limitations. Firstly, since this research only looks at the process of one partnership, using qualitative methods, generalisability is not possible. Secondly, this study relied on qualitative data exclusively and this brings with it several restrictions. If this research was to be replicated there may be some value in using a quantitative measure, for example the partnership self assessment survey (Center for the Advancement of Collaborative Strategies in Health, 2003-2009). Social desirability bias may also have created a limitation particularly since the group are working so closely and may have answered what they perceived to be “correct” or what they thought the researcher wanted to hear (Parahoo, 1997). Finally, this research was subject to recall bias as information was garnered primarily at the end of each year (phase). Recall bias can either exaggerate or underestimate the information provided, which threatens validity (Beaglehole et al., 1993).

5.6. Conclusion

The achievements of the CMHP can be seen on a number of levels, namely working with vulnerable men, staying together as a group during the tough economic climate, co-ordinating and delivering two short programmes and a number of PR activities. Furthermore, the CMHP engaged in an ongoing learning process on how to engage a group of vulnerable men and how to work in partnership. A number of challenges to working in partnership also emerged from the data. These were the effect of the current economic climate, coupled with the challenges of engaging men. Nonetheless, it appears that the CMHP worked from a strong community development ethos and are in their fourth year of partnership. Although it is difficult to prescribe a “one size fits all” solution to partnership working, the aim of this component of the research was to identify the factors necessary to help a partnership engage with men. The findings of this research reveal a number of “Rules of Engagement” for partnerships which are outlined below;

1. It is important that all partners share a common view of the partnerships objective i.e. to engage vulnerable men with their health. In the early stages of partnership work, an exercise should be conducted to establish the groups objectives and boundaries for community based men’s health promotion.
2. Emphasise the importance of shared responsibility and ensure that leadership does not reside with one partner. This is a task which could be completed as part of an initial meeting where ground rules are set.
3. Developing a contingency plan to deal with unexpected changes in personnel, resources etc.
4. Ensure partners engage in team building exercises and men’s health training on an ongoing basis.
5. Plan interventions using the REAIM planning tool. This will allow partnerships to identify perceived challenges and make relevant changes before they deliver their intervention.
6. Generate positive group dynamics and a safe environment that fosters communication between partners, organisations and with men.
7. It is necessary that partnerships develop a mechanism in which roles, responsibilities and actions are clearly articulated i.e. through the use of operational plans.

8. Ensure that a monitoring component of partnerships efforts is incorporated from the very beginning. This will provide partnerships with a mechanism to review progress and take corrective action where necessary.
9. Find an appropriate way to include vulnerable men in partnership steering committees to ensure that services are meaningful and acceptable to their needs.
10. Finally, conduct a variety of activities and not just programmes which can be very resource intensive and de-motivate the partnership if unsuccessful. Awareness activities such as letters, articles, seminars etc should be conducted in parallel to programmes.

Conclusion

6.0. Conclusion

It is well established that men suffer poorer health than their female counterparts and that a number of factors influence their health status. One of the key challenges to emerge from the literature is how to successfully engage men with their health. It is now acknowledged that men's health is a complex issue requiring input from a variety of disciplines. There has been a move towards the use of non traditional settings and community based health promotion but there is still a lack of available literature on how effective this approach is. The aim of this piece of research was to investigate the development and implementation of a community based strategy to improve the health and wellbeing of vulnerable men. It is hoped that the data emerging from this research will enable practitioners to successfully engage men in similar settings. Drawing on the available literature on men's health, as well as the findings from the current study this final chapter will outline the limitations of this research, the contribution it has made in terms of identifying good practice for engaging men and the implications for future practice and research.

The CMHP successfully adopted a community development approach to men's health. By conducting a HNA assessment at the very beginning they were able to ensure that their strategy was addressing the particular needs identified by men. Although the initial Men's Health Programme did engage a group of vulnerable men, particularly in the urban area, it was not as cost effective as the PA programme. It emerged that this group of vulnerable men wanted a more structured programme with tangible outcomes. Nonetheless, the research findings enabled the CMHP to apply the feedback from men and their own learning's to the subsequent PA programme. The feedback gathered from the men involved in the PA programme suggested that it was very successful. Although it could be argued that the numbers that attended the short programmes were small the CMHP were effective at reaching their target group of vulnerable men. Future programmes need to look in finding effective "hooks" and adopting strategies to engage more men. The recommendation for a screening type intervention was often recommended by men. The individual components of programme design associated with effective engagement of vulnerable men will be summarised below.

It appeared from the results that the six week print media campaign was well received by men. A number of factors contributed to the success of particular articles such as the use of testimonials and visuals of men whom the target group can identify with. Additionally, the use of text boxes to highlight key information meant that men may have been more likely to attend to these messages. However, it must be acknowledged that the literacy demand of the articles was high and therefore the content may not have been understood by the target group. The men made a number of recommendations about how to enhance future media campaigns which should be considered i.e. positioning articles in the sports section or page three and the use of the internet. By partnering with the local newspaper, the CMHP have established a relationship which can be utilised for dissemination of future research findings.

Despite the challenges of working in partnership during the current economic climate, the CMHP were successful at planning and delivering a number of interventions to their target group of vulnerable men. Even though the target group were not directly involved in the CMHP steering committee, there was a good mechanism in place for feedback. However, in order to progress this strategy further, it must be acknowledged that no one can give a greater insight into the issues affecting vulnerable men, than a vulnerable man himself. This might also help improve recruitment for programmes and also increase awareness of the CMHP. To conclude, engaging a cohort of vulnerable men with their health and maintaining a community based partnership through a very tough economic climate has been a key success of the CMHP. Furthermore, the motivated and committed staff involved in the CMHP, their clear and realistic vision of what they could achieve and their ability to access existing local resources and services must also be acknowledged.

6.1. Limitations

- **Social desirability bias** – Social desirability occurs when participants answer questions with what they think they should say rather than what they have actually done or feel and therefore may prefer to report that they had changed attitudes, behaviours etc (Bechofer and Paterson, 2000; Black, 1999). It is possible that this may have occurred during data collection. Additionally, it is important to acknowledge the effect the researcher can have on the data

collection process. The nature and quality of the data collected is determined by the interpersonal skills of the researcher (Bryman and Burgess, 1994)

- **Hawthorne effect** – This is where the presence of a programme, and not the programme itself, is associated with favourable changes in outcome measures. This occurs when people work harder to make lifestyle changes when they are participants in research because of the attention they receive, not because of the programme itself (Farag et al., 2010). Although this study used pre and post intervention questionnaires with the men there was no control group. However such quantitative measures were not central to the programme objectives.
- Since participation in the research was voluntary, it is possible that already motivated men may have participated. However, it appears from the demographic findings that a variety of men engaged in the research.
- For physical activity intervention, the pre intervention was conducted in week two and therefore the validated questionnaire had to be adapted. The group felt that it may alienate men if the questionnaire was distributed on week one. This undoubtedly caused a higher than expected baseline physical activity levels.
- Dootson (1995) highlights the limitation of inexperienced researchers embarking in the process of data collection. Nevertheless, research at Master's levels is generally regarded as training, during which knowledge and skills in research methods are still being gained and thus the researchers' experience is acknowledged as a limitation

6.2. Contribution of Research

The main strengths of this research is the contribution it makes to men's health in Ireland particularly in relation to engaging vulnerable men in community based health promotion. At the end of each of the main chapters, the research listed a number of 'rules' or 'guidelines' which health professionals should follow when working with men. However, one must remember that a "one size fits all" approach will not be successful in men's health. Health professionals need to ensure their

programmes are tailored to address the needs of their particular group of men, the venue and the participants' social circumstances.

6.2.1. Rules for engaging men in community based health promotion

1. Use creative advertisement and recruitment methods as these are necessary when try to engage men. Men in the PA programme suggested using a form of snowball recruitment as others might adopt the “if he can do it so can I” attitude. Particularly for PA it is important not to show images of very fit men as this can seem unattainable for participants. Therefore, using an image of a male from the target group, from the local area is recommended.
2. Identify and use suitable “hooks” or “incentives” to get men to attend programmes. It has emerged that an assessment of health status or health screening might be an effective mechanism.
3. Identify locations and venues which can be easily accessed by vulnerable men. Additionally, make health services available in non traditional settings where men convene i.e. sporting events, betting shops etc.
4. Remove barriers such as cost and time factors for men. It appears that many of the men who the researcher liaised with would have preferred programmes to be run later in the evening. Therefore, it might be worthwhile offering men a choice of times.
5. Target an experienced facilitator as their approach is fundamental to keeping men engaged in an intervention. Facilitators need to pitch the programme appropriately to the needs and abilities of each individual man.
6. Give a clear outline of the programme to the men so that they know what they will be doing. Furthermore, men in this particular study wanted to attend a structured programme with tangible outcomes.
7. Generate positive group dynamics (social support & cohesion). Again the approach of the facilitator here is key to ensuring men are comfortable. The use of humour seemed crucial to men in the PA programme.
8. Ensure sustainability is accounted for by including the men themselves in the long term planning of the programme. If it is not possible to have men on a

steering committee it is essential to provide a mechanism for the men to be consulted with.

6.2.2. *Rules for communicating health messages to men*

1. Careful planning (REAIM planning tool) is necessary to assess the needs and segment a small and homogenous target group.
2. Allow time to conduct formative evaluation with the target group to establish effective messages that are understood and to identify the most effective channels to reach the target audience.
3. Incorporate media campaigns into a multi component, community based initiative.
4. Build partnerships with local editors to ensure health is placed more firmly on their agenda and ensure that they have access to important men's health research findings.
5. It is necessary to assess all health information in terms of literacy demand, message content and design to ensure message are easily interpreted by men.
6. Use images and quotes of men whom the target group can identify with. Localisation of stories is crucial as it can make health issues more personally relevant for men and as previously mentioned enhance recruitment to programmes.
7. Ensure there is an avenue for further contact that can be easily accessible to men i.e. helpline number, websites, support groups etc.
8. Think creatively about how and where to target men with health messages for example beer mats in pubs or the use of information technologies such as the social networking, websites or mobile phones.
9. Build in a monitoring component to ensure the health campaign is achieving its aims and objectives. This can help guarantee that funds are being spent on the most effective channels.

6.2.3. Rules for partnership working for men's health

1. It is important that all partners share a common view of the partnerships objective i.e. to engage vulnerable men with their health. In the early stages of partnership work, an exercise should be conducted to establish the groups objectives and boundaries for community based men's health promotion.
2. Emphasise the importance of shared responsibility and ensure that leadership does not reside with one partner. This is a task which could be completed as part of an initial meeting where ground rules are set.
3. Developing a contingency plan to deal with unexpected changes in personnel, resources etc.
4. Ensure partners engage in team building exercises and men's health training on an ongoing basis.
5. Plan interventions using the REAIM planning tool. This will allow partnerships to identify perceived challenges and make relevant changes before they deliver their intervention.
6. Generate positive group dynamics and a safe environment that fosters communication between partners, organisations and with men.
7. It is necessary that partnerships develop a mechanism in which roles, responsibilities and actions are clearly articulated i.e. through the use of operational plans.
8. Ensure that a monitoring component of partnerships efforts is incorporated from the very beginning. This will provide partnerships with a mechanism to review progress and take corrective action where necessary.
9. Find an appropriate way to include vulnerable men in partnership steering committees to ensure that services are meaningful and acceptable to their needs.
10. Finally, conduct a variety of activities and not just programmes which can be very resource intensive and de-motivate the partnership if unsuccessful. Awareness activities such as letters, articles, seminars etc should be conducted in parallel to programmes.

6.3. Implications for practice and research

Practice

- Assumptions that men do not care about their health and will not engage in health promotion programmes needs to be challenged.
- Consult and involve men in the development and delivery of user friendly men's health services. It is also necessary to seek the advice of those men who choose not to attend a health programme as their insight is fundamental.
- Develop gender specific health information that is easy accessible to those men most vulnerable.
- Ensure that there is a clear focus to men's health programmes and that men are informed of this prior to commencing the programme.
- Men appeared to have really valued the outreach health checks conducted as part of HNA.
- Develop a national men's health training programme for health professionals.
- Promote and encourage inter agency collaboration and partnerships to share ideas and resources.
- Monitor and evaluate men's health promotion initiatives that support men

Research

- It is acknowledged that interagency collaboration and sharing of resources is both necessary and beneficial. However further research of men's health partnerships is necessary to establish definitions of effective partnerships.
- An enhanced understanding of masculinity and the wider determinants of health is essential if men's health problems are to be correctly analysed and understood. This would also assist health professionals in the development and delivery of more appropriate services.
- Given the current economic downturn, it may be timely to conduct some research with unemployed men to establish the effects of the recession on their health and how to address them.

- Conduct formative evaluation with men to establish their perspectives on health and health promotion to gain an insight into the needs of men.
- Review on an ongoing basis current practice in the area of men's health and incorporate research findings into practice.

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7.0. References

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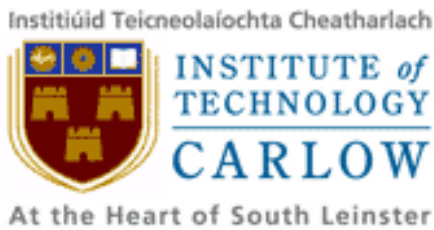
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Appendices

Carlow Men's Health Project

Health Needs Assessment

Questionnaire



Carlow Partnership

John Wallis

1.1. Health Needs Assessment Questionnaire

Event: _____

Code: _____

Protocol for Administrator:

1. Use the code assigned to the participant on the health screening results sheet and put in the space provided above.
2. Read the instructions below to the participant prior to administering the questionnaire. In particular insure that the participant gives their consent to participating in this phase of the study.
3. When necessary, use block capitals when documenting evidence, otherwise clearly mark the answer given.

Explain the following to the participant:

As part of the Carlow Men's Health Project we are conducting a health needs analysis among men in Carlow. We will use this information to develop a strategy to support men in Carlow Town and County to achieve optimum health and wellbeing. We would appreciate it if you could take the time to answer a few questions. Please note the following;

1. All information will be held in the strictest of confidence. All questionnaires are coded so the interviewee is not readily identifiable. All data will be stored securely and only the primary researchers will have access to the raw data. Information compiled as a result of this study will be used to inform the development of the "Carlow Men's Health Project". The findings from this study may also be disseminated via a variety of media; however, at no point will personal details be included in any report or paper published. Data will be stored for 5 years post publishing and will be destroyed thereafter (in accordance with WITs Data Protection Policy)
2. While there are no physical risks to from participating in this project, you will be asked some personal questions. However, as stated above, all data will be documented with the utmost respect and sensitivity and will be held in the strictest of confidence and stored anonymously.
3. You will not be paid for your participation in this study but by way of expressing our gratitude for answering these questions, your name will be included in a draw for a weekend away for two people.
4. You are free to refrain from answering any question you choose to and/or to withdraw from this study at any time without consequence.
5. If you do not know the answer to some of the questions, just choose the Don't Know option. This information is just as useful to us.
6. If you consent to participate in this research study please tick the box

1.1. Health Needs Assessment Questionnaire

Section A: Demographics

This section will include questions that tell us about yourself. The interviewer will insert your chosen answer(s) in the boxes or spaces provided.

1. Please state your **year of birth** _____

2. Please state your **country of birth** _____

3. **What is your ethnicity?** (Tick **one** box only)

White (Irish, Irish Traveller, Any other white background)

Black or Black Irish (African or Any other black background)

Asian or Asian Irish (Chinese or Any other Asian background)

Other (including mixed background)

4. **What did your education include?** (please tick **one** box only)

Primary education only

Some or completed secondary education

Some or completed third level education

5. **What is your present marital status?** (Please tick **one** box only)

Married / cohabiting Widowed

Separated /divorced Single

6. **Have you any children?** If yes, go to Q6a Yes No

If no, please go to Q7

6a. **How many children have you?** _____

6b. **What ages are your children?** _____

6c. **Are you currently living with your children (<18 years)** Yes No

If yes go to Q7, if not married/cohabiting and have children please go to Q6d

1.1. Health Needs Assessment Questionnaire

6d Are you a lone parent? Yes No

7. Are you living alone? Yes No

8. Do you have other dependants? If yes go to Q8a Yes No

8a Who are your dependants?

9. Regarding your house where you live, are you?

Paying a mortgage An owner occupier Parents' house
renting privately a Local Authority tenant

10. Which of the following best describes you? (Please tick **one** box only)

Employed (full time) Employed (part time)
Self employed Unemployed and looking for work
Looking after home/family Retired from paid work
Unable to work due to long term illness/disability Other

10a. If you have/had an occupation, please name it _____

11. What is your main source of income?

employment social welfare pension
Farm subsidies other _____

12. Which of these gross income brackets would your family fit into? (Please tick **one** box only)

<€10,000 €10,000 - €20,000 €20,000 - €30,000
€30,000 - €40,000 €40,000 - €50,000 >€50,000

1.1. Health Needs Assessment Questionnaire

Section B: Health

This section will include questions that tell us about your perception of your health.

Explain to participant that when they think about 'health' they should think not only about physical health but also mental (e.g. happy, worried, feeling down) and social health (involvement in communities, relationships)

13. In general, would you say your health is...

- | | | | | | |
|-----------|--------------------------|-----------|--------------------------|------------|--------------------------|
| Excellent | <input type="checkbox"/> | Very good | <input type="checkbox"/> | Good | <input type="checkbox"/> |
| Fair | <input type="checkbox"/> | Poor | <input type="checkbox"/> | Don't Know | <input type="checkbox"/> |

14. In comparison to 12 months ago, would you say your health is...

- | | | | | | |
|--------|--------------------------|-------|--------------------------|----------------|--------------------------|
| Better | <input type="checkbox"/> | worse | <input type="checkbox"/> | about the same | <input type="checkbox"/> |
|--------|--------------------------|-------|--------------------------|----------------|--------------------------|

15. Do you believe that you have control over your future health outcomes?

- | | | | | | |
|----------------|--------------------------|--------------------|--------------------------|-------------------|--------------------------|
| Strongly agree | <input type="checkbox"/> | No strong feelings | <input type="checkbox"/> | Strongly Disagree | <input type="checkbox"/> |
|----------------|--------------------------|--------------------|--------------------------|-------------------|--------------------------|

16. Have you got a family doctor? If yes, go to 10a Yes No

16a. When was the last time you attended your family doctor?

- | | | | | | | | |
|----------|--------------------------|-----------|--------------------------|---------|--------------------------|----------|--------------------------|
| <1 month | <input type="checkbox"/> | <6 months | <input type="checkbox"/> | <1 year | <input type="checkbox"/> | > 1 year | <input type="checkbox"/> |
|----------|--------------------------|-----------|--------------------------|---------|--------------------------|----------|--------------------------|

1.1. Health Needs Assessment Questionnaire

17. When was the last time you had any of the following health measures taken? (Please note that measures have to be taken from health/allied health professional)

Weight <1 month <6 months <1 year > 1 year Never

BMI <1 month <6 months <1 year > 1 year Never

Waist Cir <1 month <6 months <1 year > 1 year Never

Cholesterol <1 month <6 months <1 year > 1 year Never

Blood Press <1 month <6 months <1 year > 1 year Never

18. Have you got a Dentist? If yes, go to 17a Yes No

18a. When was the last time you attended your dentist?

<1 month <6 months <1 year > 1 year

19. Do you have any physical health problems? Yes No

If yes, please specify

1.1. Health Needs Assessment Questionnaire

20. During the past month have you felt down, depressed or hopeless or have you been worrying a lot about everyday problems?

If yes, would you like to say more about this Yes No

(close family friend or family member that you talk to about things that are bothering you.)

21. What, if any, aspects of your life are causing you significant stress at the moment?

none relationship work home life

money health study Other _____

Would you like to say more about this?

Prompts: How do you manage the stress? Query affordability of food.
Draw on interviewing techniques re repeating certain words etc to draw out rich qualitative data in this section.

22. Are there particular things that you do to look after your health, things you enjoy perhaps?

23. Are there particular things you would like to do to look after your health? Use prompts here to try to find out what they would like to see in our strategy for men's health in Carlow.

1.1. Health Needs Assessment Questionnaire

Section C: Health Behaviours

This section will include questions that tell us about your perception of your health behaviours. The interviewer will insert your chosen answer(s) in the boxes or spaces provided.

Physical Activity

Interviewer keep the following in mind as a definition of regular physical activity: At least 30 minutes/day of moderate activity (Dancing, brisk walking, gardening, cycling etc) 5days/week (150mins a week)

24. Tell me about what kinds of activity you do? How often? Interviewer ticks the appropriate box below depending upon feedback from participant.

I am not regularly physically active and do not intend to be so in the next six months

I am not regularly physically active but am thinking about starting in the next six months

I do some physical activity but not enough to meet the description of regular physical activity

I am regularly physically active but only began in the last six months

I am regularly physically active and have been for longer than six months

If not regularly physically active go to Q24a

1.1. Health Needs Assessment Questionnaire

24a. What would you say is the main reason why you are not (more) physically active at this time?

Not interested	Not motivated	No time to do it	No facilities to exercise/be active	Injury/disability/medical condition	Other, specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Are you actively trying to manage your weight? Yes No

If yes go to Q25a, if no go to Q26

25a. Is it to lose, gain or maintain weight?

Lose weight	Maintain weight	Gain weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Please circle the most appropriate response to the following 3 statements.

For those who do not eat a healthy diet, go to Q26a

	Most of the time	Quite often	Now and again	Hardly ever
I make conscious efforts to try and eat a healthy diet	1	2	3	4
I try to keep the amount of fat I eat to a healthy amount	1	2	3	4
I don't need to change my diet as it is healthy enough	True <input type="checkbox"/>		False <input type="checkbox"/>	

1.1. Health Needs Assessment Questionnaire

26a. What would you say is the main reason why you do not eat a healthier diet?

Not interested	Interested but do not know what constitutes a healthy diet	No time to do it	Do not know how to cook	Do not do the shopping or food preparation	Other, specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Smoking

27. Do you now smoke every day, some days, or not at all?

Every day	Some days	Not at all (go to 34)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[INT: CURRENT SMOKERS ONLY]

28. How many cigarettes do you smoke on an average day?

Less than 1 a day	1-10	11-20	21-30	≥30
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1.1. Health Needs Assessment Questionnaire

29. Are you currently? If trying, actively planning or thinking about quitting go to Q29a

Trying to quit	Actively planning to quit	Thinking about quitting but not planning to	Not thinking about quitting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29a. What would you say is the main barrier to you quitting smoking?

Possible weight gain	Stress	Socialising	Lack of know how (re patches etc)	Lack of support	Other, specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. How often do you have a drink containing alcohol? If never go to Q34

Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1.1. Health Needs Assessment Questionnaire

31. How many drinks containing alcohol do you have on a typical day when you are drinking? _____

[INT: A DRINK IS: - A HALF PINT OR A GLASS OF BEER, LAGER OR CIDER

- A SINGLE MEASURE OF SPIRITS (E.G. WHISKEY, VODKA, GIN)

- A SINGLE GLASS OF WINE, SHERRY OR PORT

- BOTTLE OF ALCOPOPS (LONG NECK)]

32. During the last 12 months have you?

	Yes	No
Got into a fight when you had been drinking	<input type="checkbox"/>	<input type="checkbox"/>
Been in an accident of any kind when you had been drinking	<input type="checkbox"/>	<input type="checkbox"/>
Regretted something you said or did after drinking	<input type="checkbox"/>	<input type="checkbox"/>
Felt that your drinking harmed your friendships or social life	<input type="checkbox"/>	<input type="checkbox"/>
Felt that drinking harmed your home life or marriage	<input type="checkbox"/>	<input type="checkbox"/>
Felt that drinking harmed your work or studies	<input type="checkbox"/>	<input type="checkbox"/>
Felt that drinking harmed your health	<input type="checkbox"/>	<input type="checkbox"/>

I have been told by whom? (family, friend, health professional) that I drink too much alcohol

1.1. Health Needs Assessment Questionnaire

33. Do you ever feel the need to cut down on your drinking?

Yes No

If yes, please explain

Section D:

This section will include questions that tell us about services you would like to support you to achieve optimum health and wellbeing. Remind participant of the broad nature of health, probe what they think might be causing the health concern and focus on supports for this.

34. Have you any health concerns? If yes, go to Q34a Yes No

34a. Give details of your concerns

35. What would you say are the most important health concerns to be addressed for men in Carlow Town/County?

Prompt: not meeting people regularly (isolation), individual lifestyle behaviours, medical problems as a result of poor health behaviours, risk taking, family/relationship problems, money problems, unemployment or not having a structure to the day.

1.1. Health Needs Assessment Questionnaire

36. What do you think would help either you or other men in Carlow Town/County to address those health concerns?

3.1. REAIM Planning Tool

Questions to Improve Reach:

- 1. Do you hope to meet all members of your target population?**
- 2. Breakdown of demographics?**
- 3. How confident are you that your programme will successfully attract all members of your target population regardless of age, ethnicity, socio economic status and other important characteristics, such as health literacy?**

1 2 3 4 5 6 7 8 9 10

(NOT AT ALL)

(EXTREMELY)

- 4. What are the barriers you foresee that will limit your ability to successfully reach your intended target population?**
- 5. How do you hope to overcome these barriers?**
- 6. How confident are you that you can overcome these barriers?**

1 2 3 4 5 6 7 8 9 10

(NOT AT ALL)

(EXTREMELY)

Questions to improve Effectiveness:

- 1. Would you categorise your intervention as evidence-based or a new intervention?**
- 2. Why did you choose this intervention and its components?**
- 3. What are the strengths of your intervention?**
- 4. Have you come to agreement with key stakeholders about how you will define and measure “success”?**

3.1. REAIM Planning Tool

- 5. List the measurable objectives that you wish to achieve in order to accomplish your goal.**
- 6. What are the potential unintended consequences that may result from this programme?**
- 7. Are you confident that your intervention will achieve effectiveness across different subgroups including those at risk and having fewest resources? If no, what can be done to increase the chances of success for these groups?**
- 8. Rate your confidence that this intervention will lead to your planned outcome.**

1 2 3 4 5 6 7 8 9 10

(NOT AT ALL)

(EXTREMELY)

Questions to improve Adoption:

- 1. What percent of other organizations such as yours will be willing and able to offer this program after you are done testing?**
- 2. How confident are you that your program will be adopted by those settings and staff who provide services for people in your target population who have the greatest need?**

1 2 3 4 5 6 7 8 9 10

(NOT AT ALL)

(EXTREMELY)

- 3. What do you think will be the greatest barriers to other sites or organizations adopting this program? Do you have a system in place for overcoming these barriers?**
- 4. What percent of your organisation will be involved in supporting or delivering this programme?**

3.1. REAIM Planning Tool

Questions to improve Implementation:

- 1. How confident are you that the program can be consistently delivered as intended?**

1 2 3 4 5 6 7 8 9 10

(NOT AT ALL)

(EXTREMELY)

- 2. How confident are you that the program can be delivered by staff representing a variety of positions, levels and expertise/experience of the organization?**

1 2 3 4 5 6 7 8 9 10

(NOT AT ALL)

(EXTREMELY)

- 3. Is the programme flexible to changes or corrections that may be required midcourse?**

- 4. Do you have a system in place to document and track the progress of the programme and effect of changes made during the course of the programme?**

Questions to improve Maintenance (individual):

- 1. What evidence is available to suggest the intervention effects will be maintained six or more months after it is completed?**

- 2. How confident are you that the programme will produce lasting benefits for the participants?**

1 2 3 4 5 6 7 8 9 10

(NOT AT ALL)

(EXTREMELY)

- 3. What do you plan to do to support initial success and prevent or deal with relapse of participants?**

3.1. REAIM Planning Tool

4. What resources are available to provide long-term support to programme participants?

Questions to improve Maintenance (community):

1. How confident are you that your program will be sustained in your setting a year after the grant is over and or a year after it has been implemented?

1 2 3 4 5 6 7 8 9 10

(NOT AT ALL)

(EXTREMELY)

2. What do you see as the greatest challenges to the organizations continuing their support of the program?
3. What are your plans for intervention sustainability? Will additional funding be needed?
4. Do you have key stakeholder commitment to continue the program if it is successful?
5. How will the intervention be integrated into the regular practice of the delivery organization

3.2. Letter for Men's Health Programme

Dear _____,

As part of the Carlow Men's Health Project you recently participated in a health screening and consultation and in our follow-up evaluation. We are delighted that you were one of the 162 men that you took the time to get involved in this health initiative; your contribution has been extremely valuable and has informed our plans for 2010. Thank you again for your time.

In reporting our findings, we are glad to note that during the course of completing the health questionnaire, many men reported that they would like support in relation to exercise and nutrition. *This is good news as a willingness to be proactive in relation to exercise and nutrition can positively impact on the health statistics outlined below. We sincerely hope that you will join us in participating in some of the events which we will run in 2010.*

Both the high level of engagement with men through this initiative and their interest in exercise and nutrition goes some way towards dispelling the myth that men are not interested in their health. Indeed it seems to highlight that with the right approach, men are more than willing to take responsibility for and to be more proactive about their own health.

We would like to take this opportunity to let you know of some of the findings from the project to date;

- 41% of men reported physical health problems
- 61% of men had high blood pressure
- 28% of men had high cholesterol levels
- 40% of men reported feeling down, depressed or worried a lot in the last month
- 83% of men were overweight or obese

We are currently planning a Men's Health Programme for men in Carlow, such as yourself, to target some of the issues raised here. We will be in touch in the coming weeks to let you know how you can get involved in activities in your area. We look forward to working with you in 2010.

Sincerely Yours,

Midge Nolan

Chair Carlow Men's Health Project

Carlow Men's Health Project - Supporting Better Health for All Men in Carlow

3.2. Letter for Men's Health Programme

In the last few years there has been a growing awareness, and concern, about the level of ill-health faced by men in Ireland. In fact it now seems clear that not all men in Ireland benefited from the recent economic boom. There is now strong evidence to suggest that those who face economic difficulty and disadvantage suffer from poor health.

In response to health issues impacting on men's lives in Carlow town and county, a number of local services have come together to support vulnerable men to improve their health. The Carlow Men's Health Project (CMHP), which began in June 2007, is presently represented by *Carlow County Council - RAPID, Health Promotion Department, HSE South Area, Carlow County Development Partnership, St. Catherine's Community Services Centre, Men's Development Network, County Carlow Sports Partnership, Open Door Community Development Project, Waterford Institute of Technology and IT Carlow.*

To date the Carlow Men's Health Project has;

1. Organized a variety of activities to raise awareness among men of their health and to support them to be proactive about caring for their health. These have included, Healthy Dads Day and Health Awareness Raising Days.
2. Conducted a number of free community based health checks and health needs assessment at places where men gather (e.g. cattle marts, sporting and community events). A total of 162 men availed of this check and contributed to our assessment, both of which have informed the development of a plan to support men locally. It is intended that activities in the plan, which will be based on ideas raised by the men we have met, such as yourself, will start early in 2010.

IF YOU WOULD LIKE MORE INFORMATION ABOUT THE CARLOW MEN'S HEALTH PROJECT OR WHAT IS HAPPENING IN YOUR AREA IN SUPPORT OF MEN

Please contact one of the following between 9am and 5pm – Monday to Friday:

Carlow Town: Thomas Farrell 059 9138 703

County Carlow: John Wallis 059 9133 457

3.3. Dialogue for Phone Calls

*Please remember when making the phone calls that it is simply our intention to **BRIEFLY** check in with the men, find out if they got the letter and invite them to the start of the Carlow Men's Health Programme.*

- It will begin on Tuesday 2nd March 1pm in the Cathedral Centre Carlow (URBAN)
- Or Friday 5th March 1pm in the Teagasc Centre across from Tullow mart, Co. Carlow (RURAL)
- Both events will run for One Hour (food/refreshments provided)
- The Programme will run for 6 weeks same day, same time, same place and will build on supporting the men towards better health.
- It will address the findings of the health check and respond to their requests from their completed questionnaires.

PHONECALL

Hello..... Say who you are and where we are from (Have Press Release near the phone also)

1. Is this a good time to speak briefly?
2. Thanks again for taking part in health check and questionnaire in Carlow/Tullow
3. Did you get the letter from us, what did you think?
4. We are now starting a Health Programme based on the findings and the men's named interests towards improving their health
5. It will be a lunchtime meeting / name time / venue
6. The programme will address the findings from the health check and focus on how we can make changes towards supporting better health
7. Hope you can attend, again really appreciate your involvement. Do you think you will/can attend? (Need to know numbers for lunch)
8. Looking forward to seeing you
9. DON'T FEEL IF YOU CAN'T MAKE ONE YOU CAN'T ATTEND
10. Thanks, go well. Hope to see you

3.4. Focus Group- Men's Health Programme

Aim:

To provide men with the opportunity to share their experiences of 6 week program and their aspirations for the development and implementation of the strategy

1. Can you maybe tell me a little bit about why you decided to attend the programme?

- What motivated you?
- As a result of health check

2. So can you tell me a little bit about how the group has affected you?

- Lifestyle changes
- Meeting new people
- Personal development
- Greater knowledge
- Coping strategies

3. What did you like or not like about the group?

Like

- Opportunity to talk
- Flexibility

Not like

- Going alone/not knowing anyone else
- Embarrassment
- Lack of structure

4. If Se was to start the 6 weeks over again, what improvements could be made to the program?

- Longer course

5. Would you attend another program organised in the future

- What type of programme

3.5. Interview with facilitator (Men's Health Programme)

1. Can you tell me a little bit about your background in men's health?

- What is your approach to men's health work and why?
- Type of experiences you have

2. Do you think the target group of men were successfully reached?

- Those most vulnerable
- If not, why do you think this was so
- How might the CMHP reach this group in the future

3. Why do you think this group of men attended?

- Screening results

4. Working with men

- Level of interaction between men
- Key barriers to participation
- What helped men to complete the 6 weeks
- What worked
- What didn't work

5. What do you think the men will have gained as a result of participating in this programme?

6. Recommendations for future work with men

- Your recommendations
- Steps that need to be taken to successfully engage men and improve their health

3.6. Letter to men

Re: Free 6 Week Walking/Jogging Programme for Men. Date: 20th April 2010.

Dear Participant,

The Carlow Men's Health Project would like to invite you to participate in a FREE 6-week walking/jogging programme for men. Guided by an expert tutor in the field you will have the opportunity to complete an individualised walking/jogging programme designed according to your activity level. All activity levels will be catered for!

To register your place on the programme please come along to the Éire Óg GAA Clubhouse on O'Brien Road, Carlow **this coming Tuesday, 27th April, at 4.30pm.**

The programme will then commence the following Tuesday, 4th May at 4.30pm in Éire Óg and run each subsequent Tuesday to the 8th June. Each week the tutor will guide you through a session of your programme and provide vital information (e.g. nutrition, hydration etc.) to support you during the programme.

To celebrate International Men's Health Week 2010 (14th – 20th June), a 3Km/5Km/10Km walk/jog/run is being held for men on the 16th of June in the Phoenix Park, Dublin. You can choose your distance and how you would like to do it. The purpose of this event is to encourage men of all activity levels to "Get Up, Get Out and Get Going!" If, at the end of the 6-week walking/jogging programme, you would like to participate in this event, we will support you to do so by paying your registration fee and travel to and from the event.

Finally, if you would like additional information on the Carlow Men's Health Project or what is happening in your area in support of men in the County please contact one of the following:

- Carlow Town: Thomas Farrell 059 9138703 (9am - 5pm, Monday to Friday)
- County Carlow: John Wallis 059 9133457 (9am - 5pm, Monday to Wednesday)

Yours sincerely,

Midge Nolan

Chair Carlow Men's Health Project

Men of Carlow.

Interested in Getting Active?

**6 week walking and jogging
programme for men.**

All fitness levels catered for.

Expert Tuition.

Absolutely free!

Registration:

**4.30pm, Tuesday April 27th @ Eire Og Clubhouse.
O'Brien Road, Carlow.**

Further Information:

**Contact Ciaran on 9172452 or
email info@carlowsports.ie**

**A Carlow Men's Health Project
Initiative.**

3.8. Locations of Physical Activity Programme - Poster

Location	Number
Department of Social Welfare and Family Affairs	2
FAS	1
Doctors Surgeries	2
The Monastery Hostel (homeless men)	1
St Catherine's Community Services Centre	1
The Vault -Training Room Youth Links Programme (18 to 23yr olds)	1
Open Door CDP 1	1
Carlow County Development Project	1
Carlow Town Council	2
Drug & Alcohol Outreach Services HSE	1
Drugs Outreach Worker 1 & Carlow Based Drugs Initiative	1
Motor Tax office & County Council	2
Posters also emailed to	Barnardos, VEC, Gardai, Carlow Regional Youth Services (Tullow Road & Graiguecullen), Graiguecullen Community Development Group, Carlow Jobs Club, Carlow Volunteer Centre, Carlow Youth Training Centre, Graiguecullen Parish Centre & Rehab Care Centre, CRYS, Carlow Amenity Trust Scheme and Graiguecullen Parish Centre

Run, Fatboy, Run! Here's your chance to shed a few pounds!

By Mairead Wilmot

FANCY looking like you stepped off the cover of *Men's Health*? Well, dear men of Carlow, we may just have the thing for you.

The kind folks behind Carlow Men's Health Project are inviting men of all shapes and sizes and from all walks of life to join them in a free six-week get fit programme. The idea behind the project is for men to indulge in a spot of running or jogging guided by an expert tutor.

Anyone interested in taking part will have the opportunity to complete an individualised walking/jogging programme designed according to their own activity level. And don't

fret, because all activity levels will be catered for, from the couch potato to the man who plays a game of soccer once in a while!

To book your place, all you have to do is come along to the Éire Óg GAA Clubhouse on O'Brien Road, Carlow this coming Thursday, 29 April, at 4.30pm. The programme will start the following Tuesday, 4 May, at 4.30pm in Éire Óg and run each subsequent Tuesday until 8 June.

Each week the tutor will guide you through a session of your programme and give you handy hints and tips on everything from nutrition to hydration so you'll be in tip-top physical condition. And if that's not enough, anyone who

has taken part in the six-week programme and feels up to it can take part in either a 3km, 5km or 10km walk, jog or run which is being held for men on 16 June in the Phoenix Park, Dublin. If you would like to take part in that event, Carlow Men's Health Project will support you by paying your registration fee and helping you out with travel to and from the event.

If you want more information on the Carlow Men's Health Project, contact Thomas Farrell on 91 38 703, from 9am to 5pm on Monday to Friday for the Carlow town area and contact John Wallis 9133 457, between 9am and 5pm on Monday to Wednesday, for County Carlow.

3.10. Carlow People Article

Carlow men invited to join health programme

THE CARLOW Men's Health Project are accepting applications from men in Carlow to participate in a free six-week walking/jogging programme for men.

Guided by an expert tutor in the field participants will have the opportunity to complete an individualised walking/jogging programme designed according to their own activity level when all activity levels will be catered for.

To book your place simply come along to the Éire Óg GAA Clubhouse on O'Brien Road, Carlow this coming Thursday, April 29, at 4.30 pm.

The programme will commence the following Tuesday, May 4 at 4.30pm in Éire Óg and run each subsequent Tuesday to June 8. Each week the tutor will guide you through a session of your programme and provide vital information (e.g. nutrition, hydration

etc.) to support you during the programme.

To celebrate International Men's Health Week 2010, a 3Km/5Km/10Km walk/jog/run is being held for men on June 16 in the Phoenix Park, Dublin.

The purpose of this event is to encourage men of all activity levels to "Get Up, Get Out and Get Going!" If, at the end of the six-week walking/jogging programme, you would like to participate in this event, the men's group will support you to do so by paying your registration fee and travel to and from the event.

Finally, if you would like additional information on the Carlow Men's Health Project or what is happening in your area in support of men in the County please contact Thomas Farrell on (059) 9138703 or John Wallis on (059) 9133457.

3.11. Physical Activity Readiness Questionnaire (PAR-Q).

The Physical Activity Readiness Questionnaire (PAR – Q) is designed to help you help yourself. Many benefits are associated with regular exercise and the completion of the PAR-Q is a sensible first step to take if you are planning to increase the amount of physical activity in your life.

For most people physical activity should not pose any problem or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or for those who seek advice concerning the type of activity most suitable for them.

Common sense is your best guide to answering these few questions. ***Please read them carefully and check the YES or NO opposite the question if it applies to you.***

1. Has your doctor ever said that you have a heart condition and recommended only medically approved physical activity? YES NO
2. Do you have chest pain brought on by physical activity? YES NO
3. Have you developed chest pain at rest in the past month? YES NO
4. Do you lose consciousness or lose balance as a result of dizziness?
YES NO
5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity? YES NO
6. Is your doctor currently prescribing medication for your blood pressure or heart condition? (diuretics or water pills) YES NO
7. Are you aware, through your own experience or a doctor's advice, of any other reason against your exercising without medical approval? YES NO

If you answer yes to one or more of the above questions, you should consult your doctor before undertaking our exercise programme.

I have read and understood and completed this questionnaire:

Name: _____ **Date:** ____/____/____

(BLOCK LETTERS)

Signature: _____

3.12. Physical Activity Programme – Questionnaire



Waterford Institute *of* Technology

VOLUNTEERS IN RESEARCH DATA

Please print clearly

Name: _____

Date of Birth: _____

Address: _____

Telephone Number: _____

Code Assigned: _____

3.12. Physical Activity Programme – Questionnaire

Physical Activity and Health

Questionnaire



Waterford Institute *of* Technology

The aim of this study is to evaluate the work of the Carlow Men's Health Project (CMHP) who are developing a men's health strategy to improve the health and wellbeing of men in Carlow. The result of this investigation will help improve the delivery of future programmes.

Your input is greatly appreciated and should only take a few minutes.

Regards

Lisa Kirwan

3.12. Physical Activity Programme – Questionnaire

PARTICIPANT CONSENT FORM

Who is doing the research?

Ms. Lisa Kirwan from Waterford Institute of Technology

Why?

To evaluate the work of the Carlow Men's Health Project

How?

The research will be done by a combination of short questionnaires and interviews with both yourselves and the programme organisers. A follow-up study consisting of a short interview or questionnaire will be conducted approximately 6 months after the programme finishes. All information will be entirely anonymous and confidential.

Questions for you to consider:

1. I confirm that I have had the purpose and nature of the above study clearly explained to me.
2. I understand that my participation is voluntary and I am free to withdraw at any time without giving a reason.
3. I agree to take part in the above study by completing a questionnaire and/or taking part in an interview, today, at the end of the six weeks and again after 6 months
4. If interviewed, I agree to written notes being taken by the interviewer.
5. If interviewed, I agree to the interview being audio-recorded.
6. I agree to the use of anonymous quotes in the research report.

Signed: _____

Date: _____

3.12. Physical Activity Programme – Questionnaire

Section A: Demographics

This section will include questions that tell us about yourself. The interviewer will insert your chosen answer(s) in the boxes or spaces provided.

1. Please state your **year of birth**

2. Please state your **country of birth**

3. **What is your ethnicity?** (Tick **one** box only)

White (Irish, Irish Traveller, Any other white background)

Black or Black Irish (African or Any other black background)

Asian or Asian Irish (Chinese or Any other Asian background)

Other (including mixed background)

4. **What did your education include?** (please tick **one** box only)

Primary education only

Some or completed secondary education

Some or completed third level education

5. **What is your present marital status?** (Please tick **one** box only)

Married / cohabiting Widowed

Separated /divorced Single

6. **Have you any children?** If yes, go to Q6a Yes No
If no, please go to Q7

6a. **How many children have you?**

6b. **What ages are your children?** _____

6c. **Are you currently living with your children (<18 years)** Yes No

If yes go to Q7, if not married/cohabiting and have children please go to Q6d

3.12. Physical Activity Programme – Questionnaire

6d Are you a lone parent? Yes No

7. Are you living alone? Yes No

8. Do you have other dependants? If yes go to Q8a Yes No

8a Who are your dependants?

9. Regarding your house where you live, are you?

Paying a mortgage An owner occupier Parents' house

Renting privately A Local Authority tenant

10. Which of the following best describes you? (Please tick **one** box only)

Employed (full time) Employed (part time)

Self employed Unemployed and looking for work

Looking after home/family Retired from paid work

Unable to work due to long term illness/disability

Other

10a. If you have/had an occupation, please name it

11. What is your main source of income?

Employment Social welfare Pension

Farm subsidies Other _____

12. Which of these gross income brackets would your family fit into? (Please tick **one** box only)

<€10,000 €10,000 - €20,000 €20,000 - €30,000

€30,000 - €40,000 €40,000 - €50,000 >€50,000

3.12. Physical Activity Programme – Questionnaire

We are interested in finding out about the kind of physical activities that you do as part of your everyday lives. The questions will ask you about the time you spent being physically active **during the last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** activities that you did **during the last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think *only* about those physical activities that you did for at least 10 minutes at a time.

1. **During the last seven days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling?

_____ **days per week**

No vigorous physical activities **➔** *Skip to question 3*

2. How much time did you usually spend doing **vigorous** physical activities on one of those days?

_____ **hours per day**

_____ **minutes per day**

Don't know/Not sure

3.12. Physical Activity Programme – Questionnaire

Think about all the **moderate** activities that you did **during the last seven days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

3. **During the last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

_____ **days per week**

No moderate physical activities → *Skip to question 5*

4. How much time did you usually spend doing **moderate** physical activities on one of those days?

_____ **hours per day**

_____ **minutes per day**

Don't know/Not sure

Think about the time you spent **walking during the last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

5. **During the last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

_____ **days per week**

No walking → *Skip to question 7*

3.12. Physical Activity Programme – Questionnaire

6. How much time did you usually spend **walking** on one of those days?

_____ **hours per day**

_____ **minutes per day**

Don't know/Not sure

The last question is about the time you spent **sitting** on weekdays **during the last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. **During the last 7 days**, how much time did you spend **sitting** on a **week day**?

_____ **hours per day**

_____ **minutes per day**

Don't know/Not sure

3.12. Physical Activity Programme – Questionnaire

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (*e.g. work, study, housework, family or leisure activities*)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

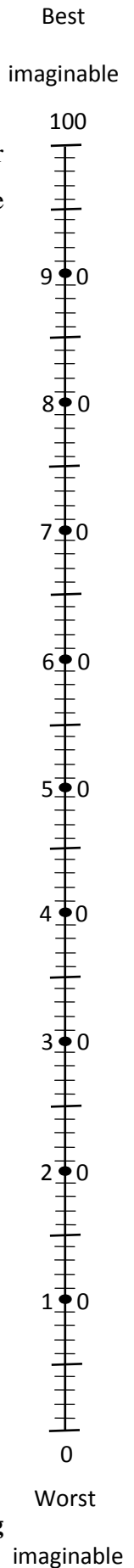
- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

3.12. Physical Activity Programme – Questionnaire

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

**Your own
health state**



This is the end of the questionnaire, thank you for participating

3.13. Interview Schedule for PA facilitator

- Firstly, could you tell me about your experience in facilitating Physical Activity programmes (or other similar experience)?
- Was it difficult to take over from another tutor and how did you manage this?
- What kind of men attended the PA programme? (physical ability, vulnerable etc)
- How did these men develop over the weeks you have spent with them? (did you observe increases in PA levels/lose weight etc? Your own observations)
- What was your content/structure/layout of the sessions program?
- What types of support materials did you provide men with?
- Approaches used to engage men in physical activity (e.g. goal setting etc)
- Why do you think these men return each week?
- How did you deliver the program? How closely did participants follow the program?
- Problems/difficulties with way program was delivered?
- Did you have to adapt the program to suit this group of men? If so what type of adaptations did you make?
- Have you any recommendations for the CMHP on how to engage vulnerable men in Carlow around their health
- What do you think is key to engaging men in physical activity and other areas of their health?
- Any additional comments?

3.14. Interview Schedule for Physical Activity Programme – Men

Aim: To provide men with the opportunity to share their experiences of the PA programme and how it has impacted on their lives

Why did you decide to attend the programme?

- What motivated you/Why did it appeal to you?
- How did you hear about program?
- What did you expect from the programme prior to attending?
- What were your initial thoughts about?
- What concerns did you have before/during programme?

If you were asked to run a similar programme for men, what aspects of this programme would you copy? Why?

- Which aspects would you change? Why?
- What was so good about the programme? (Timing, Tutor, Activities, Others in the group, Recruitment, Organisation)

What changes in yourself have you noticed as a result of taking part in this programme?

- Lifestyle changes (diet, exercise, alcohol intake etc)
- Meeting new people
- Personal development
- Have your family or friends noticed any changes in you like this one.
- Have you noticed changes in any other members

Did you take part in the MHFI event?

- Can you tell me about your experience of the day
- What event did you participate in? Did you walk or jog?
- What were your feelings having completed the event

What will happen to your health or lifestyle after the programme finishes?

- What would you need to support you to remain active?

Any additional comments

YOUR HEALTH MATTERS

IN ASSOCIATION WITH THE CARLOW MEN'S HEALTH PROJECT



WHAT YOU NEED TO DO!

THINK LESS, ACT NOW

IT could save your life to pay your doctor a visit. Do not wait until things get really serious before reacting. Get checked early on; it could save you money, needless worry and even your life.

LIST KEY HEALTH PROBLEMS AND WORRIES

Sometimes there are a number of things that you want to discuss with your doctor or questions you want to ask. It can often be helpful to make a list before you go so that you can get the most out of your visit. It is helpful to list signs, symptoms, timeline of symptoms or any concerns or worries you may have.

TELL THE DOCTOR THE TRUTH

It is not uncommon for people to play down the extent of their symptoms/habits when talking to the doctor. Smoking habits, alcohol consumption or sexual practices can be underestimated. It is very important to be honest with your doctor about the full extent of your symptoms/habits so that accurate diagnoses can be made and proper treatment given.

DOCTORS HAVE HEARD AND SEEN IT ALL

There is nothing you can say or show the doctor that they haven't already seen before. The doctor is not there to judge you and they are used to seeing parts of the body that are less than attractive.

GETTING TREATMENT EARLY IS BEST

Don't delay in seeing your doctor if you feel there is something wrong. The problem will not just disappear, so it is better to be reassured rather than stressing in silence.

SECOND OPINIONS AND CHANGING DOCTORS

If you feel unable to talk to your doctor, get the treatment you feel you need, or have little confidence in your doctor, then maybe you need to change to another one. The patient/doctor relationship is very important to your health.

PREVENTATIVE HEALTH CHECK UP

You don't have to be ill to visit the doctor. It is perfectly normal to visit the doctor in times of good health to make sure everything is as it should be. Prevention is better than cure, as they say!

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Don't wait until it's too late to visit your GP

In the first of a series of six weekly articles on men's health issues, Dr Paula Carroll explains that men's reluctance to seek medical advice is putting their health at risk



IT IS well documented that many men put off visiting their doctor. For some, getting a medical examination can be seen as a weakness or an unmanly thing to do. Very often it takes the intervention of a wife or girlfriend to get their man through the doors of their GP. So why is it that men are so reluctant to visit their doctor?

The *American Journal of Public Health* found that the main reason why men don't visit their doctor is due to the waiting time involved. Sitting around waiting to see the doctor is something men don't like to do and would stop them visiting their doctor.

Another reason is the waiting room. Waiting rooms are nearly always filled with women, children and older people, which can make men feel uncomfortable. This, coupled with the feminine décor (and women's magazines), can also make men feel unwelcome.

Medical consultations can involve discussions about emotions, stress, depression or sexual problems. Talking about emotions or mental health problems can be very difficult for some men. They may feel embarrassed or uncomfortable.

Either way, it is easier to avoid going and therefore avoid embarrassing conversations.

Unlike women, many men do not see the doctor unless there is something obviously wrong. Men tend to view the doctor in terms of emergencies, surgery or dealing with sick people. Most men do not see the use of preventative care such as screening, blood pressure checks and cholesterol checks.

Men in Ireland die on average six years younger than Irish women. The 'don't fix it until it's broken' attitude of men puts them at greater risk of developing diseases such as cardiovascular disease, diabetes and even obesity. Seeking medical advice from your GP is essential to maintaining health and quality of life. In fact, many men may avoid unnecessary health problems and treatments by presenting to their GP in the early stages of the condition, as is Jim Carroll's experience.

For two years, 61-year-old, Jim Carroll suffered consistent pain in the back of his legs and back. He began to lose his balance and mobility. "I was losing my balance, losing my dexterity, I just didn't

know what the hell was wrong with me," he says.

For Jim, even sitting down or putting on his jacket became problematic. Over time, Jim's mobility became so impaired it affected how he walked. Jim's condition soon took its toll as he began to lose his independence and it soon became too much to go out in public.

"Well, I felt embarrassed," he recalls. "I didn't go out much at night time; I didn't socialise. I was embarrassed about being in public like this, and I was scared stiff because I didn't know what the outcome was."

Jim admits that the fear of what the problem might be was what stopped him from going to the doctor for so long. "I was afraid to go to the doctor because I was afraid of what he was going to tell me, and that's the truth." When Jim did go to the doctor,

he was immediately diagnosed as suffering from Parkinson's Disease. The prescribed treatment Jim has since received has been very effective and his quality of life has greatly improved. However, he does regret delaying going to see his doctor.

"I would say bad quality of life for two years was a direct result of not going to the doctor in time," he says. "Had I gone and been treated earlier, my body function wouldn't have deteriorated as much in my opinion, and I wouldn't have as big a hole to climb out of as I subsequently had."

So don't wait 'til it's too late. It takes courage to make that first step, and it makes a lot of sense to be proactive about your health.

Next week: *Tip on how to stay physically active without even realising it!*

About the Carlow Men's Health Project

THE Carlow Men's Health Project (CMHP) was set up in June 2007 with a view to supporting better health for all men in Carlow town and county. The project is presently represented by Carlow County Council RAPID, the Health Promotion Department, HSE South Area, Carlow County Development Partnership, St Catherine's Community Services Centre, Men's Development Network, County Carlow Sports Partnership, Open Door Community Development Project, Waterford Institute of Technology and IT Carlow.

To date, the CMHP has organised healthy dads' day, health awareness raising days, free community-based health checks and a weekly physical activity programme. So far, it has received a great response but there is still more to be done.

According to Midge Nolan, chairwoman of CMHP and Carlow RAPID co-ordinator: "These are challenging times for men who may be struggling with the stress

or threat of unemployment, relationship difficulties and/or having to take on a different role in the home. CMHP has been supporting men in very practical ways to pay attention to and take care of their health. I want to encourage men to get more involved in all aspects of the project: participate in the programmes, let us know how we can support you, help raise awareness of the issues impacting on men and take an active role in planning and organisation or events.

"The work of CMHP is interesting and worthwhile. We have some very committed individuals and agencies working together to bring about an improvement in the quality of the life of men in the Carlow."

For further information on the Carlow Men's Health Project, contact John Wallis on 059 9133457 or Thomas Farrell on 059 9138703.

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MEN'S HEALTH MATTERS

IN ASSOCIATION WITH THE CARLOW MEN'S HEALTH PROJECT



Ten reasons to be active any way, anywhere

- Energy.** Activity helps to increase energy, helping you to become more alert
- Metabolism.** More energy is burned at rest as a result of being active, so it's great for maintaining or losing weight
- Mood.** Activity stimulates the 'happy hormones', which makes you feel good
- Concentration.** Activity helps to refocus the mind and improves the quality and quantity of work
- Stress.** Activity can help to relax the mind and body and helps to reduce the build-up of tension
- Strength.** Regular activity helps to keep your bones and muscles strong, including your heart
- Health.** Regular activity can help to improve the quality of your life. It can help to reduce the risk of developing major diseases such as heart disease, stroke, obesity, diabetes, some cancer, anxiety and osteoporosis
- Immunity.** Activity boosts the immune system, helping to prevent illness
- Self-esteem.** Physical activity can help you to develop skills, build confidence and feel more in control of your life
- Social life.** Activities in teams, club or leisure centres are great for meeting people outside of work to expand your network of friends.

Just a few small changes can make all the difference

- Wash your car by hand every week
- Play active games with your children
- Take the dog for a good long walk
- Cut the grass and dig over the flower beds
- Organise a friendly game of soccer, Gaelic, rugby or hurling with your friends
- Go for a swim
- Play interactive movement-based computer games
- Walk to the bus or the train and jump off a stop or two before your destination
- Park the car further away from your destination and walk the last part of the route
- Use the stairs rather than the lift.

Men of Carlow: Get Up! Get Out! Get Going!

Want to feel better? Have more energy? Live longer? Then physical activity is the solution for you!

THE benefits of physical activity have been well documented. Regular exercise reduces the risk of chronic diseases such as coronary heart disease, type 2 diabetes, stroke, cancer, osteoporosis and depression. It also reduces stress, improves sleeping patterns, builds up bone and muscle strength and helps to control weight.

However, Irish men are not meeting their recommended daily amount of physical activity and, worryingly, it's predicted that by 2015 a third of us will be obese.

Traditionally, men didn't have to worry that they weren't getting enough exercise as their labour-intensive jobs provided more than enough activity. Nowadays, however, men have entered into more sedentary roles in the workplace and can often be sitting at a computer for most of the day. The car has replaced the bicycle or walking as the most common form of transport. These are all having a negative impact on men's waistlines.

The experts tell us that 30 minutes of activity five times a week is enough to stay in shape. That doesn't mean it has to be 30 minutes down in the local gym. Activities such as walking the dog, climbing the stairs, or mowing the lawn can be beneficial.

The Carlow Men's Health Project is currently running a physical activity programme for men in Carlow. The aim is to encourage men who wouldn't be normally active to get involved!

According to Ciaran Ó hIarnáin from Carlow County Sports Partnership: "We are the lead agency for physical

activity element of the CMHP. The programme consists of the men coming together on a weekly basis in Éire Óg at 4.30pm every Tuesday. At the moment, we have about 17 men showing up who previously wouldn't have undertaken any physical activity. After six or seven weeks, we have three different groups: active walkers, light to active joggers, and full-on joggers who are doing in the region of two-and-a-half miles every evening, where previously they wouldn't have been."

Paddy Robinson, a participant on the programme, explains the benefits he has got from taking part: "I couldn't do a round of either pitch without severe pain in my back. Now I can do three or four rounds and I haven't got a problem. I've also lost close to a stone weight in the weeks I have been here. As well as that, the course we are doing with the weights with Brian are brilliant for my back."

Another participant, John Core, encourages men who are reading this article to get involved: "I would tell them to get out and do it because you meet great friends. You are in great form and looking forward to meeting all these lads once a week."

If you find it hard to get motivated, the support and encouragement of the rest of the participants will spur you on. If you can't meet the time, why not try the Men's Health Forum Ireland (MHFI) 12-week online fitness training programme. It will guide total beginners through the preparation process for either a 5km or 10km run, and it can be done in your own time. See

<http://www.mhfi.org/training.htm> for more details. This can help you prepare for MHFI men's run on 4 September if you're up for it!

Still not convinced? Why not try it for yourself and see. And remember:

- Some physical activity is always better than none
- A lot of physical activity is always better than some
- Everything you do will have some health benefits.

For further information, contact Midge Nolan on 037 203 3841. Next week's article:



John Core: 'You are in great form and looking forward to meeting all these lads once a week'

Feeling stressed? Get and manage your stress tips on how to recognise levels.

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MEN'S HEALTH MATTERS

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Stress: A male perspective Don't let stress take over

The ongoing recession has affected almost everybody in some way, but emerging research suggests that men in particular are being hit hard. More men and young men in particular, are becoming unemployed and it is taking its toll on their physical and mental health. Many men who have worked all of their lives are struggling with having time on their hands and for some, adapting to their new situation is daunting.

Men in general tend to carve their personalities, friends, colleagues, and much more based on what they do for a living, and when this is lost it can have devastating effects on their mental well being.

Loss of employment can bring loss of confidence, drive

and ambition. Financial worries, boredom (having too much time to think) among other issues are undoubtedly raising the stress levels of many unemployed men. Dealing with stress can be a challenge. Many men are reluctant to

discuss their insecurities, concerns or feelings of failure.

In a study conducted in the South East (Getting Inside Men's Health http://www.dohc.ie/publications/mens_health.html), Tony a 38 year old bouncer says that men's preference for dealing with stress is to

ignore or conceal it.

"Definitely men don't want to talk about stress, they don't want to deal with stress, and they don't want to admit stress. I think they relate that to a mental illness and that's a big no no; you're a man, you should handle this and if you can't there is something wrong".

There are many ways to manage stress. Exercise is a very effective way to manage stress on a daily basis. Just 30 minutes of moderate to vigorous activity is enough to get rid of negative emotions and improve mood, motivation and sense of satisfaction.

And you'll see from our stress buster tips that there are so many more to choose from - you simply have to find what works for you!

Next week's article: Get tips on how to eat well for a longer life.



- Some stress busting tips!**
- Get it all off your chest! – Talk to someone you really trust.
 - Learn to accept things that are unchangeable.
 - Get plenty of sleep and rest.
 - Do not overwhelm yourself – take things one step at a time.
 - Agree with somebody. Life doesn't have to be a constant battle ground.
 - Organise your time better.
 - Don't try to please everybody – learn to say "no".
 - Make time for yourself – work and family commitments should not take up all of your time.
 - Eat healthily.
 - Learn to relax.
 - Humour – laughing can release pressure and built up tension.
 - Massage – Massage will ease out aches and pains.
 - Breathing technique – Breathing exercises are a great way to relieve stress.

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Getting the balance right when it comes to healthy eating

IN TODAY'S hectic lifestyle getting the balance right when it comes to eating is not always easy. Most of us find ourselves rushing around with little or no time to think about what we are actually putting in our mouths!

The "Grab and Go" concept is becoming increasingly familiar, much to the detriment of our health.

Good food gives us the nutrients and energy we need to stay alive and well. Eating a well balanced diet can reduce risk of illness such as heart disease, diabetes, cancer as well as defend against depression. A balanced diet should contain essential vitamins, minerals, proteins, carbohydrates and other necessary nutrients the body needs. It can improve our health by boosting our energy, sharpening our memory and stabilise our mood. So why is it that so many men fall short of a healthy balanced diet?

Health eating is predominantly seen as a "woman's thing". Generally, men don't seem to associate food with health. Rather, they view it in terms of fuel. Men tend to eat more meat, processed carbohydrates, fast food, and snacks that are high in fat, sodium, and calories than women. Many men have poor nutritional knowledge and tend not to know the nutritional content of food or the effects of poor diet on health.

Health eating is not about depriving yourself of the foods you love. It's about

feeling great, having more energy, and keeping yourself as healthy as possible.

Dr Paula Carroll of Carlow Men's Health Group explains the importance of eating a healthy diet: "There is a myth out there that a healthy diet means restricting yourself to small portions of tasteless foods. A healthy diet is balanced and varied; the food pyramid is a really good tool to see what constitutes a healthy diet and there are really good tips on the Irish Heart Foundation website about this (<http://www.irishheart.ie/iopen24/good-eating-t-82.html>). Good food is essential to give us energy to work and play and get the most out of life. While healthy eating is predominantly associated with women, it is also essential for men to eat well to maintain their strength, virility, stamina and vitality for living".

Men's lack of control over their own diet has been cited as a reason for poor dietary habits.

Long hours spent driving and away from the home has also seen a shift in reliance on convenience food. It seems every where we look, less healthy options are tempting us.

#Since men naturally have more body mass than women, they need to consume more calories for sustained energy. However, those calories do not have to come from high fat, high sugar foods. By controlling portions, getting the right carbohydrates and including nutrients in their meals, men can live a healthy lifestyle and get the calories they need to get through the day.

Eating healthy doesn't have to be a chore but it does need to become a way of life. Just a few small changes can make all the difference to your health.

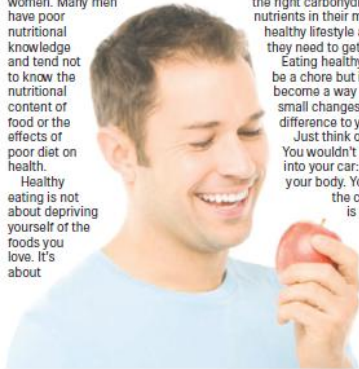
Just think of your body as a car. You wouldn't put the wrong fuel into your car: the same goes for your body. Your body needs all the correct nutrients if it is to function properly.

And remember: You are what you eat!

For further information contact Midge 087-2033841

Tips for better nutrition

- Follow the Food Pyramid guidelines
- Watch for added fats to your diet such as butter/margarine on bread, mayo in sandwiches, etc.
- Consider how a food is prepared and go for items that are baked, roasted, poached or steamed.
- Include at least a serving of vegetable at every meal.
- Get your 2-4 servings of fruit each day - snack on fruits between meals or with meals.
- If you are having a big meal later, have a lighter lunch.
- Avoid all-you-can-eat buffets.
- Drink in moderation if you socialise often (alcohol pack a whopping 150 calories per can of beer, 100-120 calories per shot of whiskey, another 150 calories for a can of soft drink)
- Drink 6 to 8 glasses of water each day.



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HEARTLAND COMES TO LAOIS

Last year marked the 75th anniversary of the setting up of the Turf Development Board which later became Bord na Móna. To mark this significant milestone we are holding a public exhibition which we have named Heartland. The Heartland exhibition celebrates 75 years of progress, innovation, pioneering work and community involvement.

Please all come along and see this wonderful exhibition for yourselves and bring your friends and family.

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MEN'S HEALTH MATTERS

IN ASSOCIATION WITH THE CARLOW MEN'S HEALTH PROJECT



Don't suffer in silence!

HERE is a list of local numbers you can contact if you ever need to talk to someone or want to get involved in something locally:

- Talk It Over, 086 3364961
- Carlow Mental Health, 059 9136416
- Grow Mental Health, 056 7761624
- Open Door Community Development Project, 059 9137470
- Bagenalstown Family Resource Centre, general counselling, 059 9723196
- Forward Steps Family Resource Centre, Tullow, general counselling, 059 9152776
- AWARE, 051 565693
- Follaine Counselling Services, 085 2780307
- County Carlow Drugs Initiative, 059 9140616
- Carlow Volunteer Centre, 059 9173033
- Carlow Sports Partnership 059 9172452
- County Carlow VEC Adult Educational Guidance and Information Service, 059 9133123
- Fighting Cocks GFC (chairman, 086 3849657)
- St Catherine's Training Centre, 059 9142819
- Teach Bride, Tullow, 059 9152465.

Alone in the crowd: how to avoid isolation

HOW many men reading this piece chose to read it because they could relate to the word 'isolation'? Isolation is a word that is often used, but do we really understand what it means to be isolated?

Isolation takes many forms; perhaps the most familiar is the old man living alone in a rural area. While this is one form of isolation, there are also many others. Many men living in urban areas, surrounded by a family and a community, can also feel alone and are in need of support.

John Wallis, a rural development officer with Carlow County Development Partnership, describes the types of isolation experienced by some men in Carlow today: "Isolation is very common but unseen in many communities. More and more men are experiencing isolation due to the changing nature of working and living patterns. Many men can also experience isolation simply by being a man who has learned that 'real men' soldier on alone and don't bother people with their problems."

A decline in the rural population and increased commuting times have resulted in fewer neighbours and less opportunity for social interaction with those neighbours that are around. Many men work shifts that also make social interaction



difficult. Emotional isolation is also a reality for many men who may have many acquaintances but few friends with whom they share their thoughts and unburden themselves. Unemployment, coupled with the loss of income and one's status within the family and community, can also isolate men as they

struggle to grapple with their new situation. Traditionally, men have been bred to 'produce', 'provide', 'have all the answers' and 'not seek help'. Therefore, when their role drastically changes with becoming unemployed, many men struggle alone.

Some men may be isolated from their communities because of their sexual orientation and the fear of judgement. Whatever the source of a man's isolation, loneliness is an inevitable by-product that can have devastating effects on a man's mental and physical health. When we don't have anyone to share experiences with, we are at risk of becoming detached from others and

ultimately ourselves.

You can help yourself and others to overcome isolation. If you know of someone who may be at risk of becoming isolated, drop in to them for a chat. Encourage them to get involved in something locally and even bring them along – there are a variety of options currently available in Carlow to suit all interests, from sports to night classes to volunteering in any number of organisations (see panel). Men who are unemployed could take this time to learn new skills or keep their skills up to date in a variety of ways that serve the local community. There is a wealth of skills among the men in Carlow that should not be

underestimated and could be put to good use. By doing so, it would also help local men to beat the isolation trap.

A man can also support himself by having the courage to reach out to a person he trusts. Another person's perspective and opinion may be really useful when dealing with a problem and you'll probably get some relief by sharing your burden. Most men experience some form of isolation at some point in their lives, so remember: "It's not how far you fall, it's how you land".

For more information, contact Midge on 087 2033641. **In next week's final article: Know your (health) score!**

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MEN'S HEALTH MATTERS

IN ASSOCIATION WITH THE CARLOW MEN'S HEALTH PROJECT



Men of Carlow: know your (health) score!

DID YOU know that men in Ireland die in greater numbers of all of the leading causes of death and at all ages than women? Young men (18-35 years) and men on low incomes are at an even greater risk of dying prematurely. Dr Paula Carroll of the Carlow Men's Health Project explains that by having a simple health check and knowing your score you can take the necessary steps to take control of your health and prevent many health conditions. "As part of its campaign to raise health awareness among men in Carlow, the Carlow Men's Health Project conducted a series of free community-based health checks from August to November

2009. The checks took place in various different locations around the country where men (specifically those on low incomes) gather, such as the social welfare office, the cattle mart and community events.

The response to the health screening was very positive. One hundred and sixty-two men availed of the free check that included blood pressure, cholesterol, body mass index (BMI, which uses weight and height to determine health risk), stress and lifestyle factors. All men also completed a health questionnaire."

So how did the men of Carlow score?
 ● 41% of men reported physical health prob-

- lems
- 61% of men had high blood pressure
- 28% of men had high cholesterol levels
- 40% of men reported feeling down, depressed or worried a lot in the last month
- 83% of men were overweight or obese.

The good news is that many men asked for support in relation to exercise and nutrition and both the high level of engagement of men through this initiative and their interest in doing something to improve their health goes some way towards dispelling the myth that men are not interested in their health. Indeed, it seems to highlight that, with the right

approach, men are more than willing to take responsibility for and to be more proactive about their own health.

The Carlow Men's Health Project used this information to develop health initiatives for men in Carlow, and to date many have engaged with much success. A six-week health programme was held in the Cathedral Parish Centre and at the



Tullow Mart in February and March. Since April, a weekly men's physical activity programme is up

and running at Éire Óg GAA grounds and, given its success, the original programme has been extended and numbers are increasing.

Looking to the future, the Carlow Men's Health Project has many more initiatives in the pipeline to help raise awareness of men's health issues and to further support men in Carlow in taking control of their own health and lives. The Irish Cancer Society will be coming

to Carlow in October for a men's health evening highlighting issues around cancer. So watch this space as while there is a lot done, there is more to do and so many ways for you to get involved. *This is the last in this series of articles. To learn more about the Carlow Men's Health Project and for details of how you can get involved contact Midge on 087 2033841.*

TIPS FOR A HEALTHIER LIFE

IF YOU missed our previous articles, don't worry: here are some basic tips to help you live a long and healthy life.

EAT HEALTHILY

- Eat a variety of fruits, vegetables, and whole grains every day
- Limit foods and drinks high in calories, sugar, salt, fat and alcohol
- Eat a balanced and varied diet to help keep a healthy weight
- See <http://weigh2live.safefood.au/> for more information on healthy eating.

BE ACTIVE

Be active for at least 30 minutes most days of the week. Include activities that raise your breathing and heart rates and that strengthen your muscles. See <http://www.irishheart.ie/iopen24/physical-activity-t-73.html> for more information.

PROTECT YOURSELF

- Wear helmets, seat belts, sunscreen, and insect repellent.
- Wash hands to stop the spread of germs
- Avoid smoking and breathing other people's smoke.

MANAGE STRESS

- Balance work, home, and play
- Get support from family and friends
- Stay positive
- Take time to relax
- Get seven to nine hours of sleep each night
- Get help or counselling, if needed

GET CHECK UPS

- Ask your doctor or nurse how you can lower your chances for health problems based on your lifestyle and personal and family health histories
- See your doctor or nurse as often as he or she says to do so. See him or her sooner if you feel sick, have pain, notice changes or have problems with medicine.
- See <http://www.cdc.gov/family/checkup/index.htm>.

NEWS

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4.7. Awareness Raising Questionnaire



Waterford Institute *of* Technology
INSTITIÚID TEICNEOLAÍOCHTA PHORT LÁIRGE

QUESTIONNAIRE CONSENT

Aim: To evaluate the work of the Carlow Men's Health project. This questionnaire should take no longer than 5 minutes to complete.

Researchers Script:

- *Would you mind if I asked you a few questions for a research study I am doing.*
- *It will take less than 5 minutes.*
- *I am evaluating the work of a local group.*
- *It is entirely anonymous and confidential and you are free to withdraw at anytime.*
- *The results will be used in my masters and to feedback to the local group.*

I confirm that I have had the **purpose and nature** of the study clearly explained to me and agree to participate in the study.

Signature: _____

(Explain that this page will be kept separate to the questionnaire)

4.7. Awareness Raising Questionnaire

1. Have you ever heard of the Carlow Men's Health Project?

Yes No

2. If yes, what do you know about CMHP?

3. Are you aware of any men's health promotion activities in Carlow over the past twelve months?

Yes No

If yes, please list activities you remember

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

4. Did you hear of any of the following?

Health Screening (<i>marts/social welfare</i>)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Radio Show (<i>South East radio</i>)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Health Program (<i>Tullow/Carlow town</i>)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Physical Activity Program (<i>Eire Og</i>)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

5. Do you read the Nationalist newspaper

Yes *If yes continue with questionnaire*

No *If no, skip to question 15*

6. Over the past 6 weeks, can you remember seeing any men's health articles in the Nationalist?

4.7. Awareness Raising Questionnaire

Yes No

7. Which articles do you remember seeing?

(Show articles to men individually and give men a chance to remember articles)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

*For those men **who recall** at least 1 articles continue with questionnaire
For those men **who do not recall** articles, skip to question 15*

8. Which of the following newspaper articles can you remember seeing?

1. Don't wait to visit GP

Yes

No

2. Stress/Unemployment

Yes

No

3. Avoiding isolation score

Yes

No

7. Prostate Cancer

Yes No

4. Physical activity

Yes

No

5. Healthy eating

Yes

No

6. Knowing your health

Yes

No

9. How much of the newspaper article have you read?

4.7. Awareness Raising Questionnaire

<u>Article</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
All of it thoroughly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than half	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than half	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Just flicked through it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None of it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Did you find the information in the article useful?

<u>Article</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>
Very useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somewhat useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not very useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not useful at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. What do you remember from the articles that you read?

(Show men titles if necessary and prompt - do you find that information was relevant to you/what did you find useful)

12. Have you learnt anything new from reading these newspaper articles?

Yes No

If yes, please explain.

13. Did you make any changes as a result of reading these articles?

4.7. Awareness Raising Questionnaire

Yes

No

If yes, please explain.

14. Did any of the articles make you think differently about your health?

Yes

No

If yes, please explain.

Skip to question 18

For those men who did not see articles ask the following having shown them articles

15. If you had seen this article in the paper, would you have read it?

Yes

No

16. After seeing the articles, do you think they would have got your attention?

Yes

No

17. Do you think the newspapers are a good way to reach men about their health?

Yes

No

If not, what are other ways of getting men's attention regarding their health

4.7. Awareness Raising Questionnaire

Continue with questionnaire

18. Any additional comments?

(please write any comments men made regarding articles here)

Demographics

19. Age: _____

20. Which of the following best describes your education?

- Primary education only
- Some or completed secondary education
- Some or completed third level education

21. In relation to your employment, are you?

- | | |
|---|--|
| Employed (full time) <input type="checkbox"/> | Employed (part time) <input type="checkbox"/> |
| Self employed <input type="checkbox"/> | Unemployed and looking for work <input type="checkbox"/> |
| Looking after home/family <input type="checkbox"/> | Retired from paid work <input type="checkbox"/> |
| Unable to work due to long term illness/disability <input type="checkbox"/> | Other <input type="checkbox"/> |

Thank you for your time

4.8. “Dummy” Article on Prostate Cancer

Action Prostate Cancer celebrates 3rd anniversary

By Gilda Howard Saturday May 16th, 2009



ACTION Prostate Cancer (an Irish Cancer Society initiative) celebrated its third anniversary when it launched its Prostate Cancer Awareness Week recently. Since its inception in April 2006, 10,000 people sought information and advice on prostate health, with 82% of those enquiries from men.

This illustrates that more than ever that men living in Ireland are taking positive action when it comes to their health, yet there are a still many who keep putting off going to their GP for this simple blood test which can point to the presence of prostate cancer, simply because they are afraid of being told that they have prostate cancer and they need treatment. A lot of different types of cancer can be cured if they are diagnosed in time and this also goes for prostate cancer which is one of the more curable ones if it is diagnosed in the early stages.

The latest data from the National Cancer Registry of Ireland states that 2,536 new cases of prostate cancer were diagnosed in 2007. The National Registry also estimates that there will be a 275% increase in the incidence of prostate cancer by 2020, which means that 3,768 new cases of prostate cancer will be diagnosed in 2020. Sixty-nine per cent diagnosed with prostate cancer survive for five years or longer.

Johnny Giles launched Prostate Cancer Awareness Week 2009. Typical calls from undiagnosed men relate to a raised prostate specific antigen blood test that can point to the presence of prostate cancer. Some are also anxious about waiting times for tests and investigations and have questions on prostate cancer. On the other hand, typical calls from diagnosed men relate to treatment options, especially the merits of hormone treatment and/or quality of life issues related to the consequences of treatment.

For further information or to obtain your copy of Manhood or any other publications or factsheets on erectile dysfunction, urinary incontinence and hormone therapy that are available from Action Prostate Cancer, please contact Freephone 1800 380 380 or email www.cancer.ie or via live cancer chat which is available at www.cancer.ie/chat (Monday to Thursday, 9am–7pm, Friday until 5pm).

4.9. CDC criteria used for assessment of articles

Message Content

- Have u limited your messages to three to four messages per document (or section)?
- Have you taken out information that is “nice to know” but not necessary?
- Is the most important information at the beginning of the document?
- Is it repeated at the end?
- Have you indentified action steps or desired behaviours for your audience?
- Have you post tested your materials?

Text appearance

- Does your document have lots of white space? Are margins at lease ½ inch?
- Is the print large enough (at least 12 points)? Does it serifs?
- Have you used bold, italics, and text boxes to highlight information?
- Have you avoided using all capital letters?
- Is the text justified on the left only?
- Did you use columns with a line length of 40 to 50 characters of space?
- Have you post-tested your materials?

Visuals

- Is the cover attractive to your intended audience? Does it include your main message and show who the audience is?
- Are your visuals simple and instructive rather than decorative?
- Do visuals help explain the messages found in the text?
- Are your visuals placed near related text? Do they include captions?
- If you read only the captions, would you learn the main points?
- Have you post tested your materials?

Layout and design

- Is information presented in an order that is logical to your audience?

4.9. CDC criteria used for assessment of articles

- Is information chunked, using headings and sub headings? Do lists include bullets?
- Have you eliminated as much jargon and technical language as possible? Is technical or scientific language explained?
- Have you used concrete nouns, an active voice, and short words and sentences?
- Is the style conversational?
- Have you post-tested your materials?

Translation

- Are the language and content culturally appropriate?
- Are the visuals culturally appropriate?
- Have you had the piece back translated?
- Is the translator fluent in the same linguistic variation as the intended audience?
- Have you post-tested your materials

Understandability

- Have you tested the complexity of the language used in your material for comprehension?
- Have you pre-tested your materials with members of your intended audience?
- Have you post-tested your materials with members of your intended audience?

5.1. Interview Schedule with CMHP partners – Year One

1. Describe your current job?

- Ethos of your organisation
- Approaches you use in your work
- Motivations/Frustrations

2. Describe the CMHP to someone who doesn't know anything about it?

- Evolvement of group?
- Your experience of it?
- What is CMHP trying to achieve?
- Strengths/Weakness of project and steering group?
- What are the challenges for the group?

3. What was your experience of Health Needs Assessment days?

- What purpose did they serve?
- Why were these days organised?
- What worked well/needs to be improved?
- What issues do you think will have emerged for these men?

4. The group have said that they want to develop a strategy to promote men's health in Carlow. How will you develop this strategy?

- What do you see as your role and the role of your organisation in the development and implementation of this strategy
- Challenges and opportunities in the development and implementation of this strategy
- If there is a list of 20 issues how will you prioritise these?
- Once prioritised what will have to happen to develop an action plan for addressing key issues.
- How is project going to be sustained?

5.2. Interview Schedule with CMHP partners – Year Two

Aim: To investigate how the CMHP worked together to engage vulnerable men in 2010

1. Could you describe how the CMHP has evolved in the last year?

- What was CMHP trying to achieve in 2010?
- How did group work together to achieve their goals?
- What was your experience of it? Group dynamics, communication, atmosphere etc
- What were the challenges of working in partnership? / How were these overcome?
- Could there have been value in adding new partners to the steering committee?

2. What was your experience of developing the strategy?

- What did you see as your role?
- How did the group work together to priorities needs identified?
- Strengths/Weakness of the steering group?
- How did the group come up with the 3 components? (short programmes, PR and Process)
- How were roles and responsibilities allocated?

3. What was your experience of and implementing the strategy?

- What role do you feel you played in implementing the strategy?
- What did you feel worked well/would need to do differently?
- What do you think men gained from this strategy in 2010?
- How did the group measure success of the strategy?

4. Future

- What did your agency gain from its investment in the CMHP?
- What do you see as you/your agencies input over the coming months?

Any further comments?

5.3. Focus Group with CMHP partners – Year One

Aim: to give participants the opportunity to discuss their experience of the CMHP to date and also to discuss their ideas for Phase 2 of the project

Introduction (10 minutes)

- Welcome participants and introduce yourself.
- Explain the general purpose of the discussion
- Explain the presence and purpose of recording equipment and introduce Barry.
- Outline general ground rules and discussion guidelines such as the importance of everyone speaking up, talking one at a time, and being prepared for the moderator to interrupt to assure that all the topics can be covered.
- Address the issue of confidentiality.
- Inform the group that information discussed is going to be analyzed as a whole and that participants' names will not be used in any analysis of the discussion.

I. Icebreaker question (5 minutes)

- Allow each person to speak about their feelings about the CMHP today

Topics

- Challenges faced by the group
- Opportunities to overcome these challenges
- Developing the strategy
- Action plan – Roles and Responsibilities
- Implementing the strategy
- Sustaining the strategy

II. Closing the focus group (5 minutes)

- “My hope for this group for 2010 is.....”

5.3. Focus Group with CMHP partners – Year One

Aim: to give participants the opportunity to discuss their experience of the CMHP in 2010 and their aspirations for the future

Introduction (10 minutes)

- Welcome participants and explain the general purpose of the discussion
- Explain the presence and purpose of recording equipment.
- Outline general ground rules and discussion guidelines such as the importance of everyone speaking up, talking one at a time, and being prepared for the moderator to interrupt to assure that all the topics can be covered.
- Address the issue of confidentiality.
- Inform the group that information discussed is going to be analyzed as a whole and that participants' names will not be used in any analysis of the discussion.

Icebreaker question (5 minutes)

- Allow each person to speak what has motivated them in their work with the CMHP during 2010

Topics

- Developing and implementing the strategy
- Action plan – Roles and Responsibilities
- Implementing the strategy
- Three components: Short programs, PR and Process
- Challenges faced by the group in 2010
- How did CMHP overcome these challenges
- Most successful and least successful aspects of the strategy
- Next step - Sustaining the strategy

III. Closing the focus group (5 minutes)

- “My hope for this group for the CMHP is.....”

Research Outputs

Awards

- Advanced Scholar Award for the School of Health Science in Waterford Institute of Technology for the Academic Year 2009/2010.
- Best poster presentation for the School of Health Science at the Research Day – 2010, Waterford Institute of Technology.

Presentations

- Kirwan, L., Lambe, B., and Carroll, P. Developing a strategy to address the health needs of vulnerable men in Carlow. Research Day. Waterford Institute of Technology, May 2010
- Kirwan, L., Lambe, B., and Carroll, P. Community based health checks for vulnerable men: Hook or Intervention? Multidisciplinary Approaches to Men's Health. National University of Ireland, Galway, June 2010
- Kirwan, L., Lambe, B., and Carroll, P. More than just a physical activity programme. Future perspectives for intervention, policy and research on men and masculinities. Quebec, March 2011
- Kirwan, L., Lambe, B., and Carroll, P. Implementation of a community based strategy to improve the health and wellbeing of vulnerable men. Research Day. Waterford Institute of Technology, April 2011